Midlife Suicide: Examination Through an Ecological and Interpersonal Lens

Jayna Bonfini

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MIDLIFE SUICIDE: EXAMINATION THROUGH AN ECOLOGICAL AND
INTERPERSONAL LENS

A Dissertation

Submitted to the School of Education

Duquesne University

In partial fulfillment of the requirements for
the degree of Doctor of Philosophy

By

Jayna E. Bonfini

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MIDLIFE SUICIDE: EXAMINATION THROUGH AN ECOLOGICAL AND INTERPERSONAL LENS

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ABSTRACT

MIDLIFE SUICIDE: EXAMINATION THROUGH AN ECOLOGICAL AND INTERPERSONAL LENS

By

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2019

Dissertation Supervised by Dr. Lisa Lopez Levers

Suicide has increased over the past decade among midlife adults in the United States. It is the fourth leading cause of death among persons aged 35–54 years and the eighth leading cause of death among persons aged 55–64 years. The primary purpose of this hermeneutic phenomenological study is to examine, describe, and understand the lived experiences of midlife adults who have contemplated suicide and who have sought assistance and support from their peers via an online forum for those with an interest in and/or history of suicidality. Bronfenbrenner’s (1977) bioecological model, Joiner’s (2005) interpersonal theory of suicide, and van Manen’s (1990) phenomenological method provide lenses through which these experiences may be understood. The four categories that emerged from the data include the following: biopsychosocial considerations, specifically physical decline and economic risk; mental health concerns stemming from psychiatric conditions;
illness; connectivity with others; and a desire to end pain. The findings suggest that experiencing suicidality as a midlife adult is a largely isolating experience and that online forums may provide a respite from loneliness and disconnection. This inquiry identifies relevant implications for counselor education and counseling practice as well as offering suggestions for future research.
ACKNOWLEDGEMENT

_Straight roads do not make skillful drivers – Paulo Coelho_

My path to a career as a clinician, educator, and supervisor was not a straight-forward one. I took a more circuitous route; some turns were small and effortless to navigate, while others were more like a switchback, making it very important for me to keep my eyes on the road. This dissertation process often seemed more like driving in circles. However, I kept driving through the stormy weather, detours, traffic, and stopped to ask for directions because I knew that there would be an open road just ahead. Through all my professional and personal experiences, I have learned the importance of pushing myself to take on tasks and responsibilities that thrust me into areas where I need to learn and grow. As I look toward the future, I would like to thank the people who participated in this process during my counseling and academic journey.

I am eternally grateful to Dr. Lisa Lopez Levers, my chair, mentor, teacher, and exemplar, for her patience and unwavering encouragement. From the number of hours spent reviewing research concepts to discussing my dissertation to your expert feedback, thank you for your time and sincere interest in my success. You have supported me, encouraged me, and challenged me and for that I am a better counselor, researcher, and person.

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Last, but certainly not least, I would like to recognize my family, especially my mother, husband, and children. I will never be able to pay you back for all the encouragement that you have given me over the years, but I will do my very best to pay it forward. Your continued patience and support helped me cross this finish line. Without you, this accomplishment would not have been possible.
TABLE OF CONTENTS

Page

ABSTRACT ........................................................................................................................................... iv

ACKNOWLEDGEMENT .................................................................................................................... vi

LIST OF TABLES .................................................................................................................................. xiv

LIST OF FIGURES .......................................................................................................................... xv

CHAPTER 1: INTRODUCTION ......................................................................................................... 1

  Background of the Study ......................................................................................................................... 4

  Suicide and the Helping Professions ......................................................................................................... 5

  Statement of the Problem ....................................................................................................................... 7

  Purpose of this Study .............................................................................................................................. 7

  Questions of the Study ............................................................................................................................ 8

  Data Source .......................................................................................................................................... 9

  Importance of the Study ......................................................................................................................... 11

  Theoretical Frameworks ....................................................................................................................... 12

    Ecological Development ..................................................................................................................... 12

    The Interpersonal Theory of Suicide .................................................................................................. 14

  Definition of Terms .............................................................................................................................. 15

    Acquired ability to enact lethal self-injury ............................................................................................ 15

    Ecological transition .......................................................................................................................... 15

    Human development .......................................................................................................................... 16

    Middle adulthood .............................................................................................................................. 16

    Baby boomer ................................................................................................................................... 16
Constructivism: ................................................................. 16

Generation X ................................................................. 16

Hermeneutic phenomenology: ........................................ 16

Perceived burdensomeness ........................................... 16

Suicide ............................................................................ 16

Suicide attempt ................................................................ 16

Suicidal ideation ............................................................. 16

Thwarted belongingness ................................................ 17

Delimitations and Limitations ........................................ 17

Assumptions .................................................................... 19

Organization of Study .................................................... 20

CHAPTER 2: LITERATURE REVIEW ........................................ 21

Methodology for Literature Review .................................. 23

Description of Literature Searches .................................. 23

Analysis and Synthesis of Selected Literature .................. 24

Development in Midlife .................................................. 25

Generational Profiles of Midlife Adults Today .................. 26

Baby Boomers ............................................................... 28

Characteristics of Baby Boomers .................................... 29

Baby Boomer Trends ....................................................... 30

Generation X ................................................................. 33

Generation X Characteristics ........................................... 34

Generation X Trends ....................................................... 35
Midlife Challenges ........................................................................................................... 40
Midlife Stress .................................................................................................................. 41
The Midlife Crisis .......................................................................................................... 42
Suicide ............................................................................................................................. 45
Suicide Risk Factors ...................................................................................................... 48
Internal Risk Factors ...................................................................................................... 49
Psychiatric Disorders .................................................................................................... 50
Military Service .............................................................................................................. 55
Personality Traits .......................................................................................................... 56
Race and Suicide ............................................................................................................ 57
Sex and Suicide .............................................................................................................. 60
External Risk Factors ...................................................................................................... 63
Interpersonal Risk Factors ............................................................................................. 67
Access to Firearms .......................................................................................................... 68
Economic Risk Factors .................................................................................................... 69
Protective Factors ........................................................................................................... 72
Methodological Literature ............................................................................................. 75
Phenomenology .............................................................................................................. 76
Hermeneutic Phenomenology ....................................................................................... 77
van Manen’s Framework ............................................................................................... 77
Theoretical Underpinnings ............................................................................................. 78
Bronfenbrenner’s Bioecological Model of Development .............................................. 79
Microsystem .................................................................................................................... 81
<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Revisiting the Research Question</td>
<td>186</td>
</tr>
<tr>
<td>Hypotheses Generated</td>
<td>191</td>
</tr>
<tr>
<td>Implications for Counseling Practice</td>
<td>192</td>
</tr>
<tr>
<td>Researcher’s Impressions</td>
<td>197</td>
</tr>
<tr>
<td>Limitations of the Research</td>
<td>197</td>
</tr>
<tr>
<td>Recommendations for Future Research</td>
<td>199</td>
</tr>
<tr>
<td>Conclusions</td>
<td>200</td>
</tr>
<tr>
<td>References</td>
<td>202</td>
</tr>
<tr>
<td>Appendix A</td>
<td>244</td>
</tr>
<tr>
<td>Appendix B</td>
<td>245</td>
</tr>
</tbody>
</table>
LIST OF TABLES

Table 1. Birth Years by Generational Cohort .................................................................27
Table 2. United States Number of Suicides by Region, 1996-2016........................................47
Table 3. United States Suicide Deaths by Race, and Sex, Ages 45-64, 1999 and 2014 ..............58
Table 4. Race and Ethnicity of Suicide Decedents with and without Known Mental Health
       Conditions, 2015 ........................................................................................................59
Table 5. Suicide Deaths by Age, Method, and Sex, 2016 .......................................................62
Table 6. Durkheim’s Relational Structures and Forms of Suicide ...........................................64
Table 7. Suicide Rates by Sex and Age, 1999-2016 ..............................................................94
Table 8. Methodological structure ......................................................................................117
Table 9. Description of Five Quality States for Trustworthy Criterion of Authenticity ..........136
Table 10. Suicide Forum, Antiquitie’s Friends Forum, 2014 ..................................................140
Table 11. Organizing Categories and Themes .......................................................................142
Table 12. Categories, Themes, and Examples from Data Analysis .........................................143
Table 13. Cross Thread Comparison: Biopsychosocial Considerations .................................153
Table 14. Cross Thread Comparison: Mental Health Concerns .............................................161
Table 15. Cross Thread Comparison: of Response Type.......................................................168
Table 16. Cross Thread Comparison: Connectivity ...............................................................169
Table 17. Cross Thread Comparison: Desire to End Pain ....................................................170
Table 18. van Manen’s Lived Existentials and Quotations of Significance ............................174
# LIST OF FIGURES

<table>
<thead>
<tr>
<th>Figure</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Nested System Level Influences in Bronfenbrenner's Bioecological Theory</td>
<td>13</td>
</tr>
<tr>
<td>2</td>
<td>Joiner’s Interpersonal Theory of Suicide</td>
<td>15</td>
</tr>
<tr>
<td>3</td>
<td>Visual Overview of Literature Review Content</td>
<td>22</td>
</tr>
<tr>
<td>4</td>
<td>Bronfenbrenner’s Bioecological Model</td>
<td>81</td>
</tr>
<tr>
<td>5</td>
<td>Suicide in Midlife in the United States by Age and Decade</td>
<td>96</td>
</tr>
<tr>
<td>6</td>
<td>Mortality by Cause, White non-Hispanics ages 45–54</td>
<td>98</td>
</tr>
<tr>
<td>7</td>
<td>Guiding Philosophical and Methodological Framework for Study</td>
<td>105</td>
</tr>
<tr>
<td>8</td>
<td>Depiction of the Hermeneutic Circle</td>
<td>114</td>
</tr>
<tr>
<td>9</td>
<td>Intersection of Themes</td>
<td>173</td>
</tr>
<tr>
<td>10</td>
<td>Visual Model of the Four Existentials</td>
<td>189</td>
</tr>
</tbody>
</table>
CHAPTER 1: INTRODUCTION

Mr. Murray struggled with major depression for most of his adult years, even as he married, raised two children, and owned a successful lawn-maintenance business. In 2004, a back injury forced him to go on disability and on powerful, addicting pain medications. In 2010, he attempted suicide twice via overdose and was revived in the emergency department at his local hospital. Then, two days after his 49th birthday in 2011, he killed himself with a shotgun (Bahrampour, 2013). His wife described him as a perfectionist, a man who did everything well. Though he was grateful for his disability checks, it was very hard for him to accept that he was not contributing to his family in the way he once had. He felt diminished.

Mrs. Jones, a woman in her late 50s, whispers to her doctor, “I just can’t do this anymore,” as she lies in her hospital bed in the intensive care unit (Riddle, 2016). Except for the bandage around her neck and hospital gown, she is well-kempt, looking as though she could be going to lunch with friends. When her doctor asks what it is, specifically, that she cannot do, she replies, “Life” (Riddle, 2016). Mrs. Jones once had a life full of friends and family, with children and grandchildren to keep her busy. However, her husband died suddenly five years ago, and her friendships faded with her widowhood. With her kids busy as well, Mrs. Jones did not find a reason to get out bed in the morning. To end her pain, Mrs. Jones tried to end her life; underneath the bandage is a self-inflicted stab wound (Riddle, 2016).

Mr. Murray and Mrs. Jones represent an increasingly common situation among the middle-aged, with many factors – depression, drug addiction, chronic pain, job loss, loss of status, relationship difficulties – contributing to what they believe is a permanent solution to end their pain. In 2016, suicide ranked 10\(^{th}\) as a frequent cause of death among Americans (Centers for Disease Control and Prevention [CDC], 2016). From 1986 to 1999, suicide in the United...
States was on a steady decline, but that trend reversed and has increased steadily in the 15-year-period from 1999-2014 (Curtin, Warner, & Hedegaard, 2016; Hu, Wilcox, Wissow, & Baker, 2009). These rates remained elevated in 2015 and 2016 (Stone et al., 2018), and by 2016, Americans were nearly twice as likely to die by suicide as from homicide.

Specifically, suicide has increased over the past decade among midlife adults (Curtin et al., 2016). It is the fourth leading cause of death among persons aged 35–54 years, and the eighth leading cause of death among persons aged 55–64 years (Curtin et al., 2016; Hedegaard, Curtin, & Warner, 2018; Hempstead & Phillips, 2015); in fact, it is one of just three leading causes of death that are increasing (Kochanek, Murphy, Xu, & Arias, 2017). Between 1999-2016, nearly every state in the United States experienced an increase in its suicide rate (Stone et al., 2018). The single exception was Nevada, a state that already had a higher-than-average suicide rate.

The increase seems more recognizable to the general public, according to a report about the trends in suicide rates by the Centers for Disease Control and Prevention (Stone et al., 2018), which was released in early June 2018. This report was quickly disseminated by the national news media (Greenfield Boyce, 2018; Scutti, 2018). During the same week that this report was released (Stone et al., 2018), acclaimed fashion designer Kate Spade took her own life. Three days later, chef and television personality Anthony Bourdain also died by suicide. Sadly, high profile deaths by suicide often lead to an uptick in suicide or suicidal ideations. Andrew Solomon, writing in the June 8, 2018 New Yorker, explained:

High-profile suicides such as these cause copycat suicides; there was a nearly ten percent spike in suicides following Robin Williams’s death. There is always an upswing following such high-profile events. You who are reading this are at statistically increased
risk of suicide right now. Who knows if Bourdain had read of Kate Spade’s suicide as he prepared to do the same thing? (Solomon, 2018).

An upswing in the wake of high-profile suicides might already be in motion. Pamela Elarabi, a 49-year-old mother in New Jersey, took her own life on June 22, 2018 (Paul, 2018). Earlier in the month she had posted on Facebook about the suicides of Kate Spade and Anthony Bourdain while acknowledging her own suffering (DailyMail, 2018). Two weeks later, she cryptically posted disturbing messages to the social media platform (Paul, 2018). Her last post was an image of her preparation for her own suicide via the same method as Spade and Bourdain. This image remained on her Facebook page for three days for all of her “friends” to view (DailyMail, 2018; Paul, 2018). Elarabi’s family and friends implored Facebook to remove the disturbing images, but it was her 26-year-old daughter who located her mother’s password in a notebook and removed the post (Paul, 2018).

The National Center for Health Statistics released their own data about the increase in suicide rates in early June 2018 (Hedegaard et al., 2018). The statistics revealed a troubling trend: suicide rates increased on average by about 1% per year from 1999 through 2006 and by 2% per year from 2006 through 2016 (Hedegaard et al., 2018). Not only is the rate of suicide increasing but also the gap between men and women in terms of completed suicides has narrowed considerably. Most compelling in the data was the life-stage in which the increase in suicide rates is most apparent: midlife adulthood (Curtin et al., 2016; Hedegaard et al., 2018).

Once thought of as the developmental stage in which individuals have achieved significant accomplishments in their careers and relationships, it is recognized today that midlife also brings challenges that may have been overlooked. In the academic literature, midlife seems to be the terra incognita of human development (Lachman, 2004). We seem to know less about
the experiences of those in the three decades between 35 and 64 than any other age group
(Kuehn, 2014; Maris, 1995). To address this gap, the goal of this study was to examine and
explicate suicidality in this stage of development through those with lived experiences of this
phenomenon.

**Background of the Study**

Suicide may be simply defined as intentionally ending one's own life. It is a tragic event
with strong emotional and economic repercussions for its survivors, for the families of its
victims, and for society. There are multiple causes for suicide. Exacerbation of an underlying
psychiatric diagnosis is a primary stressor for suicide, in particular diagnoses of major depressive
disorders, bipolar disorder, and/or substance abuse (Mann, 2003; Mościcki, 1995; O’Boyle &
Brandon, 1998). Suicide prevention is often oriented toward mental health conditions alone.
Prevention is usually consisting of three steps: identifying suicidal persons, treating mental
health conditions, and preventing reattempts. However, the most recent data reported by the
CDC found that approximately half of reported suicides did *not have a known mental health
condition* (Stone et al., 2018). Thus, it is probable that many in this population of suicides were
not diagnosed (or properly diagnosed), given that mental disorder is a strong predictor of suicide.
Psychological autopsy studies suggest that 50–90% of people who die from suicide suffer from a
diagnosable mental disorder (Cavanagh, Carson, Sharpe, & Lawrie, 2003; Ernst et al., 2004;
Leenaars et al., 2018). However, it should be noted that some researchers believe that
psychological autopsy studies are methodologically flawed because it is difficult, if not
impossible, to assign a reliable diagnosis of a mental disorder to a deceased person by
interviewing someone else (Hjelmeland, Dieserud, Dyregrov, Knizek, & Leenaars, 2012). It also
is known that the risk of suicide accumulates over time. Thus, additional focus on non-mental
health factors may provide important information for those seeking to identify and counsel adults struggling with suicidality. These risk factors interact with broader areas of personality, neurobiology, culture, and life stressors, such as grief and loss, financial set-backs, legal/criminal matters, and unemployment (Leenaars et al., 2018; Stone et al., 2017).

Although the largest increase in the number of suicides in the United States since 1999 has occurred among people ages 45 to 54, many suicide prevention programs focus solely on helping adolescents navigate their suicidal ideation. Given the raw data on suicidality and its trends, comprehensive suicide prevention strategies and activities are necessary to address the full range of factors relating to suicide across the lifespan. Midlife adults are often juggling caregiving and support responsibilities for their families. Therefore, they may require additional supports outside of interventions from clinicians. Stone et al. (2017) suggested that prevention strategies ought to include strengthening economic supports, such as housing stabilization policies and household financial support, and teaching coping and problem-solving skills. Promoting social support is particularly necessary for persons at risk, such as military veterans, as is creating protective environments (e.g., reducing access to lethal means among persons at risk for suicide). These ideas and interventions across multiple layers of society are recommended to support midlife adults on a variety of levels (Stone et al., 2017). A study such as the one proposed here investigates those factors that midlife adults consider most critical to their lives in order to design interventions that may alleviate suicide risk in this developmental stage.

**Suicide and the Helping Professions**

Those in the helping professions cannot turn away from the reality of suicide and increased risk in this population. It cannot be ignored, nor can it be assumed that others will step
in to meet the challenges arising from an increased risk of midlife suicide. The role of professional counselors is to be clinically competent, proactive, and able to diagnose, treat, or appropriately refer an individual at an early stage of mental health disorder or significant life stressor. For a mental health practitioner in any setting, being clinically competent means being informed about suicide, suicidal behaviors, and suicidal ideation in all stages of the human lifespan.

Professional counselors are trained to assess for suicidality, yet existing suicide prevention programs are geared toward intervening when individuals are actively and intensely contemplating suicide, or are engaging in suicidal behaviors or a suicide attempt (Capuzzi & Gross, 2014). Such an approach seems odd, given that the vast majority of practicing mental health counselors will encounter a suicidal client in the course of their careers (Brown & Salvatore, 2017). Findings from this study may offer insight into specific cues (e.g., feelings of hopelessness, lack of familial or societal connection) that could be used to identify at-risk adults. Thus, such adults may be identified earlier by clinicians and, consequently, be referred to the appropriate level of care and outside resources before they exhibit more severe suicidal behavior. Additionally, the results of this study could be applied to developing specific psychoeducational workshops for clinicians and counselors-in-training to hone their clinical skills in preventing, identifying, and treating suicidal adults. Finally, results from this study may be used as the foundation for broader interventions that could be implemented by agencies, health systems, or non-profit organizations (e.g., National Alliance for Mental Illness) to improve societal connections for struggling midlife adults and their families, consequently reducing individuals’ risk for suicide and fostering their resiliency.
Statement of the Problem

Despite the increased prevalence of suicide among middle-aged adults, specific literature on this population beyond the numbers is unavailable. It seems that not much is known about midlife suicides. Almost all the empirical studies of suicide prevention have focused on adolescents (Gould, Greenberg, Velting, & Shaffer, 2003) and the elderly (Lapierre et al., 2011), likely because data collection may be more efficient in the schools, hospitals, or primary care offices frequented by these two groups. Indeed, in 1999, the year that began the uptick in midlife suicidality, the office of the Surgeon General of the United States specifically emphasized suicide prevention in adolescents and elderly in its national suicide prevention agenda (Davidson, Potter, Ross, & Public Health Service (DHHS), 1999). Thus, midlife suicide requires further examination to provide clarity to an otherwise murky situation.

It is a major societal problem that suicide rates for people in middle age are higher than for other age groups in the United States, and this rate is rising quickly. Understanding why suicide is on the rise in this age group is just as important as—if not more than—knowing who is choosing to die and how. Middle-aged suicide seems especially catastrophic as it implies resignation and a sad acknowledgment that if things are not better at this life stage, they might never be. Additionally, the voices of those who have survived an attempt and/or those who are contemplating this final solution are rarely articulated in the literature. These voices ought to be heard to provide a more nuanced view of their struggles so that counselors and other helping professionals may intervene.

Purpose of this Study

Given the background and nature of the research problem described, the primary purpose of this hermeneutic phenomenological study was to examine the lived experiences of midlife
adults who have contemplated or are contemplating suicide, and who are seeking assistance and support from their peers via an online forum for those with the same interest in and/or history of suicidality. Though this study employed a specific forum on a specific site during a specific year, it may reveal some of the factors involved in the general rapid increase of completed suicides in midlife.

**Questions of the Study**

A thorough review of the literature related to suicide and midlife adults revealed a paucity of research on this topic. Thus, this study addressed the lived experiences of middle-aged adults who are contemplating suicide or have done so. This exploration lent itself to a phenomenological approach to discover the meaning an individual ascribes to his or her own experiences. To design questions for this study for discovering what contemplating suicide in midlife is really like, van Manen’s (1990) hermeneutic phenomenological method was used. It has been suggested that researchers in a qualitative study develop a central question and state it as broadly as possible (Creswell, 2009). The questions should also be asked in such a way that they become working guidelines, not conventional truths. Given these descriptors, the guiding question for this study was as follows: How do midlife adults contemplating suicide describe their experiences—their feelings, thoughts, assumptions, and/or situations for ending their lives?

The guiding question prompted subsidiary questions that reflected the concept of the lived existentials (van Manen, 1990), the ecological theory of human development (Bronfenbrenner, 1977), and the interpersonal theory of suicide (Joiner, 2005). The four dimensions of the existentials address the experiential depth of a person’s world and were a guide for reflection throughout this research process: lived space (spatiality), lived body (corporeality), lived time (temporality), and lived human relation (relationality or communality)
The ecological model posits the linkages of systems that interactively exert protective or risk-enhancing factors on each person’s propensity for suicide over time. Finally, the interpersonal theory of suicide provided a lens for ascertaining three attributes that suicidal midlife adults may possess—and which may have contributed to—their current thoughts, feelings, and situations: a thwarted sense of belongingness, perceived burdensomeness to society, and an acquired capability to overcome the pain and fear of suicide (Joiner, 2005).

Following the phenomenologically-oriented approach and the theoretical framework, the three subsidiary questions were formulated as follows: 1) What meaning is derived from the struggle of suicidality? 2) What factors seem to enhance or diminish suicidality? 3) How are individuals struggling with suicidality interacting with anonymous peers on an online message board? These subsidiary questions formed a guiding structure for the analysis in Chapter 3.

**Data Source**

This study explored the phenomenon of midlife suicide using a publicly available message board on Suicide Forum (www.suicideforum.com) that individuals contemplating suicide might visit for resources (e.g., crisis hotline information) and anonymous peer interaction and support. Suicide Forum started in 2005 as a peer-to-peer support site, staffed entirely by volunteers. No staff or members on Suicide Forum have any specialized training or therapeutic skills. It is a place for peers to meet and discuss issues with peers. Members in genuine crisis or at risk of harming themselves are advised to seek proper professional support and return to Suicide Forum when the crisis is over for continued peer support.

The support forums on the site contain over 120,000 discussion threads and more than 1.4 million replies. The main priority of Suicide Forum is to provide resources and references that may help individuals facing daily issues and mental health challenges, and positive pro-living
support in a safe, non-religious affiliated environment. The support forums offer the insight only possible to those who have dealt with the same issues faced by the members. This allows all who visit and post to the forums to speak anonymously in a safe environment without fear of judgment or harassment.

Specifically, the forum entitled “Antiquitie's Friends,”¹ which is for the middle-aged who are struggling with suicidal thoughts or are sharing their prior experiences with suicidality, was used for this study: all of the posts for 2014 were analyzed in order to examine trends as the year progressed (e.g., assess if the uptick in suicides during the summer months was reflected qualitatively or if the risk decreased during the holidays). In 2014, actor Robin Williams was one of 44,000 individuals in the United States who took their lives (sadly, the 2016 data indicates that it is now nearly 45,000; CDC, 2017), many of whom were in midlife. As mentioned previously, a high-profile suicide is thought to heighten the risk of suicidal behavior (Solomon, 2018), and it was hoped that comparing the posts for the year of Williams’s death might illuminate the reasons why the risk remains heightened. Additionally, 2014 was the most recent year of data included when the CDC first released their report detailing the uptick in the suicide rate over a 15-year period (1999–2014), propelling the issue from the desks of health statisticians to our consciousness (Curtin et al., 2016).

The posted contributions of individuals in the population under examination were valuable for providing an account of the phenomenon of those considering (or attempting)

¹ In 2016, the Suicide Forum made several changes to its website. Among these changes was the migration of the postings from the Antiquitie’s Friends Forum to the archive and the creation of new forum topics. One of these main topics is the “Generation Gap” forum that contains categories for individuals at various stages of life, including “Midlife and getting older,” among other developmental categories. However, for this study, the Antiquitie’s Friends Forum will be accessed via the archived posts.
suicide in midlife. A secondary purpose of this study was to provide a foundation of research that would illuminate the experiences of midlife adults contemplating suicide in ways that can contribute to professional counseling, with a special emphasis on enhancing counselors’ understanding of suicide risk-enhancing and risk-diminishing factors in this life stage.

**Importance of the Study**

Suicide is a serious public health problem. Rates of suicide have been on the rise for more than a decade. The economic costs alone are astronomical, amounting to billions of dollars each year (Saxena, Krug, & Chestnov, 2014). Its human impact has a ripple effect that is far-reaching, as each one of us likely interacts with suicide survivors, those with lived experience, and those with thoughts of suicide on a daily basis—at home, at work, and in our communities.

Fortunately, like many societal problems, suicide is preventable. Through awareness, education, and action, the suicide rate in midlife and across the lifespan may subside. The current study contributes to academic research in that it fills a gap by augmenting the understanding of midlife individuals who have struggled with suicidality and of the uptick in completed suicides nationwide. Suicide contagion may be defined as indirect exposure to suicide or suicidal behaviors that influences others to attempt to kill themselves. As Solomon (2018) explained, publicity around suicide (such as that which occurred after Robin Williams’s 2014 death and the deaths of Kate Spade and Anthony Bourdain in June 2018) is thought to heighten the risk. In the days that followed the deaths of Spade and Bourdain, the United States Suicide Prevention hotline (1-800-273-8255) saw a 25% spike in calls (Korte, 2018). Thus, this study is quite timely, having relevance and importance for counselor educators, supervisors, and clinicians, as well as other public health fields, for identifying the meaning and factors behind the raw numbers, and ultimately designing interventions to halt the increasing rates.
Theoretical Frameworks

The conceptual assumptions, informed by the phenomenologically-oriented approach of inquiry, are bolstered by Bronfenbrenner’s ecological theory of human development and Joiner’s interpersonal theory of suicidal behavior, both of which served here as a basis to examine the phenomenon of midlife suicide. The theme of the phenomenologically-oriented approach is intentionality, which requires researchers to bracket their common sense, prior knowledge, and assumptions (van Manen, 1990). It also is critical to recognize the assumptions of the two theories of the theoretical framework for this study. These theories presuppose the proximal and distal, intrapersonal and interpersonal, and other interactional factors that contribute to midlife suicidality. Examining the assumptions that underlie these theories enables the researcher to detect the unique experiences, as well as those in common, of the individuals under investigation.

Ecological Development

In this study, the ecological theory of human development was used as one of the theoretical instruments for examining midlife suicide. This theory assumes that ecological transitions and changes take place throughout the lifespan (Bronfenbrenner, 1979). Individuals develop in the context of one or more microsystems, such as family, peer group, or workplace, and in turn, these microsystems cluster together into a group of microsystems, also called a mesosystem, which is nested in the macrosystem (e.g., culture). Figure 1 provides a conceptual model of Bronfenbrenner’s bioecological model.
Figure 1. Nested System Level Influences in Bronfenbrenner's Bioecological Theory

As Figure 1 demonstrates, the systems are nested within one another. Much of the existing research on predicting or preventing suicidal behavior has involved implicitly or explicitly identifying important risk and protective factors within one or more systems (Borowsky, Ireland, & Resnick, 2001; Laser, Luster, & Oshio, 2007; Pietrzak et al., 2010). For midlife adults who are contemplating suicide, besides negotiating the typical transitions that relate to growing older, they are dealing with factors such as living in an unstable economy, political divisions, cultural tribalism, and the world at war (again). This is in conjunction with navigating a society that obsessively values youth. The conceptual assumptions of the ecological theory of human development offer a relevant perspective for understanding the people, important social ties, and other factors in the environment that influence midlife adults who are contemplating suicide.
The Interpersonal Theory of Suicide

Thomas Joiner (2005) articulated the interpersonal theory of suicide, asserting that when individuals hold two specific psychological states in their minds simultaneously, and when they do so for long enough, they develop a desire for death. The two psychological states are perceived burdensomeness and a sense of low belongingness or social alienation. Self-preservation is a powerful enough instinct that few individuals may overcome it. However, the few who have developed a capability for suicide have lost their fear of pain, injury, and death; then, according to Joiner (2005), they acquire the capacity for suicide. Such people often have a history of self-injury, but they can have other experiences as well, such as repeated accidental injuries and numerous physical fights, or be in occupations like physicians, nurses, construction, or military personnel where exposure to pain and injury, either directly or vicariously, is common.

Individuals will not die by suicide unless they have both the desire to die by suicide and the ability to do so (Van Orden et al., 2010). This typically occurs after they have held the view of burdensomeness and lack of belonging for an extended period, leading to feelings of hopelessness about their life situation and the desire to do something about it (Joiner, 2009). The Venn Diagram in Figure 2 demonstrates how the elements in Joiner’s theory interact (Van Orden et al., 2010).
Figure 2. Joiner’s Interpersonal Theory of Suicide

Taking this into consideration, the conceptual underpinnings of the interpersonal theory of suicide offer a relevant perspective for understanding the individuals contemplating suicide in midlife and how they view their role in the lives of others and in society writ large.

Definition of Terms

Several concepts needed to be defined for purposes of this inquiry. The meanings of these concepts as used in this investigation are provided below.


Ecological transition: Experiences that occur “whenever a person’s position in the ecological environment is altered as the result of a change in role, setting, or both” (Bronfenbrenner, 1979, p. 26).
Human development: “Lasting change in the way in which a person perceives and deals with his environment” (Bronfenbrenner, 1979, p. 3).

Middle adulthood: For purposes of this study, middle adulthood or midlife consists of individuals between the ages of 35 and 64 in 2014.

Baby boomer: Those persons born between January 1, 1946 and December 31, 1964. They have been characterized as optimistic, competitive, and ambitious (Lancaster & Stillman, 2003).

Constructivism: A philosophy that seeks to explain how knowledge is constructed in human beings through their experiences (Schwandt, 2007).

Generation X: Those persons born between January 1, 1965 and December 31, 1980. Also known as the “slacker generation” or 13th generation, they have been characterized as skeptical, independent, and entrepreneurial (Lancaster & Stillman, 2003).

Hermeneutic phenomenology: A research methodology aimed at producing rich textual descriptions of the experience of selected phenomena in the world of individuals who are able to connect with the experience of all collectively (Smith, 1997). The goal of this methodology is to produce rich meaning in terms of the essence of lived experiences (Laverty, 2008).

Perceived burdensomeness: Perception that one is a burden and the perception that this state is permanent and stable, and that death is a solution to the problem (Joiner, 2005, p. 98)

Suicide: Death caused by self-directed injurious behavior with intent to die as a result of the behavior (CDC, 2017a).

Suicide attempt: A non-fatal, self-directed, potentially injurious behavior with intent to die as a result of the behavior (CDC, 2017a).

Suicidal ideation: Thinking about, considering, or planning suicide (CDC, 2017a).
**Thwarted belongingness:** Unsatisfied need to belong via interactions with others and a feeling of being cared about (Joiner, 2005, p. 96).

**Unobtrusive measures:** methodologies which do not involve direct elicitation of data from the research subjects (Webb et al., 2000).

**Delimitations and Limitations**

Given that part of my objective in conducting a study was to communicate a problem and its significance as comprehensively as possible, it is important to explicate clearly the delimitations and ensuing limitations of the study. Doing so helps to clarify the potential boundaries of the study and factors that may be outside of the researcher’s control, but which were also evaluated as constituting a part of the overall design and analysis. Delimitations refer to study parameters that were under the researcher’s control but that still had the potential to affect the study (Roberts, 2010). The following four delimitations are associated with this study.

First, the study participants were delimited to those individuals who self-identified as middle-aged adults. As user information is anonymous, it is possible that those younger than the target group (unlikely) or older (more likely) may have posted in that forum. It also was difficult from the posts to know the sex of an individual; thus, an accurate account of sex-related differences was not fully possible.

Second, the study participants were delimited to English speakers who had access the World Wide Web, created a unique user name, and posted online based on their lived experiences. Many people are anonymous members of Suicide Forum and do not post to the site. These individuals use the Forum to get information and links to support or to read the postings and exchanges of others; however, they do not themselves post a desire for assistance, nor do they respond to other members.
Third, a further delimiting factor was the type of post included for this study. For example, a single post with no response was not included, nor was a post with one response, purportedly answering a question or providing feedback. The posts under examination included at least two responses. consisting of an initial post followed by more than one reply or an initial post, a reply, and a concluding post by the initial poster.

Fourth and finally, I must recognize that as a constructivist researcher, I was the human instrument for data collection. Thus, as a novice researcher, my abilities to interview effectively, analyze the data, and identify themes must be considered a delimitation as such could have affected the overall findings.

The delimitations also inform several ensuing limitations. Limitations are defined as study parameters that were not controlled by the researcher yet have the potential to affect the study (Roberts, 2010). There were two primary limitations. First, the intent of this study was to provide rich description so that readers might be able to transfer the ideas into their unique context, rather than attempting to generalize across populations. It is relevant to note, however, that the delimitations cited above (e.g., participants’ meeting specific criteria) may restrict the transferability of the findings. Second, a reliance on previously published literature on the topic that surfaced through the database searches from a United States research institution was a limitation on the knowledge that could be obtained to inform the study, particularly the data analysis and interpretation. The delimitation regarding the capability of the constructivist researcher informs this limitation, as it may affect the data obtained, subsequent analysis, and interpretation of the themes. The result might affect the description provided for the reader, which can also influence transferability.
Assumptions

Assumptions help the researcher to identify clearly what is taken for granted in the study (Roberts, 2010). Several assumptions informed the pursuit of this research study, as identified below.

1. Developing a deep understanding of the lived experiences of midlife individuals who have struggled with suicidality was best accomplished through a constructivist inquiry paradigm and hermeneutic phenomenology methodological tradition because this approach allowed for co-construction of multiple views.

2. The largely open dialogue in Suicide Forum, and user anonymity facilitated discussion in such a way that the real lived experiences of the individuals would be describable and interpretable.

3. The initial posters and their respondents provided open, honest feedback and clarifying questions, which informed the thicker descriptions. This furthered the understanding of the phenomenon being studied.

4. While the term “midlife” as defined for this study encompasses two generational cohorts, Baby Boomers and Generation X, each generation has unique characteristics, values, and preferences that are may not be represented in other generational cohorts. Thus, an assumption is that there are discernible differences among the cohorts.

5. Finally, this study may illuminate the experiences of midlife adults contemplating suicide and may explain, in part, the uptick in the suicide rate among individuals in this developmental category.
Organization of Study

In Chapter 1, I have described the background of the study, the importance of the study, and its significance. Chapter 2 offers a review of the literature, including a summary of the current available data on midlife suicide and an examination of suicide risk-enhancing and risk-diminishing factors. The chapter concludes with an in-depth discussion of the theoretical grounding for the study. Chapter 3 explains the methodology and design of the study and includes a discussion of the procedures by which the data was gathered and interpreted, the specifics of the methodology of the study, and the approach to research design. Chapter 4 provides the results of the data collection. Chapter 5 consists of an explication and analysis of the data, the implications for the field of mental health treatment, and suggestions for further study.
CHAPTER 2: LITERATURE REVIEW

In a paper articulating the centrality of the literature review in educational research—specifically in doctoral dissertations—Boote and Beile (2005) remarked, “To be useful and meaningful, educational research must be cumulative; it must build on and learn from prior research and scholarship…” (p. 3). To that end, the goal of this chapter is to provide the foundational theories and a review of the significant literature relating to midlife development and suicide. This task, in and of itself, could be a Herculean effort. The literature about each of these topics separately has been extensively studied and researched for both academic and clinician-based publications.

To focus this literature review, this chapter has the following objectives, as depicted in Figure 3: to (a) define and provide the theoretical underpinnings of the generations of midlife adults today; (b) characterize the two primary generational cohorts for this study – Baby Boomers and Gen Xers – and highlight current economic and cultural trends that may be affecting their lived experiences; (c) provide and define the theoretical and empirical underpinnings of suicide; (d) discuss suicide’s current trajectory in the United States, as well as its risk and protective factors; and, (e) synthesize and summarize the literature.
Figure 3. Visual Overview of Literature Review Content
Methodology for Literature Review

A literature study was undertaken to review, critique, and synthesize representative literature concerning two generations (Baby Boomer and Generation X), suicide prevalence data, suicidal risk and protective factors, and phenomenology. Although the constructs of various generations and suicide have depth and breadth in terms of academic research, knowledge relating to the recent uptick in midlife suicide is sparse. Because a literature review is inherently a process that requires sampling (Boote & Beile, 2005), the sampling criteria for the database searches needed to be determined first. As such, primary data sources were obtained from the library at Duquesne University in Pittsburgh, Pennsylvania, in the United States. Search terms came from the counseling and psychology, human development, and education fields; and databases included Academic Search Elite, PsychArticles, PsycINFO, and ERIC. Other sources of medical and psychological interest were obtained through the PubMed® Central, a free full-text archive of biomedical and life sciences journal literature at the U.S. National Institutes of Health's National Library of Medicine, located online at https://www.ncbi.nlm.nih.gov/pmc/.

Description of Literature Searches

The research was obtained through an extensive search of scholarly, peer-reviewed journals, historical texts, and contemporary counseling and psychology readings. The key subject areas included (a) Baby Boomers, (b) Generation X, (c) cultural and societal changes during midlife generations, (d) suicide rates, (e) risk factors of suicide, (f) protective factors of suicide, (g) midlife (or middle age) suicide, (h) phenomenology, and (i) hermeneutic phenomenology. For the generation searches, most of the literature was recent, defined as being published within the past 15 years (2003-2018). Suicide research was taken from the past quarter century because the uptick in suicide rates began in 1999 after a decade of decline. Many of those studies and
data reports from various governmental agencies have relevance to this study; therefore, they were included in the literature review.

Several academic and clinician publications augmented the database searches. These texts were foundational to understanding the study’s constructs, and they are included in the literature summary. Specifically, for a historical and theoretical understanding of generations, Strauss and Howe’s seminal work *Generations* (1991) was used. Bronfenbrenner’s *The Ecology of Human Development: Experiments by Nature and Design* (1981) and Joiner’s book, *Why People Die by Suicide* (2005) provided the theoretical underpinnings of this work and were heavily employed. Finally, *Researching Lived Experiences* by van Manen (1990) provided the hermeneutic phenomenology methodology used in this study.

**Analysis and Synthesis of Selected Literature**

Given that literature reviews are concept centric, a thoughtful approach to analysis and synthesis of the selected articles is critical (Boote & Beile, 2005). Literature was selected for inclusion that provided for a greater understanding of the topic being researched. Specifically, a journal article or text was selected if it was judged as enhancing an understanding of suicidality in midlife. Articles were also selected if they helped provide a better understanding of the trends that may be affecting the lived experiences of midlife adults. Literature was excluded if it involved specific populations other than those in midlife. Moreover, as the focus for this study was individuals in the United States, the selected literature was limited to that relevant to this country. All articles deemed to meet the criteria were selected to be examined for potential inclusion in this study’s literature review.
Development in Midlife

Thoroughly unprepared, we take the step into the afternoon of life. Worse still, we take this step with the false presupposition that our truths and our ideals will serve us as hitherto. But we cannot live the afternoon of life according to the program of life’s morning, for what was great in the morning will be little at evening and what in the morning was true, at evening will have become a lie (Jung, 1933, p. 108).

Jung’s afternoon of life, or midlife, has recently been of interest to “scholars of the lifespan” because the demands of middle adulthood are different from those earlier in the lifespan and require adjustments to negotiate life changes (Lachman, 2004, p. 306). First appearing as a term in Funk and Wagnall’s Standard Dictionary in 1895, “midlife” is defined as the “part of life between youth and old age” (Cohen, 2012). Midlife is the central period of a person's life, spanning from approximately age 40 to age 65 (Psychology Today, 2018). Lachman noted that middle-aged adults, often seen as “sandwiched” between the role of child and that of parent, are often linked to the welfare of others (e.g., children, parents, coworkers). While adults in midlife have much to offer society, they must address their own needs as well, particularly since chronic illness or disease may surface during midlife (Lachman, 2004, p. 306-307). Despite this importance, less is known about this period of development than other periods, such as infancy or old age (Lachman, 2004, p. 307). The reason for this lack of study may be…because of assumptions that it is a quiet period with little change, that there is too much diversity and too little regularity to capture the midlife experience, or that middle-aged subjects are difficulty to obtain for research because of their busy work and family schedules (Lachman, 2004, pp. 307–308).
Most midlife adults are unlikely to attend school or frequent research hospitals regularly where they would have more opportunity to become part of a research study. In addition, even when groups of midlife adults do agree to participate in research, the results are less than satisfactory because no one group of people can be said to represent midlife adults as a group, like the AARP for the elderly. In my research for this project, I could not find a study that worked with a representative sample of all people in midlife, let alone one that dealt with suicide. Rather than violate basic research principles of representativeness, it may be that researchers have eliminated studies of midlife adults from their research agendas. It is easier to gather large samples of children, adolescents, young adults, and even elderly people from organized groups, agencies, and schools than to do likewise from midlife adults.

While not all midlife adults are alike, just as not all infants or elderly persons are alike, it is still valuable to study this period of development. Doing so is particularly important, given the population explosion of adults in midlife with the Baby Boom Generation moving through midlife in record numbers followed by the next generational cohort, variously called Baby Bust, Generation 13, and most commonly, Generation X.

**Generational Profiles of Midlife Adults Today**

In their book *Generations*, Strauss and Howe (1991) postulated that our attitudes form in early childhood. Thus, the historical point history at which we live our childhood plays a large part in shaping our attitudes and beliefs (Strauss & Howe, 1991). Further, Strauss and Howe suggest that an additional formative period occurs in early adulthood. This is consistent with other developmental literature about emerging adulthood (Arnett, 2000). The challenges that individuals face as they become independent adults determine their approach to life. These insights mean we can divide the population into generational cohorts, each spanning roughly 20
years. Each generation consists of people who were born and came of age at the same point in history. People in each generation had similar experiences and gravitated toward similar attitudes. Generations may be considered a “crossroads phenomenon that links a number of different fields and levels of analysis” (Biggs, 2007, p. 695). Strauss and Howe (1991) defined a generation as a “cohort-group whose length approximates the span of a phase of life and whose boundaries are fixed by peer personality” (p. 60). Table 1 highlights the significant variability in birth years for each cohort from both academic and popular/contemporary publications. For this study, the range of birth years for the Baby Boomers and Gen Xers was determined by what was most commonly used within the literature. Therefore, the Baby Boom Generation is defined as persons who were born between the years of 1946-1964 and Generation X is defined as persons who were born between the years of 1965 and 1980.

Table 1

<table>
<thead>
<tr>
<th>Source</th>
<th>Baby Boomers</th>
<th>Generation X</th>
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<tbody>
<tr>
<td>Twenge, Campbell, &amp; Freeman, 2012</td>
<td>1946-1964</td>
<td>1965-1981</td>
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The two generations whose people are experiencing midlife today, Baby Boomers and Generation Xers, are discussed in this section to highlight the generational differences in characterization, values, and experiences as seen in both academic and popular literature. The
The intent of this section is not to stereotype the generations but to identify and discuss the popular conceptions (and misconceptions) of each cohort. Additionally, although the goal is to highlight general characteristics of each cohort, two issues blur the lines that divide the generations. The first is that individuals born on the cusp of each generation, either at the beginning or at the end, might identify with historical events, values, and preferences from two separate generational cohorts (Strauss & Howe, 1991). For example, “Generation Jones,” a term first created by author Jonathan Pontell, defines generational members of the second wave of Baby Boomers and younger Generation X members (individuals born 1954-1965) who might not exclusively fit into one cohort (Pérez-Peña, 2017). Individuals born in the second wave of the Baby Boom did not experience a nation at war or the draft, and few had fathers who were members of The Greatest Generation (Brokaw, 2001). Contrast these individuals to the first wave of the Baby Boom, wherein many individuals had fathers who served in World War II. Many in the first wave were themselves drafted into war or had classmates or friends that were sent half a world away. The Vietnam War was a central presence in the lives of this first wave, as well as the cultural and political battles faced by the United States during that time (Pérez-Peña, 2017).

Second, there is a potential “crossover effect” which comes from “especially significant events that affect every generation, such as John F. Kennedy’s assassination or the Challenger incident” (Strauss & Howe, 1991, p. 126). Thus, consideration should be given to a blurring of the generations and their experiences and values.

**Baby Boomers**

Baby Boomers, the 75.4 million individuals born between 1946 and 1964, represent about a quarter of the current U.S. Population (U.S. Census Bureau, 2015). In 2010, the oldest of the Baby Boomer cohort turned 65 years old and by the year 2030, the entire Baby Boomer
generation will be 65 or older. The size of this generational cohort is massive. Thus, with improved longevity, projections are that the average age of the United States’ population will rise (Adams-Price, Turner, & Warren, 2015; U.S. Census Bureau, 2015). Baby Boomers have had extensive influence over economic and political priorities (Gurwitt, 2012), and have had to compete with others in their cohort with everything from the high school pep squad to college acceptance to key positions in organizations or government (Westerman & Yamamura, 2007).

The Baby Boom cohort grew up in a historical timeframe wherein there was a strong work ethic and economic prosperity. Salient events such as the President Kennedy and Dr. King assassinations, the Vietnam War, and the social/sexual revolution helped shape their collective beliefs. Many Boomers saw the political and social injustices in the world and felt that it was their role to effect change (e.g., protesting the Vietnam War, advancing civil rights). Additionally, this cohort tends to have more traditional beliefs about the role of government and the expectation of government support and intervention when necessary (Croker & Dychtwald, 2007; Lancaster & Stillman, 2003; Strauss & Howe, 1991).

**Characteristics of Baby Boomers**

Most Baby Boomers would characterize themselves as hard-working, reliable, and high-achieving (Croker & Dychtwald, 2007; Smith & Clurman, 2007). In fact, as the name suggests, Boomers were born in a time of optimism, in the post-World War II era, when the economy was booming (Lancaster & Stillman, 2003; Strauss & Howe, 1991). During their formative years, some of the major influencers expressed sentiments of social change and idealism, such as Dr. Martin Luther King, Jr., President John F. Kennedy, and Gloria Steinem (Erickson, 2009; Lancaster & Stillman, 2003; Russell, 2004). The Baby Boomers were raised to fulfill the
American dream. Consequently, they tend to value extrinsic rewards such as money, titles, and other markers of prestige, such as the corner office (Lancaster & Stillman, 2003).

Given their large cohort size, Baby Boomers have always had to be competitive to succeed and stand out among their peers. This competitive nature has translated into the workforce where Baby Boomers have striven and excelled at their careers (Lancaster & Stillman, 2003). Their high motivation for work and for what they can accomplish has been extrinsically rewarded (Lancaster & Stillman, 2003). Given their ambition and need for extrinsic rewards, they are the most prosperous generational cohort with the least amount of money saved (Beinhocker, Farrell, & Greenberg, 2008). However, it has been implied that Baby Boomers live to work (Lancaster & Stillman, 2003), and this characterization has implications for their physical and mental health, as well as their close relationships (Martin & Gentry, 2011). Even with the relative prosperity experienced by Baby Boomers, the results are mixed in terms of evidence for whether Baby Boomers are actually healthier than prior generations; some findings document poorer mental health status, increased rates of obesity, hypertension, diabetes, and other conditions (King, Matheson, Chirina, Shankar, & Broman-Fulks, 2013). This will be further explored in the current trends section below.

**Baby Boomer Trends**

*Workforce.* At the turn of the 21st century, there was great concern within the United States regarding the potential impact on the economy of the aging of the American people. It was thought that the number of workers per retiree would decrease exponentially with the retirement of the Baby Boomers. In addition, because of this, the Social Security system would begin to run a deficit in 2017 (Mermin, Johnson, & Murphy, 2007). However, the reality has been that many economic, social, and political changes have occurred in the last decade that have made it
difficult for Baby Boomers to retire (e.g., the Great Recession in 2008 and raising the Social Security retirement age from 65 to 67). Consequently, within the U.S. workforce, Baby Boomers have continued working well into their typical retirement years (U.S. Bureau of Labor Statistics, 2017). The AARP has found that 68% of older workers intend to work into retirement (as cited in Mermin et al., 2007). Other sources also suggest that Boomers want to continue to work (Beinhocker et al., 2008).

The reasons to continue working are complex. Findings from this literature review seemed to indicate that the economic forces at play during the last decade have influenced Baby Boomers to continue to work. The 21st century has been hard for American workers because globalization, technology advances, and fierce competition have changed the way companies and organizations are conducting business. Many employees, Baby Boomers included, have seen their jobs eliminated due to outsourcing or downsizing. Organizations began to eliminate defined benefit pension programs that guaranteed compensation for life. For Baby Boomers who grew up with a belief that their employers would take care of them, possibly instilled by a parent for whom this indeed was the case, this change has been significant.

**Finances.** It has been reported that Baby Boomers have spent more and saved less than the previous generation, making them financially unprepared for retirement (Beinhocker et al., 2008). Inflated stock markets and soaring home prices during the latter part of the 20th century gave Baby Boomers a false sense of security and less urgency to save (Beinhocker et al., 2008). The popping of the housing bubble and financial crisis in 2008 depleted most of their accrued savings; they now have a reduced timeframe to recoup their investments. The result is a generation that is financially unprepared to retire (Beinhocker et al., 2008), even if many would like to. When asked to compare themselves economically with their fathers at the same phase of
life, “[b]oomers are evenly split over whether they are doing better or worse. Yet they overwhelmingly consider their careers better…their personal freedoms greater…and their lives more meaningful” (Strauss & Howe, 1991, p. 307)

**Health.** In terms of their health, Baby Boomers have higher rates of chronic disease, more disability, and lower self-rated health than members of the previous generation at the same age (Barrett & Toothman, 2014; King et al., 2013). Per a 2016 United Health Foundation study, when the Boomers are all retired, about 55% more senior citizens will have diabetes than there are today, and about 25% more will be obese. Overall, the report says that the next generation of seniors will be 9% less likely to say they have good or excellent overall health (United Health Foundation, 2016). King et. al.’s (2013) findings also tracked this data, documenting poorer health status with increased rates of obesity, hypertension, high cholesterol, and Type 2 diabetes. However, on a positive note, baby boomers are 50% less likely to smoke cigarettes, and they experience lower rates of emphysema and myocardial infarction than their parents (United Health Foundation, 2016). This is most likely because of public health campaigns aimed at cigarette smoking, as well as societal changes in attitudes toward smokers.

**Marriage.** The Baby Boom generation was responsible for the extraordinary rise in marital instability after 1970, becoming the first cohort to divorce and remarry in large numbers during young adulthood (Brown & Lin, 2012; Kennedy & Ruggles, 2014). It might be that the Baby Boomer generation may be more divorce-prone than other generations because of the conditions and events that they both experienced and (sometimes) created such as the great postwar economy and the sexual revolution.

The Baby Boomer pattern of high marital instability has continued with a new trend of “gray divorces,” which refers to the rising divorce rate among adults ages 50 and older today
Such an example of the “gray divorce” is a Wisconsin couple in their early 50s, Dawn and Tim, who for decades had buried their differences over finances, child-rearing, and religion (Thomas, 2012). When their last child was in her senior year of high school in 2009, Dawn could no longer overlook those differences. She had returned to school to advance her career; Tim’s work was stagnant. Dawn claimed, "We had nothing to talk about, and when we did, it was bickering" (Thomas, 2012). They had stayed together for the sake of the kids, but now that they were gone, Dawn left, too, after filing for divorce.

Remarriages also tend to be less stable than first marriages. The divorce rate for adults ages 50 and older in remarriages is double the rate of those who have been married only once (16 vs. eight per 1,000 married persons, respectively) (Stepler, 2017). Among all adults 50 and older who divorced in 2015, 48% had been in at least their second marriage (Stepler, 2017).

Splitting up on the brink of retirement can be catastrophic for financial wellbeing. Even if both partners have worked, the levels of wealth between them tend to be uneven. This affects each of the marital partners in different ways. Women, in particular, may have taken time off work for family reasons, and that eats into lifetime earnings (Moore, 2018). For men, their satisfaction with their social lives is often lessened in the wake of a divorce (Moore, 2018).

**Generation X**

Generation X describes Americans born from 1965 through 1980. This label overtook the first name affixed to this generation: the Baby Bust (Pew Research Center, 2015). In part, this generation is defined by relatively low birth rates compared with the Baby Boom generation that preceded them and the Millennial generation that followed them. Generation X is the smallest generation, representing about 46 million people born between the years 1965 and 1980 (Lancaster & Stillman, 2003). The label “Gen X” was popularized by Douglas Coupland (1991)
in his book *Generation X: Tales for an Accelerated Culture*. The childhoods of Generation X members may be characterized as unstable from growing up in a time of economic instability and societal change. They were the first generation to grow up while both parents worked or in households wherein only one parent resided because of increased divorce rates (Erickson, 2009; Strauss & Howe, 1991). Many of these children would come home to an empty house after their school day; they were called “latchkey kids” as they spent significant time at home, unsupervised (Erickson, 2009; Howe, 2014). As many Generation X children grew and took care of themselves, they became skeptical of societal norms and developed independence. Howe (2014) referred to a *Time* magazine 1990 cover about Generation X as its members approached their 20s because it illustrated precisely how many Gen Xers entering adulthood were likely to see themselves (e.g., dressed entirely in black, somberly looking in different directions).

The beliefs Gen Xers hold about the world have been influenced by historical events that occurred during their lifetimes. These events include the Cold War, the Challenger Disaster, the AIDS epidemic, and the accelerated progress of technology (Erickson, 2009). They are, on average, better educated than the Baby Boom generation as a college degree or advanced technical training was necessary for them to find a firm footing in the workforce. They are also the first “tech savvy” generation, having grown-up with computers, the launch of MTV, and music videos; playing home video gaming systems; and experiencing the start of the Internet (Goyer, 2013; Lancaster & Stillman, 2003).

**Generation X Characteristics**

Generation Xers are often viewed as cynical, compared to the optimism characteristic of the Baby Boomers. They came of age in a time when nearly every American institution was being held accountable for crimes and/or morality issues. Given the high divorce rates and other
uncertainties in their lives, Generation X as a cohort tends to be more guarded and skeptical (Goyer, 2013; Lancaster & Stillman, 2003). Members of this cohort tend to have less loyalty to their employers and to place a higher value on work-life balance, evaluating their work participation through a very different lens than previous cohorts have done (Howe, 2014). Generation Xers entered the workforce when the traditional employment model was changing. As a result, there is no expectation of job security or a comfortable retirement (Jurkiewicz, 2000). To summarize, Generation Xers can be characterized as a self-reliant cohort that seeks balance, autonomy, and freedom in their professional and personal relationships. They understand that the world is full of uncertainty and that flexibility is often necessary to survive and thrive. These characteristics and how they affect Gen Xers today are articulated in the next section.

**Generation X Trends**

**Work.** In 2019, Gen Xers will have “spent nearly two decades bumping up against a gray ceiling of boomers in senior decision-making jobs” (Fisher, 2009). This creates a challenge for Generation Xers who were hoping to move up the management ladder eventually. For example, in higher education, a survey of faculty by Fidelity Investments indicated that 74% of professors aged 49-67 plan to delay retirement past age 65 or never retire at all (Flaherty, 2013). This strategy often blocks upper level positions (e.g., named chairs, deans, department chairs) for Gen Xers. In a recent essay in the *Chronicle of Higher Education*, one Baby Boomer professor, Deborah Fitzgerald, discussed her decision to retire (Fitzgerald, 2018). She noted that the decision is a difficult one for herself and for her peers, as “great deal of the power, glory, and heart of our departments and universities is there because of our work,” before deciding that “we need to recognize when it is time to pass that on to the next generation” (Fitzgerald, 2018). Even
if droves of Baby Boomers retire, this does not automatically clear the deck to hire additional faculty, as research indicates that tenure-track positions may be replaced with non-tenure-track ones (American Association of University Professors, 2016; Campbell, 2016).

Like those in academia, members of the Baby Boom generation in other fields continue to work past age 55. The number of Generation Xers with full-time jobs had declined by as much as 7 million in 2014 (Howe, 2014). Those who did find full-time employment often did so at reduced salaries while having to pay off their college debt (Erickson, 2009). In addition, only two in five Gen Xers work at the career they intended to when they entered the workforce (Goyer, 2013). This undoubtedly influences both their perceptions of work and their career options, aligning with the overall theme of independence and self-reliance out of necessity, for which Gen Xers are known.

Generation Xers who are employed will have to work longer to access Social Security benefits. Goyer (2013) found that “Generation X may not fully understand Social Security” as most believed that they would receive full benefits at age 65, like current retirees (Goyer, 2013, p. 4). Additionally, only 30% of Gen Xers are somewhat or very confident that it will pay out all the benefits they will be eligible to receive (Goyer, 2013, p.4). Even so, “they are counting on it for their retirement, believing, as a whole, that one-third of their income will come from Social Security” (Goyer, 2013, p. 4).

Finance. Generation Xers attitudes towards work is colored by the financial challenges experienced by this generation. The first wave of Generation X (born in the 1960s) started out during the Cold War in the midst of another recession. Those in the later part of the cohort (those individuals born in the 1970s), entered adulthood during a time of economic prosperity when market valuations hit their peaks (Howe, 2014). Howe (2014) wrote, “Millions of first-wavers at
age 35 could at last hope that maybe the future wouldn’t totally suck after all. Millions of last-wavers at age 25 started out daydreaming about seven-figure stock options.” When the financial markets rise abnormally, they will eventually correct course and go down. This is precisely what happened during the first decade of the 21st century. In addition to pricey college tuitions to pay off, many Gen Xers bought their homes at the height of the housing market, had to navigate the busting of both the housing and dot.com bubbles, and were greatly affected by the 2008 recession (Erickson, 2009; Howe, 2014). Many have not recovered.

More than Boomers, Xers had bought late into the real-estate boom at punishing prices—and in exurban regions where the price declines were steepest. Since the crash, Xers in their 30s and 40s have experienced the biggest decline in homeownership—and to this day are the most likely to be underwater on the homes they still own. (Howe, 2014)

One report noted that while the average Generation Xer’s home is valued at $238,000, 17% are “upside down” on the mortgage (i.e., owing more on their mortgage than the value of the home) (Goyer, 2013).

In the popular press about the financial status of Generation Xers, there appears to be an undertone of resentment and blame toward the Baby Boomer generation. For example, the May 17, 2018, issue of Time carried an article titled “How Baby Boomers Broke America,” which pointed out that our nation’s economic-mobility engine is sputtering owing to the policies enacted by Baby Boomers. Not only is our nation’s infrastructure in need of repair but also our health and educational outcomes are terrible for what we spend compared to other developed countries, and one out of every five children live in a household that is food insecure (Brill, 2018). For Generation Xers, the chance of earning more than their parents dropped to 50% from
90% just two generations earlier (Brill, 2018). Another author posits that the resentment exists because the Boomers are

reaping more than they sowed. They graduated smack into one of the strongest economic expansions in American history. They needed less education to snag a decent-salaried job than their children do, and a college education cost them a small fraction of what it did for their children or will for their grandkids. One income was sufficient to get a family ahead economically. Marginal federal income-tax rates have fallen steadily, with rare exception, since boomers entered the labor force; government retirement benefits have proliferated. At nearly every point in their lives, these Americans chose to slough the costs of those tax cuts and spending hikes onto future generations. (Tankersley, 2012)

Regardless of who or what is to blame for the current financial situation of Generation Xers, their distrust of society, of governments, and of markets will likely lead them to conclude that they are the only ones who can get them out of the financial mess in which they find themselves (Costill, 2017; Meyer, 2016).

Health. Members of Generation X are predominately a healthy group; one extensive survey demonstrated that the clear majority (87%) self-reported good, very good, or excellent health (Goyer, 2013, p. 17). The same survey reported that almost 60% say exercise is a part of their daily lives, 13% use herbal remedies, and nearly one in 10 is meditating or practicing yoga (Goyer, 2013, p.17). This preventive approach to health care seems to align with Generation Xers’ overall distrust of institutions and self-reliance. Additionally, Gen Xers opt to find health information online (e.g., using such sites as WebMD.com and MayoClinic.org) and do their own research about symptoms, diagnoses, and treatment options. When they do visit the doctor, it is often a short-term relationship (Gopal, 2014) in order to get a prescription for a symptom or a
diagnosis confirmed. With health insurance coverage variables, many Gen Xers do not have the money for out-of-pocket expenses and may put off going to the doctor as long as possible (Sinatra, 2017).

**Marriage.** While the divorce rates are still high—applying to 40% of all first-time marriages—members of Generation X are somewhat less likely than Baby Boomers to divorce. It may be that because Generation Xers experienced firsthand the emotional carnage of their parents’ divorce, they want to avoid that for themselves and their children. A Pew Research study (Cohn & Taylor, 2010) found that baby boomers are less conservative regarding divorce than are subsequent generations: 66% of the former say divorce is preferable to staying in an unhappy marriage, compared with 54% of younger adults who say so. Generation Xers are also marrying later. In the 1970s, a couple might be married at 25 and be divorced by 30 (Kennedy & Ruggles, 2014). Generation Xers have often lived with a partner before marriage—64% according to a study by Eickmeyer (2015)—and are more knowledgeable about relationships.

As mentioned previously, Generation X couples have grown up in a treacherous economy. Like their grandparents or great grandparents, they are aware of the need to pull together for economic security. Seventy percent of marriages that began in the 1990s reached their 15th anniversary and those who wed in the 2000s are (so far) divorcing at even lower rates (Fetzer, 2017). That’s a significant increase over the 65% that made it that far in the 1970s and 1980s. Katherine Woodward Thomas (2015), a licensed marriage and family therapist, suggests that

Gen Xers are the heroes who are willing to stumble about trying to figure out how to remain a loving family after dissolving a marriage…They are endeavoring a recalibration and reinvention of family that strives to accommodate the growing needs of all of its
members, and that puts the responsibility on the parents to accomplish the necessary emotional maturation to elegantly execute such a transition, rather than expecting the children to do so.

Even when they do divorce, Generation X parents are more likely to want a “good divorce” and to split amicably, sparing their children the turmoil that they experienced (Thomas, 2015). Members of this generation seem committed to providing their children with the focus and stability that they themselves were lacking. As this generation began to have children themselves, often much later than their parents had children, “helicopter parenting” became a concern, as hyper-focused, over-parenting seems to inhibit a child’s social and emotional growth and sense of self-efficacy (Levine, 2008; Marano, 2008).

**Midlife Challenges**

Being in midlife in American society—whether one is a Baby Boomer or Gen Xer—has its challenges and expectations. One of these challenges is growing older in a culture that is obsessed with being youthful in a way that is different from cultures in other Western countries. For example, a research study comparing age identities in midlife among older Americans to Germans of the same age found that both Americans and Germans tend to feel younger than their actual age. However, there is a larger discrepancy among Americans who display a bias toward youthful identities even as their actual ages increase (Westerhof, Barrett, & Steverink, 2003). In a culture fixated on youth and mesmerized by plastic beauty, middle-aged women have particular expectations as they pass through this stage of life (Smith, 2012).

Archer (2013) observed,

It’s difficult to believe that our founding fathers powdered their wigs gray in order to appear older and wiser. Virtually every public figure from politicians to actors to TV
talking heads have had “work” done to their face or body. This mirrors our superficial culture, where anything important can be defined by 140 characters or less.

Writing in 2012, Cohen noted that midlife itself is a newer concept, given that most developmental issues have been relegated to childhood, adolescence, and late life. She wrote that women today are part of the first generation to enter their 40s and 50s after the feminist movement, and they have options that their mother and grandmothers could barely imagine. Life spans have increased as scientific advances have overcome many of the body’s once-unavoidable limitations. Viagra® has recharged the sex lives of middle-aged men. Beauty treatments like Botox® and facial fillers can erase the stigmata of facial wrinkles. New surgical procedures and recuperative strategies for worn-out knees and creaky rotator cuffs allow aging bodies to ski mogul and surf twenty-footers” (Cohen, 2012, p. 1–2).

Yet, through all of this, entering middle age is seen as a punchline or as something that must be endured by midlife adults, particularly the Baby Boomers, given their famous rebellion against authority with the warning “don't trust anyone over 30” (Smith, 2012). Now that this generation is nearly double that age, the challenges to navigating a culture focused on youth are becoming more apparent.

**Midlife Stress**

Lachman (2004) acknowledged the tensions for midlife adults who are often linked to the welfare of others, including children, parents, coworkers, neighbors, and while they have much to offer society, they are addressing their own needs at the same time. Midlife adults often feel “sandwiched” in between the needs of their children and their parents, who may be in need of
care. At the same time, midlife is when chronic illness or disease may surface (e.g., high blood pressure, arthritis pain) (Lachman, 2004, p. 307).

Midlife may also be a time of loss for many adults as their children come of age and leave home. Feelings of sadness, grief, and in some cases, depression, may coincide with this transition. Women are more likely than men to be affected by what is termed “empty nest syndrome” (Arnett, 2000; Mitchell & Wister, 2015). Often, when children leave the home, mothers are going through other significant life events as well, such as menopause or caring for elderly parents. Further, in relation to their elderly parents, as adults enter midlife, 41% have both parents alive; and when they leave midlife, 77% have no parents alive (Lachman, 2004, p. 322; Bumpass & Aquilino, 1995). The grief associated with parental loss compounds the “typical” stressors (e.g., work, children, finances, health), and this can make midlife very stressful indeed.

The Midlife Crisis

“Midway upon the journey of our life, I found myself within a forest dark. For the straightforward pathway had been lost.” - Dante Alighieri, *The Divine Comedy* (1948)

This quotation from Dante’s *Inferno* indicates that even in the 14th century, there was something unsettling about the approach of midlife. Indeed, if someone were to say the word “midlife” to you, the most likely freely associated response is “crisis.” Typing the term into Amazon reveals over 1,000 relevant titles, from the positive sounding *Life Reimagined: The Science, Art, and Opportunity of Midlife* (Hagerty, 2017) to the alarming *Male Midlife Crisis: Why It Causes Men to Destroy Their Families, Finances and Even Commit Suicide* (Oh, 2014). The inevitability of the midlife crisis has sometimes been debunked in the research literature (Wethington, 2000; Chiriboga, 1997; McCrae & Costa, 1990). It is often viewed as a cultural
construct (Brandes, 1987). Lachman (2004) claims that only about 26% of individuals over 40 years old report having had (or having) a midlife crisis (p. 315). However, for some individuals and their experiences, the midlife crisis is a useful construct to describe how they think and feel during this developmental stage.

The “midlife crisis” is thought to affect those middle-aged individuals (particularly men) who, facing the limited time left until death, pause in their current lives and take stock of what they want to achieve in the time that they have left (Freund & Ritter, 2009). At times, this means taking drastic measures to fulfill their dreams. Freund and Ritter (2009) have offered the example of Tom, aged 49, with a “slight paunch and receding hairline” who has been a husband for over two decades with children about to leave home. Tom is dissatisfied with his job as a loan officer and believes his marriage has run out of steam, so he has an affair with a “coworker 24 years his junior” and “buys a sports car – a red convertible…” (Freund & Ritter, 2009, p. 582). Freund and Ritter (2009) use Tom’s example to demonstrate that during middle adulthood “people are more likely to compare their actual self-image with their ideal self-image as well as with social expectations of what one ought to have achieved…” (Freund & Ritter, 2009, p. 589).

Lachman (2004) described how individuals handle midlife, like other developmental stages, along a continuum. For some it is a crisis, for others a peak, and most people fall somewhere in the middle (Lachman, 2004). Lachman also suggests that things may be in a state of flux in one area of the middle-aged adult’s life but other areas of function are going quite well. There are other perspectives that could be used to describe changes that may happen during midlife. Erik Erikson’s theory of psychosocial development (1963) is one of these perspectives. Erikson postulated that it might be necessary or adaptive to experience a crisis or turmoil for growth to occur. Generativity versus stagnation is the seventh of eight stages of Erikson's theory.
and takes place during midlife (approximately ages 40-65). Generativity refers to making an impact on the world through creating or nurturing things that will outlast an individual’s lifespan. Individuals give back to society through their work, raising children, and becoming involved in community activities and organizations. Through generativity we develop a sense of being a part of the larger world around us. A midlife individual who successfully completes this stage will have feelings of usefulness and accomplishment. Conversely, failure in this stage results in shallow involvement in the world. By failing to find a way to contribute, these individuals may feel disconnected or uninvolved with their community and with society.

There is empirical data to confirm the notion of midlife recalibration. A U-shaped curve of well-being has been found to exist across the lifespan, with declines from early adulthood to middle age, followed by an improvement in later adulthood (Graham & Ruiz, 2016; Schwandt, 2016). The nadir of mental health in this model occurs during middle age, ages 40–60 (Graham & Ruiz, 2016; Rauch, 2014; Schwandt, 2016). This finding, Schwandt (2016) wrote, "supports the hypothesis that the age U-shape in life satisfaction is driven by unmet aspirations that are painfully felt during midlife but beneficially abandoned and felt with less regret during old age” (p. xx. It is notable that the timeline in this research coincides with the uptick in midlife suicidality.

There is light at the end of the lifespan tunnel for most. The actual experiences reported by older Americans are better than expected by those currently in middle age (Taylor, Parker, Wang, Morin, & Cohn, 2009). Thomas et al. (2016) surveyed the physical health, cognitive function, and other measures of mental health in 1,546 adults, ages 21 to 100 years, living in San Diego County. They found that the oldest cohort had mental health scores significantly better than the youngest cohort, though the older cohort’s physical and cognitive functions were
measurably poorer than those of the younger cohort (Thomas et al., 2016). The reasons for this are not apparent, but it could be that as individuals enter old age (75 and older), they learn not to “sweat the small stuff”; or perhaps it is survivor bias in that less healthy adults survive into old age. The work of Carstensen et al. (2011) concurs with this finding, as they report from their own research that emotional well-being improves with age. In fact, they found that emotional experience predicted mortality; individuals who experienced relatively more positive than negative emotions in everyday life were more likely to have survived into old age. In her 2011 TED Talk, Carstensen explained this paradox of aging:

As we age, our time horizons grow shorter and our goals change. When we recognize that we don't have all the time in the world, we see our priorities most clearly; we take less notice of trivial matters; we savor her life; we're more appreciative; we're open to reconciliation; we invest in more emotionally important parts of life, and life gets better. And that's why we think people get happier as they grow older…. (Carstensen, 2011)

Sadly, nearly 45,000 people in the United States every year die by suicide, and 36% of these individuals—over 16,000—take their lives during middle adulthood (Stone et al., 2018; CDC, 2017). These individuals will never get to experience the improvement in well-being that accompanies older adulthood. The factors that contribute to why these individuals take their own lives are explored in the following sections of this literature review.

**Suicide**

Every 12 minutes someone in the United States dies by suicide (Drapeau & McIntosh, 2017). Because it is highly prevalent, it is likely that professional counselors will encounter suicidal clients during their careers, if not in their personal lives. Thus, it is important to take note of the current trajectory. The American Association of Suicidology publishes an annual fact
The 2016 fact sheet featured new research by Cerel et al. (2015) that found that research-based estimates suggest that for each death by suicide, 147 people are exposed to similar circumstances (6.6 million annually). Of these 147 people exposed, more than six experience a major life disruption (e.g., are loss survivors), meaning there are 269,000 loss survivors each year (Drapeau & McIntosh, 2017). If there is a suicide every 11.7 minutes, then there are more than six new loss survivors every 11.7 minutes as well (Cerel, McIntosh, Neimeyer, Maple, & Marshall, 2014; Drapeau & McIntosh, 2017; Frey & Cerel, 2015). Death by suicide often stuns the family and friends of the deceased, as they are not only grieving the unexpected death but also confused by this sudden loss. An example, mentioned in the previous chapter, was Pamela Elarabi’s June 2018 death: her nearly 800 Facebook followers viewed images of her last moments (Paul, 2018). After days that these images lingered online and multiple requests to Facebook to remove the images, her 26-year-old daughter finally hacked her account to delete the most disturbing images (Paul, 2018). Nonetheless, Elarabi’s Facebook page is still active, showing a post from the day she took her life, which reads, “Fuck This.” One can only imagine the impact that Elarabi’s death—and the indelible images of it—continues to have on her friends and family, and on anyone who reads about her death and/or searches for her name online. As of November 20, 2018, Pamela Bryce-Elarabi’s Facebook page was still active and able to be viewed publicly. Her family wanted to leave it in place as a shrine or a memorial; the disturbing images are no longer posted, but the messages before the act remain.

The far-reaching impact of these numbers cannot be understated. Nationally, the overall suicide rate has increased steadily each year, averaging 1.5% across years (Stone et al., 2018). After a reduction in the overall suicide rate throughout the 1990s, there is now a national
initiative to reduce the suicide rate 20% by 2025 (American Foundation for Suicide Prevention, 2016). Suicide rates have risen nearly 30% since 1999, and during this time, rates increased significantly in 44 states, with 25 states experiencing increases of more than 30% (Stone et al., 2018). The Mountain states—Arizona, Colorado, Idaho, Montana, New Mexico, Utah, and Wyoming—have had the highest rates of suicide out of every region of the United States for several decades, and they continue to rise (CDC, 2017). This may be owing to a variety of factors: the fact that the communities tend to be rural and isolated; the rugged individualism of people in the American West, which may negate the desire to seek help; high rates of alcohol and drug abuse; or high rates of gun ownership (Barry-Jester, 2016). Table 2 displays data from the Fatal Injury Reports (CDC, 2017) and demonstrates the rate of suicide across multiple regions of the United States. The increase is a national problem that cannot be solved with piecemeal solutions.

Table 2

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<tbody>
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<td>2,785</td>
<td>3,349</td>
<td>3,965</td>
<td>4,599</td>
<td>4,942</td>
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<td></td>
<td>(17.4)</td>
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<td>(17.9)</td>
<td>(19.8)</td>
<td>(20.7)</td>
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<td>(11.1)</td>
<td>(12.0)</td>
<td>(13.5)</td>
<td>(14.1)</td>
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<td>(12.0)</td>
<td>(13.0)</td>
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<td>(14.1)</td>
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<td>2,593</td>
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<td>(12.8)</td>
<td>(14.2)</td>
<td>(15.0)</td>
<td>(16.0)</td>
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<td>Pacific</td>
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<td>5,024</td>
<td>5,706</td>
<td>6,486</td>
<td>6,574</td>
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<td></td>
<td>(11.7)</td>
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<td>(10.6)</td>
<td>(11.5)</td>
<td>(12.5)</td>
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2 The data used in this section are gleaned from governmental data sources, particularly the Centers for Disease Control and Prevention’s WONDER database (http://wonder.cdc.gov/). This user-friendly, menu-driven system makes the information resources of the CDC available to the public by providing access to a wide array of public health information, including suicide statistics. The CDC’s Web-Based Injury Statistics Query and Reporting System and their National Center for Health Statistics, National Vital Statistics System were also used.
<table>
<thead>
<tr>
<th>Region</th>
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<td></td>
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<td>(9.7)</td>
<td>(8.1)</td>
<td>(10.9)</td>
<td>(12.8)</td>
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<td>New England</td>
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<td>1,679</td>
<td>1,742</td>
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<td>(8.4)</td>
<td>(9.8)</td>
<td>(11.4)</td>
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<td>Middle Atlantic</td>
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<td>3,605</td>
<td>4,303</td>
<td>4,336</td>
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<td></td>
<td>(8.7)</td>
<td>(7.9)</td>
<td>(7.9)</td>
<td>(8.8)</td>
<td>(10.4)</td>
<td>(10.5)</td>
</tr>
<tr>
<td>Nationwide (all states)</td>
<td>30,903</td>
<td>29,199</td>
<td>32,439</td>
<td>36,909</td>
<td>42,826</td>
<td>44,965</td>
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<td>combined</td>
<td>(11.6)</td>
<td>(10.7)</td>
<td>(11.1)</td>
<td>(12.0)</td>
<td>(13.4)</td>
<td>(13.9)</td>
</tr>
</tbody>
</table>

Note: Key to states and regions.  
**Mountain**: Arizona, Colorado, Idaho, Montana, New Mexico, Utah, Wyoming;  
**West South Central**: Arkansas, Louisiana, Oklahoma, Texas;  
**South Atlantic**: Delaware, District of Columbia, Florida, Georgia, Maryland, North Carolina, South Carolina, Virginia, West Virginia;  
**East South Central**: Alabama, Kentucky, Mississippi, Tennessee;  
**Pacific**: Alaska, California, Hawaii, Oregon, Washington;  
**West North Central**: Iowa, Kansas, Minnesota, Nebraska, North Dakota, South Dakota;  
**East North Central**: Illinois, Indiana, Michigan, Ohio, Wisconsin;  
**New England**: Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont;  
**Middle Atlantic**: New Jersey, New York, Pennsylvania

**Suicide Risk Factors**

Suicide, like other human behaviors, has no single determining cause. Instead, suicide occurs in response to multiple biological, psychological, interpersonal, environmental, and societal influences that interact with one another, often over time (Saxena et al., 2014). It is important to recognize that most individuals who are depressed, attempt suicide, or have other risk factors do not ultimately die by suicide. Furthermore, the relevance of each risk factor can vary by age, race, gender, sexual orientation, residential geography, and socio-cultural and economic status (Saxena et al., 2014).

Risk factors are often confused with warning signs of suicide. It is important to note that factors identified as increasing risk are not factors that cause or predict a suicide attempt. Risk factors are characteristics that make it more likely that an individual will consider, attempt, or die by suicide. Van Orden and colleagues examined the literature on the major risk factors for lethal...
suicidal behavior and grouped these major risk factors by degree of empirical support (i.e., the number of studies documenting such an association) (Van Orden et al., 2010). The literature indicates the most consistent and robust support (greater than 15 empirical studies) for the following as risk factors for suicide: mental disorder (particularly depression), past suicide attempts, social isolation, family conflict, unemployment, and physical illness. However, the literature also indicates the presence of other risk factors for suicide, with 6-15 empirical studies, such as family history of suicide, impulsivity, incarceration, hopelessness, seasonal variation, and serotonergic dysfunction. Other risk factors also had empirical support (less than 6 studies) and indicated areas in need of further research.

With respect to suicide risk factors specific to midlife adults, Steele et al. (2017) studied the risk factors at each stage of development. For midlife adults, the most consistent indicators of risk are being male and White with a personal history of the following: suicide attempt(s), any diagnosed psychiatric disorder, abuse (physical and/or sexual), military service, history of arrest (more arrests increase risk), family history of suicide, and less than a high school education (Steele, Thrower, Noroian, & Saleh, 2017). These factors, as well as others, are discussed in the following section.

**Internal Risk Factors**

Despite the increase in the suicide rates, the latest research and statistical findings are sometimes slow in reaching professional counselors (Brown & Salvatore, 2017). One of the goals of this project is to help clinicians better understand the phenomenon of midlife suicide by helping to clarify misconceptions and filling gaps in the knowledge base. The role that mental illness plays in suicide is an area of research that many clinicians need to understand, as well as the other associated risk and protective factors for individuals across the lifespan.
Psychiatric Disorders

The vast majority of people who die by suicide—approximately 95%—suffer from mental disorders, and a large number of studies suggest that the presence of a major psychiatric disorder is the strongest risk factor for suicide (Cavanagh et al., 2003). In fact, completed suicide in the absence of psychiatric disorders is rare, and it is quite possible that the remaining 5% suffer from subclinical variants of mental disorders or presentations of disorders not detected by methodologies such as psychological autopsies (Ernst et al., 2004).

**Depression.** Major depression is the psychiatric diagnosis most commonly associated with suicide. Research has repeatedly shown that suicide risk is substantially higher in the presence of an affective disorder (Persson, Runeson, & Wasserman, 1999), particularly major depression (Bostwick & Pankratz, 2000) and bipolar disorder (Harris & Barraclough, 1997) more than any other mental illness. Persson, Runeson, and Wasserman (1999) found that mood disorders are the most common diagnosis in their sample of suicide attempters, and approximately half of people who complete suicide meet the criteria for depression at the time of their deaths (Friedman & Leon, 2007). Approximately 15% of individuals who are diagnosed with depression eventually end their lives through suicide. Thus, the risk of suicide in people with major depression is about 25 times that of the population in general (Friedman & Leon, 2007; Simon & VonKorff, 1998). Affective disorders that co-occur with anxiety—panic attacks, anhedonia, diminished concentration, and insomnia—are all associated with increased suicide risk (Fawcett et al., 1987).

Multiple studies point to the risk factor of depression in middle age (Conwell, Duberstein, & Caine, 2002; Duberstein, Conwell, Conner, Eberly, & Caine, 2004; Joiner, 2005; Noh, Kwon, Park, & Kim, 2015; Prizer, Smith, Housman, & Ory, 2015). A 2014 CDC report
studying depression from 2009-2012 found that one in eight middle-aged women in the United States have depression (Pratt & Brody, 2014). Women ages 40 to 59 have the highest rate of depression (12.3%) of any group based on age and gender (Pratt & Brody, 2014). Men also have higher rates of depression in this age bracket than in any other. Almost 43% of persons in the study with severe depressive symptoms reported serious difficulties in work, home, and social activities, compounding the risk factor of depression with others (Pratt & Brody, 2014).

William Styron (1992) wrote vividly about his experience with depression during midlife:

The pain of severe depression is quite unimaginable to those who have not suffered it, and it kills in many instances because its anguish can no longer be borne. The prevention of many suicides will continue to be hindered until there is a general awareness of the nature of this pain. Through the healing process of time—and through medical intervention or hospitalization in many cases—most people survive depression, which may be its only blessing; but to the tragic legion who are compelled to destroy themselves there should be no more reproof attached than to the victims of terminal cancer. (Styron, 1992, p. xx)

Depression is frequently accompanied by a sense of suffering, and often the pain of existence becomes too much for the severely depressed to handle. The depressive mental state warps the thinking process and offers cognitive distortions about the perceived burdensomeness of the depressed (the upcoming section on Joiner’s concept of burdensomeness explains this in further detail), as they think that loved ones would be better off without them.

**Substance abuse.** All too often, alcohol or drugs worsen depressive symptoms, or even cause depressive symptoms. Alcoholism (Berglund, Krantz, Lundqvist, & Therup, 1987; Klatsky
& Armstrong, 1993; Sher, 2006) and substance abuse (Østergaard, Nordentoft, & Hjorthøj, 2017) are important risk factors for suicide. While two of every three people who commit suicide are depressed at the time they take their life, alcoholism plays a role in one of every three completed suicides, and opiates are present in 20% of completed suicides (Substance Abuse and Mental Health Services Administration, 2016, p. 1). In a study to estimate and test associations between substance abuse disorders and completed suicides, it was found that those with substance abuse disorders are three times more likely to attempt or complete suicide (Østergaard, Nordentoft, & Hjorthøj, 2017).

One reason why alcohol and drug abuse and misuse significantly affect suicide rates is the disinhibition that occurs when a person is under the influence or is intoxicated by the substance (U.S. Department of Health and Human Services, 2012). Additionally, many drugs have a numbing effect so that an individual may be able to inflict greater harm, as there is a lesser pain response if the user is sober. It also seems that the number of substances used (such as mixing alcohol with an opioid) is more predictive of suicide than the types of substances used, as well as use alongside a psychiatric diagnosis (U.S. Department of Health and Human Services, 2012). Based on a review of studies on alcoholism and suicidal behavior, Sher (2006) found that alcoholism is a strong risk factor for suicide. The strength of this risk factor is increased when it occurs along with major depressive episodes, stressful life events, interpersonal difficulties, poor social support, living alone, high aggression, impulsivity, negative affect, hopelessness, and comorbid substance abuse. Statistically speaking, being male and middle-aged, makes the alcoholic individual more likely to attempt or complete suicide (Sher, 2006).

Anthony Bourdain, the chef and television personality, often drank alcohol to the point of drunkenness on his programs. Bourdain openly spoke about his drug use and his recovery from
heroin addiction in his books, such as *Kitchen Confidential*, and during interviews. Jo Ann Towle in her syndicated column posited the question “Did alcoholism ultimately take down Anthony Bourdain?” Towle noted that unlike many addicts, who give up any and all substances when they get clean, Anthony Bourdain continued to drink, and she wondered if his drinking contributed to his worsening depression before he ended his life in June 2018 (Towle, 2018).

**Bipolar disorder.** A history of alcohol abuse predicts suicide in individuals with bipolar disorder, heightening an already elevated risk for these individuals (Balázs et al., 2006; Dutta et al., 2007). Bipolar disorder is a serious mental disorder that is characterized by sudden and intense shifts in mood, behavior, and energy levels. Many individuals with bipolar disorder self-medicate (Salloum & Thase, 2000). There are two main types of bipolar disorder and the difference between these two types, bipolar I and bipolar II, lies in the severity of the manic episodes caused by each type, with bipolar I having the more severe mania (American Psychiatric Association, 2013). A 2007 systematic review conservatively estimated that bipolar I patients have at least a 40% lifetime prevalence of alcohol and other drug use disorders, whereas bipolar II patients have at least a 20% lifetime prevalence (Cerullo & Strakowski, 2007). Within patients diagnosed with bipolar disorder, those with interpersonal problems with a partner and occupational maladjustment represented a high suicide risk group independent of demographic characteristics (Oquendo et al., 2000; Tsai, Lee, & Chen, 1999).

**Anxiety disorders.** Anxiety disorders have been associated with suicide risk (Khan, Leventhal, Khan, & Brown, 2002). A 2005 study of over 7,000 adults was among the first to demonstrate that a preexisting anxiety disorder is an independent risk factor for the subsequent onset of suicidal ideation and attempts (Sareen et al., 2005). Their data also demonstrated that comorbid anxiety disorders amplify the risk of suicide attempts in persons with mood disorders.
and/or substance abuse disorders (Sareen et al., 2005). The association between suicidality and anxiety might be that individuals suffering from high levels of anxiety, worry, and fear may seek escape from their suffering by considering or attempting suicide (Sareen et al., 2005).

**Schizophrenia.** The risk for suicide is heightened with a diagnosis of schizophrenia (Harris & Barraclough, 1997; Radomsky, Haas, Mann, & Sweeney, 1999). Approximately 10–13% of patients with schizophrenia die by suicide (Caldwell & Gottesman, 1992). Whereas the risk for suicide completion was found to decrease with age in the general population, the risk for individuals diagnosed with schizophrenia remained steady throughout the lifespan (Mościcki, 1995). Young et al. (1998) found that the severity of suicidality for individuals with schizophrenia changes rapidly, so that even after a period of stability, the probability of future significant suicidal ideation or behavior was predicted by low-level suicidal ideation (Young et al., 1998).

**Post-traumatic stress disorder.** Post-traumatic stress disorder has been demonstrated to elevate suicide risk (DeBeer et al., 2016; Tarrier & Gregg, 2004). Associations between various types of trauma and suicidal behaviors have been documented among psychiatric inpatients and outpatients, community samples, and individuals of different nationalities (Romans & Martin, 1995; Silverman, Reinherz, & Giaconia, 1996). Specifically, a number of studies have documented the link between childhood sexual abuse and/or physical abuse and an increased risk for suicidal behavior in adulthood (Gould et al., 1994; King et al., 2001; Pérez-Fuentes et al., 2013; Romans & Martin, 1995; Silverman et al., 1996). The one study to explore the association between childhood emotional abuse and later suicide attempts revealed that emotional abuse was highly associated with suicide attempts (Gould et al., 1994). Another more recent study found that adults with a history of childhood sexual abuse had significantly higher rates of Axis I
disorders and suicide attempts (Pérez-Fuentes et al., 2013).

Additionally, while addiction typically declines with age, particularly in middle adulthood (Chassin, Flora, & King, 2004), drug use disorders remain protracted in traumatized populations when there is additional co-occurring psychopathology (Price, Risk, Haden, Lewis, & Spitznagel, 2004). Post-traumatic stress disorder appears to prolong illicit drug disorders, particularly opioids which have a numbing effect, in traumatized populations (Breslau, 2009, Cottler et al., 1992).

**Military Service**

Concern has been growing over the increased suicide rates among both active military and veterans (Kuehn, 2009; Langhinrichsen-Rohling et al., 2011). Research indicates that the adjusted suicide rates are higher in several subgroups of Operation Enduring Freedom/Operation Iraqi Freedom veterans than in the general United States population (Kang & Bullman, 2008; Reger et al., 2015). The increased rates of suicidality recently noted in veterans may be owing to the concomitant heavy strain placed on military members by extended and concurrent wars (Snarr, Heyman, & Slep, 2010; Yamane & Butler, 2009).

Suicides are more frequent in those who develop PTSD, depression, and comorbid states because of war exposure (DeBeer et al., 2016; Monteith, Menefee, Pettit, Leopoulos, & Vincent, 2013; Pietrzak et al., 2010; Rozanov & Carli, 2012). A 2008 RAND Corporation report found that rates of combat veteran suicides are much higher than previously thought, with as many as 5,000–8,000 a year, or 22 per day, based on the 2012 Veteran’s Administration Suicide Data Report. Suicides among active duty United States Army personnel have been increasing since 2004, surpassing comparable civilian rates in 2008.
Bachynski et al. (2012) analyzed U.S. military data to assess suicide rates for 2007–2008 and found that historical trends suggest that a quarter to half of the suicides that occurred in 2008 might have been related to the major commitment of troops to combat beginning in 2003 (Bachynski et al., 2012). Combat stress and its frequency may be an important factor leading to suicide within the frame of the stress-vulnerability model, which demonstrates that the effects of stress may interact with social factors, interpersonal relations, and psychological variables to produce suicidal tendencies (Rozanov & Carli, 2012).

Price examined potentially causal roles involving PTSD, drug dependence, and suicidality over time, determining that both prevention and treatment for suicidality for veterans with trauma experience should include intervention and the prevention of drug use, as well as treatment for depression (Price et al., 2004). Many Baby Boomers served in the Vietnam War, and Generation Xers served in the various campaigns against global terrorism, as well as other combat experiences in between (e.g., deployments related to the 1995 Bosnian war). With their military careers in the rear view for many of these midlife adults, we now understand that early detection of PTSD and substance abuse could have saved many lives of individuals in their generations that would be lost to suicide (Price et al., 2004).

**Personality Traits**

Suicide risk co-occurs with certain personality traits. Individuals displaying high harm avoidance, a personality trait characterized by excessive worry, fear, and a general pessimism (Van Heeringen et al., 2003), and low agreeableness, including conduct problems (Brezo et al., 2006) and defects in interpersonal problem solving (Arie et al., 2008), have a greater risk of attempting and completing suicide. Additionally, suicide attempters typically demonstrate low self-esteem, permissive attitudes toward committing suicide, and higher state and train anxiety.
(De Wilde, Kienhorst, Diekstra, & Wolters, 1993). Regarding cognitive processes, suicidal individuals typically demonstrate deficient problem-solving strategies (Pollock & Williams, 1998; Spirito, Overholser, & Hart, 1991). Suicide risk has also been associated with high reward dependence, a personality dimension supposed to reflect biases in sensitivity to social communication (Van Heeringen, Audenaert, Van de Wiele, & Verstraete, 2000, p. 186), hostile disagreeableness (Clayton, Ernst, & Angst, 1994), low cooperativeness, and low self-directedness which may be either sub-forms or predictors of susceptibility to psychosis and mood disorders (Cloninger, Bayon, & Svrakic, 1998).

In their review, Brezo et al. (2006) found that several individual traits distinguish quite consistently between those who attempt suicide and those who do not. For example, personality traits related to extroversion were lower in attempters. Individuals attempting and completing suicide have been demonstrated to show higher introversion (Brezo et al., 2006; Roy, 2003; White et al., 2017) and higher psychoticism as compared to those who have not attempted suicide (Roy, 2003). Emotional instability and chronic anxiety were also associated with risk of suicide attempt, whereas impulsivity and aggression were shown to be significantly associated with attempts in psychiatric patients, particularly males (Brezo et al., 2006). Suicidal risk has been found to be associated with significantly higher scores on neuroticism (O’Boyle & Brandon, 1998; Roy, 2003). Neuroticism is generally higher in midlife adult attempters, especially in those with concurrent substance abuse and affective disorders (Beautrais, Joyce, & Mulder, 1996).

Race and Suicide

The suicide rate differs among racial groups in the United States. An age-adjusted suicide rate increase has been observed for both females and males in all age groups and all racial groups
except non-Hispanic Asian or Pacific Islanders (Curtin, 2016). The suicide rates are highest among non-Hispanic whites (Curtin, 2016). Table 3 compares midlife suicide data in 1999 by racial make-up to the data from 2014 (data available from the CDC WONDER online database).

Table 3

*United States Suicide Deaths by Race and Sex, Ages 45-64, 1999 and 2014*

<table>
<thead>
<tr>
<th>Hispanic origin and race</th>
<th>Female</th>
<th></th>
<th></th>
<th>Male</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Rate</td>
<td>Change in Rate</td>
<td>Number</td>
<td>Rate</td>
<td>Change in Rate</td>
<td>Number</td>
<td>Rate</td>
</tr>
<tr>
<td>White, non-Hispanic</td>
<td>1678</td>
<td>7</td>
<td>3715</td>
<td>12.6</td>
<td>80</td>
<td>5389</td>
<td>23.4</td>
<td>10617</td>
</tr>
<tr>
<td>Black, non-Hispanic</td>
<td>64</td>
<td>1.9</td>
<td>143</td>
<td>2.7</td>
<td>42</td>
<td>278</td>
<td>9.8</td>
<td>454</td>
</tr>
<tr>
<td>Asian or Pacific Islander, non-Hispanic</td>
<td>46</td>
<td>3.9</td>
<td>104</td>
<td>4.3</td>
<td>10</td>
<td>118</td>
<td>11.5</td>
<td>251</td>
</tr>
<tr>
<td>American Indian or Alaska Native, non-Hispanic</td>
<td>12</td>
<td>*</td>
<td>19</td>
<td>*</td>
<td>*</td>
<td>30</td>
<td>14.9</td>
<td>70</td>
</tr>
<tr>
<td>Hispanic</td>
<td>59</td>
<td>2.5</td>
<td>185</td>
<td>3.5</td>
<td>40</td>
<td>263</td>
<td>11.8</td>
<td>640</td>
</tr>
<tr>
<td>All races</td>
<td>1868</td>
<td>6</td>
<td>4195</td>
<td>9.8</td>
<td>63</td>
<td>6109</td>
<td>20.8</td>
<td>12099</td>
</tr>
</tbody>
</table>

*Figure does not meet standards of reliability or precision; based on fewer than 20 cases in the numerator.

The suicide rate for non-Hispanic white females aged 45–64 in 2014 (12.6 per 100,000) was 80% higher than in 1999 (7.0 per 100,000; Curtin et al., 2016). This is three to four times higher than for females in other racial and ethnic groups, even though the suicide rates for non-Hispanic black and Hispanic females also increased for those aged 45–64. Non-Hispanic white
men in this age group had the highest percentage increase (59%) for males during the same time period across all age and racial groups (Curtin et al., 2016).

Kubrin and Wadsworth (2009) found racial differences in the predictors of suicide. For example, while concentrated disadvantage (e.g., joblessness, family disruption, poverty) directly affects males of any age or race, it raises levels for young black males only according to increased access to firearms (Kubrin & Wadsworth, 2009, p. 1204). African Americans and Hispanic Americans have demonstrated lower rates of suicide, despite higher levels of disadvantage. This disparity may be related to the degree to which the black and Latino communities are better connected and integrated than White, non-Hispanic communities, a demonstration of Durkeim’s (1897) theory on suicide (Kubrin & Wadsworth, 2009, p. 1205).

Using the National Violent Death Reporting System for 27 states (2015 data), Stone et al. (2018) found that those without known mental health conditions accounted for more suicides than those who had known mental health conditions, as demonstrated in Table 4. Suicide is often attributed to mental illness, but the data shows that it is much more complicated than that and that suicide is not caused by a single factor.

Table 4

Race and Ethnicity of Suicide Decedents with and without Known Mental Health Conditions, 2015.

<table>
<thead>
<tr>
<th>Race</th>
<th>Total number (Percentage)</th>
<th>Known mental health condition</th>
<th>No known mental health condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>White, non-Hispanic</td>
<td>17,102 (83.6)</td>
<td>8,165</td>
<td>8,937</td>
</tr>
<tr>
<td>Black, non-Hispanic</td>
<td>1,228 (6.0)</td>
<td>411</td>
<td>817</td>
</tr>
<tr>
<td>American Indian/Alaska Native, non-Hispanic</td>
<td>378 (1.8)</td>
<td>112</td>
<td>266</td>
</tr>
<tr>
<td>Asian, non-Hispanic</td>
<td>576 (2.8)</td>
<td>235</td>
<td>341</td>
</tr>
<tr>
<td>Hispanic</td>
<td>1,096 (5.4)</td>
<td>463</td>
<td>633</td>
</tr>
<tr>
<td>Other</td>
<td>66 (0.3)</td>
<td>21</td>
<td>45</td>
</tr>
</tbody>
</table>
There are a few possible reasons why most of the suicide decedents had no known mental health conditions. First, there is likely some under-recognition concerning mental-health conditions in the National Vital Statistics data, perhaps because the conditions have not been formally diagnosed, or because surviving family and friends may not have been aware of a mental health diagnosis. Second, improved access to care and treatment for mental health conditions is needed in the United States so that people can get the help for which they are desperate. Mental health services are often a patchwork of care in many areas. Patients may not know what is available or whether they can afford ongoing care. Third, a stigma remains in connection with seeking psychological assistance, particularly among men who might feel shame at not being able to handle their problems on their own (Link, Struening, Rahav, Phelan, & Nuttbrock, 1997) and even more so for minority men whose experiences of racism may lead to a mistrust of the health care community (Baoku, 2018; Washington, 2008). Many individuals without a known mental health condition self-medicate through drugs, alcohol, or even food. Toxicology testing was performed for some: though they were less likely to test positive for substances overall, including opioids, they were more likely to test positively for alcohol, particularly among men (Stone et al., 2018).

Sex and Suicide

Even though men account for the majority of deaths by suicide (7 out of 10), the rate of women dying from suicide has increased exponentially, at a rate outpacing that for men, for nearly a decade (Stone et al., 2018). Thus, the male-female disparity in suicide rates (as measured by rate ratios) narrowed slightly over the period of 1999-2016. Stone et al. (2018) found that the rate of women who died by suicide increased 50%, compared with an increase of 21% for men from 2000-2016. Previous data had shown that the percent increase in the age-
adjusted suicide rate was greater for women (45% increase) than for men (a 16% increase) from 1999-2014, and that women ages 45–64 had the second-largest percentage increase in suicide rates (63%) during the same time period (Curtin et al., 2016). Thus, while the male rate of death by suicide has increased approximately 1% per year since 2010, the rate of women who died by suicide has seen an average annual growth of 3% since 2007.

Men are more likely to use guns in suicide, but guns are now the second most common method of suicide among women at 32%, surpassed only by poisoning at 33% (Hedegaard et al., 2018; Stone et al., 2018). Medical personnel and statisticians are used to seeing self-injury to females from cutting or death by poisoning and overdose. Often, these are meant as lethal attempts but do not result in death. While those means of self-harm are still clear in the data, and may result in death, more violent and lethal means are being used such as firearms, hanging, and suffocation. Table 5 compares suicides deaths by age, method and sex for the most recent year of data, 2016 (Hedegaard et al., 2018; Stone et al., 2018).
Table 5

Suicide Deaths, By Age, Method, and Sex: United States, 2016

<table>
<thead>
<tr>
<th>Sex and age group</th>
<th>Means of suicide</th>
<th>Number (percent)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Firearm</td>
<td>Poisoning</td>
</tr>
<tr>
<td>Female Total</td>
<td>3,291 (32)</td>
<td>3,382 (33)</td>
</tr>
<tr>
<td>10–14</td>
<td>34 (20)</td>
<td>17 (10)</td>
</tr>
<tr>
<td>15–24</td>
<td>335 (29)</td>
<td>189 (16)</td>
</tr>
<tr>
<td>25–44</td>
<td>1,035 (32)</td>
<td>887 (28)</td>
</tr>
<tr>
<td>45–64</td>
<td>1,361 (32)</td>
<td>1,720 (40)</td>
</tr>
<tr>
<td>65–74</td>
<td>358 (38)</td>
<td>381 (41)</td>
</tr>
<tr>
<td>75 and over</td>
<td>168 (33)</td>
<td>188 (37)</td>
</tr>
<tr>
<td>Male Total</td>
<td>19,647 (57)</td>
<td>3,316 (10)</td>
</tr>
<tr>
<td>10–14</td>
<td>126 (48)</td>
<td>0 (0)</td>
</tr>
<tr>
<td>15–24</td>
<td>2,348 (51)</td>
<td>237 (5)</td>
</tr>
<tr>
<td>25–44</td>
<td>5,362 (48)</td>
<td>1,024 (9)</td>
</tr>
<tr>
<td>45–64</td>
<td>6,579 (55)</td>
<td>1,554 (13)</td>
</tr>
<tr>
<td>65–74</td>
<td>2,574 (74)</td>
<td>308 (9)</td>
</tr>
<tr>
<td>75 and over</td>
<td>2,656 (81)</td>
<td>193 (6)</td>
</tr>
</tbody>
</table>

*Figure does not meet standards for reliability or precision; based on fewer than 20 cases in the numerator.

Note: Suicide deaths are identified with underlying cause-of-death codes U03, X60-X84, and Y87.0 from the International statistical classification of diseases and related health problems, tenth revision (ICD-10) (2008). Suicide deaths were categorized by method of injury using the following ICD-10 codes: firearm (X72-X74); suffocation (X70); poisoning (X60-X69), and other mechanisms (U03, X71, X75-X84, and Y87.0).

There are many possible reasons why women’s suicide rates are on the rise, though no substantive peer-reviewed studies to date have directly addressed this. One reason may be that women in midlife may experience increased depression and suicide risk because of midlife hormone flux (e.g., perimenopause, menopause). This physical reason may be compounded with additional midlife stressors (e.g., interpersonal, financial) that coincide with interpersonal changes (e.g., parents aging or dying, children leaving home). Additionally, despite progress in
gender equality, women often bear the mental and physical strain that comes with being the primary caregivers in their families. Many women are also the primary breadwinners for their households, trying to support their families while saving for their futures. Compound stressors, such as caregiving, affect women disproportionally, as do such stressors as pay inequality or workplace harassment. For some women who are predisposed to underlying mental health disorders or a history of trauma, it might be too much to bear.

**External Risk Factors**

The seminal work of Émile Durkheim (1897) *Suicide: A Study in Sociology* highlighted the role that external factors, particularly social factors, play in the etiology of suicide (Durkheim, 1951). Durkheim argued that suicide rates may be explained by the extent to which individuals are integrated and regulated by the constraining moral forces of collective social life. Durkheim developed a theoretical typology of four categories of suicide based on the intersection (integration and regulation) between the individual and that individual’s society (Leenaars, 2004, p. 2). Egoistic and altruistic suicide arises, respectively, from the societal under- and over-integration of the individual; anomic suicide and fatalistic suicide are caused by under- and over-regulation, respectively, in the society. Durkheim’s research is still relevant today when examining external risk factors, specifically interpersonal risk factors, for suicidal behavior. Durkheim predicted, with prescience, that in Western society, anomie would lead to increased suicide rates (Durkheim, 1951). Table 6 compares the four types of suicide as described by Durkheim and their relationship to regulation and integration.
Anomic suicide occurs when a person experiences *anomie*, a sense of disconnection from society. The feeling of not belonging results from weakened social cohesion and often occurs during periods of serious social, economic, or political upheaval. In such times, changes are often so rapid that a person may feel unmoored by changes in their world and, as a result, choose to commit suicide. An example of this would be the marked increase (two and a half times the average) to the National Suicide Prevention Lifeline in the 24 hours after the election of Donald Trump; there were 660 calls to the Lifeline just in the hour before Hilary Clinton conceded (Mettler, 2016). Additionally, over 2,000 people contacted the Crisis Text hotline, with the words “election” and “scared” as the most commonly used in that same 24-hour period (Mettler, 2016). It was thought that Clinton would easily win the election so that the perceived social progress made over the past decade (e.g., marriage equality and the Deferred Action for Childhood Arrivals Act [DACA]), would continue. It is likely that those callers were concerned about their futures and were afraid they would go backward. The “Dreamers”—those young adults who were brought to the United States as children, educated in the United States, and have
roots in the United States—were rightly concerned, given Donald Trump’s campaign rhetoric on immigration, that they would lose their status under DACA and could potentially be deported.

Altruistic suicide arises from the excessive influence over individuals by social forces, such that a person will be moved to kill themselves for the benefit of a cause. It is often viewed as a courageous act of self-sacrifice for the good of others. There is a debate, however, in the suicidology community about what constitutes altruistic suicide because determining whether or not suicide is an altruistic act is often socially constructed (Leenaars & Wenckstern, 2004). As Leenaars (2010) asked, “When is a motive praiseworthy and when not—when to be called altruistic or heroic, and when terrorist?” (Leenaars, 2004, p.1). One might argue that those who kill themselves while killing others are in no way altruistic.

Egoistic suicide can follow from a feeling of being detached from society. According to Durkeim, the problem is “excessive individualism” which is related to his assumption that humans need a goal larger than themselves and need to be connected to the social world (Durkheim, 1951). Usually, people are integrated into society by work roles, ties to family and community, and other social bonds. When these bonds are weakened through retirement, divorce, or unemployment, the likelihood of egoistic suicide increases. For example, an unmarried, unemployed, midlife individual with no children, very few friends, and a great deal of time to spend watching television is the kind of person at risk for this type of suicide.

Fatalistic suicide occurs under extreme restrictions that result in oppressive conditions leading to a denial of the self and of agency; in other words, an individual loses all hope. In such a situation, a person may elect to die rather than continue enduring. As an example, Aliverdinia and Pridemore (2009) empirically tested Durkeim’s theory of fatalistic suicide. The authors collected data for 4 years, from 1997-2000, and discovered that there was a high fatalistic suicide
The great majority of suicidal behavior stems from individual factors, most notably those related to mental illness, health problems, and other personal issues. However, numerous studies provide some support for Durkheim’s arguments that suicide can be caused by social factors, including a lack of connection to others via intimate relationships, social relationships, or through the community vis-à-vis employment. Durkheim’s 1897 findings are surprisingly consistent with what we know about suicide today (perhaps even prophetic). In the sections that follow, social factors and external factors that contribute to suicidality are explored.

When examining variation in suicide rates for a population over time, Durkheim’s theory may provide explanations for (and may predict) patterns and shifts in the suicide rate. Durkheim’s theory was not used to underpin this project because it pays little attention to individual factors. For instance, if all individuals in a society are exposed to the shifts in social forces, why then do only particular individuals, and a very small subset of them at that, die by suicide? Joiner’s Interpersonal Theory (2005) is consistent with past theoretical accounts of suicidal behavior through its proposal for a key role for social connectedness. For example, Durkheim’s egotistical suicide resonates with thwarted belongingness (e.g., social integration,
isolation, alienation) while perceived burdensomeness could be compared to Durkheim’s fatalistic suicide (e.g., oppression, lack of usefulness).

However, Joiner’s theory diverges in its proposal that an unmet need to belong (i.e., thwarted belongingness) is the specific interpersonal need involved in desire for suicide. This unmet need may be caused by a variety of factors including those related to psychiatric disorders.

**Interpersonal Risk Factors**

Indices of family conflict are robust risk factors for lethal suicidal behavior across the lifespan (Frey & Cerel, 2015). Numerous studies document the associations between suicide and familial discord, domestic violence, familial stress, and perceptions that one is a burden on family (Conwell, Duberstein, & Caine, 2002; Joiner, 2009; Stack, 2000). While familial discord is a general risk factor, there is added risk in middle age given the obligations many people have at that age to both children and parents (Birditt, Miller, Fingerman, & Lefkowitz, 2009; Clarke, Preston, Raksin, & Bengtson, 1999; Duberstein et al., 2004). For example, one study compared 86 suicides and 86 controls aged 50 years and older, matched by age, gender, race, and county of residence (Duberstein et al., 2004). Structured interviews conducted with proxy respondents for both suicides and controls revealed that family discord amplified suicide risk after controlling for demographic covariates and mental disorders. The authors suggested that interventions to decrease the likelihood of financial stress and to help families manage discord and severe physical illness may effectively reduce suicides among middle-aged and older adults (Duberstein et. al., 2004).

Associations between lethal suicidal behavior and various facets of social isolation have been demonstrated (Duberstein et al., 2004; Silva, Ribeiro, & Joiner, 2015; Van Orden et al., 2010). This would include loneliness, social withdrawal, living alone, and having few social
supports. It may also include living in non-intact families, losing a spouse through death or divorce, and residing in a single prison cell (Joiner, 2009). It is likely the social media exacerbate feelings of loneliness for some individuals, making them feel like they are missing out on having meaningful connections as they receive glimpses of others’ lives online (Luxton, June, & Fairall, 2012). While the Internet and social media can be a place of support and information for some who are struggling to find connection and a shared experience, others find information about the fastest and most painless way to die, information about the suicides of celebrities, and a barrage of bad news that contribute to a sense of hopelessness (Luxton et al., 2012).

**Access to Firearms**

Firearm ownership is more prevalent in the United States than in any other country; approximately 42% of households have firearms and a third of all adults personally own a weapon (or weapons) (Parker, Horowitz, Igielnik, Oliphant, & Brown, 2017). The evidence that a gun in the home increases the risk for suicide is overwhelming (Brent & Bridge, 2003; Kung, Pearson, & Wei, 2005; Stone et al., 2018; Wiebe, 2003). It is interesting to note that in states with stricter gun laws, like Massachusetts or New York, suicide prevalence is lower than in regions with less restrictive gun laws and more guns per household, like Montana or Wyoming (Stone et al., 2018).

In a 2014 systematic review to understand the association between firearm availability and suicide, as well as homicide, the authors found a greater association between firearm ownership and suicidality, as well as being the victim of a homicide (Anglemyer, Horvath, & Rutherford, 2014). For most families, bringing a gun into the home substantially increases the risk of suicide for all family members and the risk for women being murdered in the home (Anglemyer et al., 2014). The availability of firearms in the home may not be the catalyst for
suicidal ideation, but firearms may be a preferred method of suicide among those who have suicidal thoughts, as reported by the CDC (Stone et al., 2018). It is likely that lives would be saved if people disposed of their firearms, kept them locked away, or stored them outside the home. Many of those who attempt suicide act on impulse or under the influence of drugs or alcohol; with time, these feelings of despair might subside. Unfortunately, few survive an attempt at suicide with a firearm.

**Economic Risk Factors**

Unemployment, being a common factor among individuals who have died by suicide, is associated with elevated risk for lethal suicidal behavior. However, several studies examining associations between unemployment and suicide rates at the general population level have failed to find an association, whereas it is studies that have examined smaller, more homogeneous populations (which also tend to be higher risk samples) that tend to find an association (Lester & Yang, 2003; Stack, 2000). This pattern of findings indicates that although many individuals who die by suicide are unemployed, the clear majority of unemployed individuals do not die by suicide. Thus, it may be that unemployment is associated with elevated risk only among vulnerable individuals or only when it results in certain negative outcomes.

Economic recessions are associated with increased suicide rates, but only those recessions with marked elevations in negative outcomes, such as job losses and home foreclosures. Unemployment strikes men more than women in terms of psychological pressure: for middle-aged or older women, unemployment may even be a net positive for the entire family given that their efforts are often redirected towards family matters (e.g., caring for family members’ children, increased housework completed). Further, female labor force participation exerts pressure on male counterparts and increases the suicide rate in males (Cavanagh et al.,
As a result, a low-income family with an unemployed man and an employed woman is at higher risk for adult male suicide than the opposite scenario (Ying & Chang, 2009). Given that the most recent recession was also referred to as the “mancession,” this could partially explain the increase in suicide among middle-aged adults (Wall, 2009).

The recent rise in middle-age suicides may be attributed in part to the detrimental effects of the economic downturn of 2007-2009, leading to disproportionate effects on house values, household finances, and retirement savings for that age group. In a study published in the *American Journal of Preventive Medicine*, researchers found that external economic factors were present in 37.5% of all completed suicides in 2010, up from 32.9% in 2005 (Hempstead & Phillips, 2015). Semuels (2017a, 2017b) posited that the economic despair responsible for the deaths of white middle-aged Americans isn’t because of the economy (Semuels, 2017a, 2017b). Rather, Semuels explores a theory that people are dropping out of the workforce because they have health conditions that make working difficult; with the deterioration of their health, pain often results, along with a prescription for addictive pain medication (Semuels, 2017a). As a result, it is even more difficult for these people to re-enter the workforce (Semuels, 2017a) and even when they do enter the workforce, it may not be in their chosen field or at the same level of salary or prestige as their prior position.

Michael Gates Gill (2008) described his own story with unemployment and the fallout from his job loss as the son of an acclaimed New Yorker staff writer, who spent his childhood surrounded by famous intellectuals and the socially connected. Gill attended Yale and then was highly paid for his work at a large and successful advertising agency for 25 years. He was suddenly fired at age 53 as part of corporate downsizing. His subsequent attempt at running a
consulting business failed, and Gill found himself broke, about to get a divorce, and needing an operation for a brain tumor. Desperate for work and health insurance, he found a job at Starbucks where he still works as a barista, even after he sold his story to a publisher (Wadler, 2007). In his book, Gill claimed to be much happier in his Starbucks job as he was treated with respect and enjoyed the social interactions and validations from fellow Starbucks partners and guests (Gill, 2008). Without that job, Gill is not sure that he would have survived his employment and interpersonal crises (Gill, 2008). Starbucks, for Gill, became a cultivator of protective factors, supplying him the income, purpose, and community that he needed during his darkest days. Protective factors that often serve as a safeguard against suicide are discussed in the following section.
Protective Factors

Protective factors, or those influences that buffer against the risk of suicide, can also be found across the different domains in an individual’s life or throughout the systems of the bioecological model (Saxena et al., 2014). Protective factors are strengths which individuals develop that would assist them in tackling conflicts and challenges (Smith, 2006). In addition to developing internal protective factors to help accept and manage disappointments and adversities, protective factors may also come from others, as families, friends, and coworkers also help individuals nurture their protective strengths. Protective factors work against risk factors because protective factors are the shields that protect people from adversities and help them deal with and adapt to harsh conditions (Gilgun, 1996).

Protective factors to buffer from suicidality as identified in the literature include effective coping and problem-solving skills, moral and religious objections to suicide, strong and supportive relationships with partners, friends, and family (Gilgun, 1996b), community connectedness (Joiner et al., 2006; Van Orden et al., 2010), availability of quality and ongoing physical and mental health care (Case & Deaton, 2017; Han, Compton, Gfroerer, & McKeon, 2014; Simon & VonKorff, 1998), and reduced access to lethal means (Anglemyer et al., 2014; Brent & Bridge, 2003; Wiebe, 2003). These protective factors can either counter a specific risk factor or buffer against several risks associated with suicide.

Close relationships. Some protective factors, such as connection to others, serve to mitigate suicidality. Healthy, close relationships can increase individual resilience and act as a protective factor against the risk of suicide. One’s closest social circle—which might include partners, family members, peers, friends and significant others—have the most influence and can be supportive in times of crisis. Resilience gained from this support mitigates the suicide risk
associated with childhood trauma (Gilgun, 1996a, 1996b). In her research, Gilgun sought to delineate the processes that may lead to positive or negative outcomes among individuals who have experienced childhood adversities (Gilgun, 1996a, 1996b). She identified that long-term, close, personal relationships was one of the main factors that distinguished those who did well from those who did not. Specifically, the relationships that are most beneficial and affirming are with others who model pro-social behaviors, are emotionally expressive and facilitate emotional expressiveness in the at-risk person, praise and encourage pro-social behaviors in the at-risk person, and know and understand the risks experienced by that person (Gilgun, 1996b).

**Healthy coping.** Healthy lifestyle choices and effective positive coping strategies protect against suicide (Sisask, Värnik, Kõlves, Konstabel, & Wasserman, 2008). Healthy lifestyle choices that promote mental and physical well-being include regular exercise, adequate sleep, healthy food choices, and effective management of stress (Davidson, Babson, Bonn-Miller, Souter, & Vannoy, 2013). Well-being is shaped in part by personality traits which determine vulnerability for—and resilience against—stress and trauma. Emotional stability, an optimistic outlook, and a developed self-identity assist in coping with life’s difficulties. Having a favorable sense of self that challenges negative thinking and circumstances is also viewed as protective, as is the ability to engage in self-soothing behaviors (e.g., listening to music, imagining a worthwhile future).

**Community involvement.** Research suggests that social support is associated with decreased likelihood of a suicide attempt over one’s lifetime. "Pulling together" (e.g., gathering for sporting events, celebrations, holidays) with others has been shown to have a preventive effect because it meets the need to belong (Joiner et al., 2006; Van Orden et al., 2010). For example, suicide rates have been lower on Super Bowl Sundays than on other Sundays. It is
believed that the social connectedness that occurs from being a fan of a sports team increases one's feeling of belongingness (Joiner et al., 2006). Social support is a factor that can be modified and used to improve existing suicide prevention programs and to benefit those who may be socially isolated (Kleiman & Liu, 2013).

**Religion and spirituality.** Religion may be a protective factor because it typically provides a structured belief system and can advocate for behavior that can be considered physically and mentally beneficial (Van Praag, 2009). In addition, many religious and cultural beliefs condemn suicide, though they may contribute to the stigma around seeking professional assistance for mental health issues (Schmalz, 2018). Durkheim’s (1951) sociological research revealed that Protestants take their own lives at a higher rate than Catholics, whereas those who are Jewish die by suicide less often than Catholics do. The rates among the Jewish faithful are lower, even though both Catholics and Protestants consider suicide a sin (Durkheim, 1951). Durkheim suggested that it is because the Jewish community is often smaller and more cohesive. Simpson et al. suspected that a better test of Durkheim’s belief that religion has an independent role in suppressing suicide would be to compare Christianity with another major religion, such as Islam, given that the Judeo-Christian faiths have more similarities than differences (Simpson & Conklin, 1989). Using a 71-nation cross-national analysis, they demonstrated that Islam does have an independent effect in lowering suicide. This confirms Durkheim's hypothesis that religion itself is important as an independent factor in studying suicide.

Individuals who frequently attend religious services are less likely to die by suicide than those who do not attend so frequently (Kleiman & Liu, 2014). Religious faith exerts stronger direct and indirect effects on suicidal behavior when family support is at low levels, suggesting that in the absence of family support, religious faith may play a compensatory role in protecting
against suicidal behavior (Wang, Wong, Nyutu, Spears, & Nichols, 2016). The protective value of religion and spirituality may arise from providing access to a socially cohesive community with a shared set of values.

Malone et al. (2000) studied reasons for living among severely depressed patients who contemplated suicide. They found that religious persuasion did not differentiate the patients with suicide attempts from those without. However, the scores for moral objections to suicide differed strongly. Greater moral objection to suicide also protected against higher-lethality suicidal acts among the suicide attempters. Thus, reasons for living may be a more sensitive indicator of enduring moral/religious beliefs than the religion of origin.

Many risk factors and correlates of suicidal behavior have been identified in the literature. Rogers (2001) suggests that clinicians and researchers of suicidology should ground themselves in a theory, developing and testing models that lead to the identification of stronger prevention and intervention techniques. This, by extension, may result in a reduction in the pain and suffering that result from suicide (Rogers, 2001). The theoretical underpinnings for this study are discussed in the following sections.

**Methodological Literature**

Methodology is a “…particular social scientific discourse (a way of acting, thinking, and speaking) that occupies a middle ground between discussions of methods (procedures, techniques), and discussions of issues in the philosophy of social science” (Schwandt, 2007, p. 193). For this study, the intent was to begin to understand the lived experiences of midlife adults in the United States as they struggle with suicidality. To achieve this objective, a constructivist design was utilized to better understand the subjects’ views. Constructivist inquiry views knowledge as “…contingent upon human practices, being constructed in and out of interaction.
between human beings and their world, and developed and transmitted within an essentially social context” (Crotty, 1998). A constructivist approach to research is appropriate when there is an existence of multiple realities and a belief that those realities are subjectively co-created through our personal lived experiences (Lincoln & Guba, 1985).

Constructivist philosophy builds on knowledge by capturing the voices of individuals and understanding their opinions, values, biases, and experiences (Creswell, 2009). This philosophy was appropriate for this study to understand the multiple realities of the experienced phenomenon from the perspectives of those who have struggled with suicidality in midlife.

**Phenomenology**

Phenomenology seeks to discover the essence of a phenomenon and to understand the lived experiences of individuals, as well as the nature of meaning in one’s everyday life (van Manen, 1990). Phenomenology is located within the constructivist paradigm as it is predicated on the belief that multiple realities exist and that these realities are contextually bound (Creswell, 2009). It is also considered a methodological tradition with a rigorous focus on description (Crotty, 1998). Features of this methodology are intentional analysis and bracketing. The pure essences are derived from an intentional analysis of an object as perceived and as experienced (Moustakas, 1994). The notion that researchers are burdened with the mental baggage of their own biases that they bring to the research endeavor is fundamental to phenomenology. Phenomenologists believe that researchers must bracket or suspend their person biases, assumptions, or beliefs in order to get to the unencumbered vision of what they are trying to study (van Manen, 1990, p. 175). Bracketing is a widely accepted principle in the conducting phenomenological research (Ehrich, 1999).
Hermeneutic Phenomenology

The chosen research methodology, within the context of the constructivist paradigm and the methodological tradition of phenomenology, is hermeneutic phenomenology. Hermeneutics means to interpret or to understand, and hermeneutical phenomenology is concerned with human experience as it is lived with the goal of creating meaning and achieving a broader sense of understanding (Laverty, 2008). Hermeneutic phenomenology takes the phenomenological tradition further by not only providing rich description but also seeking to provide interpretation that elucidates meaning, informs understanding, and ultimately, elicits action for an improved human condition (van Manen, 1990; Lincoln & Guba, 1985). Thus, this methodology meshes well with the aims of this study to learn more about the experiences of midlife individuals who have contemplated suicidality and inform counseling practice and counselor education.

Hermeneutic phenomenology has two primary characteristics central to its practice: the hermeneutic circle and the fusing of horizons (Wilding & Whiteford, 2005). The hermeneutic circle “refers to the process in which people come to develop an understanding of something” (Wilding & Whiteford, 2005, p. 101) through a reflexive and ongoing cycle. The circle essentially represents a metaphor for the continued iterative and recursive process that results in the ongoing consideration, interpretation, and co-construction of the stories of lived experiences. Additionally, instead of researchers’ bracketing their own views, they are fully embedded in the process through this iterative cycle (Krajewski, 2003).

van Manen’s Framework

Van Manen’s (1990) inquiry process and framework was used as a guide to the hermeneutic phenomenological study. His process provided a general framework that is emergent and non-linear, while recognizing that all research activities need to be intertwined to
fully understand the phenomenon being studied. Van Manen proposed six activities to develop rigor in conducting this type of research:

1. Turning to a phenomenon which seriously interests us and commits us to the world
2. Investigating experience as we live it rather than as we conceptualize it
3. Reflecting on the essential themes which characterize the phenomenon
4. Describing the phenomenon through the art of writing and rewriting
5. Maintaining a strong and oriented pedagogical relation to the phenomenon
6. Balancing the research context by considering parts and the whole. (pp. 30–31).

The outcome of these activities is a piece of writing that “shows something” by explicating the meaning of human phenomena and creates understanding (van Manen, 1990, pp. 130–131). Van Manen’s process provided a framework for this study and related choices that will allow for understanding the meaning of midlife adults’ lived experiences with suicidality.

**Theoretical Underpinnings**

Two theories were used as frameworks for this study on midlife suicide: Bronfenbrenner’s bioecological model of human development (1979, 1994) and Joiner’s interpersonal-psychological theory of suicide (2005, 2009). Urie Bronfenbrenner’s (1979, 1994) bioecological model of human development posits that each person lives in the context of one or more Microsystems (e.g., family, workplace, and peer group) and these Microsystems cluster together to form the mesosystem, which is nested within a macrosystem (i.e., society, culture). These systems are linked and interactively exert risk-enhancing or protective forces on the propensity for suicide over time.

The second theoretical model was articulated by Joiner in 2005. In his interpersonal-psychological theory of suicide, Joiner theorizes that three factors are necessary to complete
suicide: a thwarted sense of belongingness, perceived burdensomeness to society, and an acquired capability to overcome the pain and fear of suicide. When all three factors are present, a lethal or near-lethal suicide attempt may be imminent. Further explanation of each of these theories and their use in this study of suicidality in midlife adults follows.

**Bronfenbrenner’s Bioecological Model of Development**

Many perspectives and theories might be used to understand suicidality in midlife adults including genetics, neurochemistry, cognitive theories, and personal psychology. However, these perspectives focus primarily on factors intrinsic to the individual, so they do not present a full picture of the factors that contribute to suicidality. The counseling profession has a perspective unique among other disciplines in that patients’ behavior is considered in the context of their own unique traits in conjunction with the social environment (Gladding, 2013). In addition, given that counseling interventions often expand beyond the individual level, into families, groups, organizations, and universities, a broader theoretical perspective that encompasses a variety of settings is helpful. This potential complexity with so many factors to consider means that a way to conceptualize and understand the array of potential influences on midlife adults and their mental health and wellbeing must be employed.

One such theoretical model is Bronfenbrenner’s ecological systems theory (Bronfenbrenner, 1977, 1979). Bronfenbrenner was concerned that developmental psychologists pay little attention to environmental influences on human development and instead focus solely on the individual (Bronfenbrenner, 1977, 1979). He wrote,

> The understanding of human development demands more than the direct observation of behavior on the part of one or two persons in the same place; it requires examination of multiperson systems of interaction not limited to a single setting and must take into
account aspects of the environment beyond the immediate situation containing the subject. (p. 21)

Therefore, Bronfenbrenner’s theory embraces a person-in-environment perspective by focusing on the individual and the context in which the individual functions. Specifically, Bronfenbrenner (1979) argued that individuals’ development is strongly influenced by their family, work, peer, neighborhood and community contexts. Thus, in order to understand human development, one must consider the entire bioecological system in which growth occurs. These environments—which Bronfenbrenner called the microsystem, mesosystem, exosystem, macrosystem, and chronosystem—significantly contribute to individuals’ wellbeing. Such environments can promote or cultivate positive overall lifespan development. In contrast, disruptions and instability in the primary settings (e.g., family, community) in which individuals’ competence and character are developed are risk factors that inhibit healthy development. Figure 4 displays how the individual is situated within the various systems in his or her own life and how the systems interact with one another. A further explanation of the systems in Bronfenbrenner’s model follows in the next section.
Figure 4. Bronfenbrenner’s Bioecological Model

**Microsystem**

The microsystem is a pattern of activities, roles, and interpersonal relations that a person experiences (Bronfenbrenner, 1979, p. 22). Within the microsystem, the individual has direct interactions with parents, children, peers, coworkers, and others. The factors of activity, role, and interpersonal relation constitute the building blocks of the microsystem (Bronfenbrenner, 1979, p. 22). Bronfenbrenner emphasized that to understand the microsystem, it is important to keep in mind that all relationships are bidirectional and reciprocal. That is, coworkers, peers, parents, children, supervisors, and significant others affect the behavior of an individual, and the characteristics of each individual (e.g., personality type) also influence the behavior of others within the system (Bronfenbrenner, 2005; Bronfenbrenner & Ceci, 1994). Microsystem level influences for midlife adults may include relationships with spouses, children, parents, coworkers, supervisors, doctors, school (for self and/or children), and peer relationships.
Mesosystem

Bronfenbrenner’s mesosystem, a system of microsystems, captures the idea that individuals develop by interacting with others within multiple settings in their microsystems (Bronfenbrenner, 1981, p. 23). The mesosystem involves links between microsystems, such as family and community. Relationships between individuals across settings create significant connections in the life of an individual. For example, the mesosystem of a midlife woman may change depending on her role in a specific setting, such as employee, mother, or student. The dynamics and demands that she experiences interpersonally through these various roles might be viewed as complementary or positive to her growth or development; they might also be viewed as conflicting or as a risk factor to her development. As an employee in her work environment, she may have pressure to take on more responsibility and put in additional hours in order to keep her job in a shaky economy. As a mother, she tries to maintain balance with her family life, creating schedules to maximize the quality time that she spends with her children while running a household. As a student, she may be inspired by the learning process, increasing her level of educational attainment as she is hopeful about what a degree might do for herself and her family. However, she might also be frustrated by expectations and schedules that seem more suited for the traditional college student than a working, middle-aged mother. Thus, the mesosystem expands the developmental perspective to consider how the back-and-forth of experiences across multiple settings shapes individual adult development.

Exosystem

The exosystem refers to social settings in which an individual does not have an active role in influencing his or her experiences. The exosystem is a more distal context that may not directly include given individuals but may significantly affect them (Bronfenbrenner, 1979). For
example, it is unlikely that a spouse has an active role in the other spouse’s employment. But if one spouse would lose his job, everyone in the household would be affected, even if they have nothing to do with the reasons for the loss (e.g., layoff, failing a drug test, fight with a supervisor). If an employment situation is depressing for one partner, the couple (and the family) may find relationships suffering at home.

**Macrosystem**

Unlike the other systems, the macrosystem, the outermost level of Bronfenbrenner’s model, is not context specific. The macrosystem is comprised of the “overarching patterns of micro-, meso-, and exo- system characteristics of a given culture, or other extended social structure” (Bronfenbrenner, 1993, p. 25). The macrosystem involves the broader culture (e.g., values, laws, customs) in which individuals live. The macrosystem refers to the consistencies in the form of systems at the level of the subculture or of the entire culture (Bronfenbrenner, 1981, p. 26). An example of this would be that across American society, our public schools, our post offices, and our voting booths are similar in form and function. It can also consist of attitudes and behaviors that might not be apparent to an individual but might be seen in the culture as a whole. For example, some believe that American society is structured on capitalism, privilege, and patriarchy. Individuals may be over-privileged or disadvantaged on the basis of gender, race, class, sexual orientation, and other divisions (Hess & Schultz, 2008, p. 61). Thus, the power relations that exist within the macrosystem can be expected to be an integral part of the everyday lived experience of individuals at the micro-, meso-, and exosystemic levels.

**Chronosystem**

Lastly, the chronosystem represents environmental events, transitions, and sociohistorical conditions of an individual’s development. Environmental events are natural events such as
hurricanes, tornadoes, and earthquakes. Sociohistorical circumstances are large socially historical events in that person’s life. For midlife adults, this might be the end of the Cold War, the shift to a knowledge-based economy, or the election of the first African American President. The variable of time on the other systems of development give a contour to human development; humans are a product of their times (Hess & Schultz, 2008, p. 61).

Bronfenbrenner’s social-ecological model is the cornerstone of the violence prevention activities espoused by the Centers for Disease Control and Prevention (CDC) (Stone et al., 2017). The CDC depicts a four-level prevention model in which the individual is nested within relationships, then community, and finally society. Thus, Bronfenbrenner’s bioecological model is a useful framework for viewing and understanding suicide risk and protective factors identified in the previous section of the literature review. Risk and protective factors for suicide exist at each level (Stone et al., 2017). For example, risk factors include the following:

- **Individual level**: history of depression and other mental illnesses, substance abuse, personality traits, previous suicide attempt, trauma, and genetic and biological determinants
- **Relationship level (Microsystem)**: high conflict or violent relationships, sense of isolation and lack of social support, family/loved one’s history of suicide, financial and/or work stress
- **Community level (Exosystem)**: inadequate community connectedness, barriers to health care (e.g., lack of access to providers and medications)
- **Societal level ( Macrosystem)**: availability of lethal means of suicide, unsafe media portrayals of suicide, stigma associated with help-seeking and mental illness.
Much of the existing empirical research on predicting and preventing suicidal behavior has involved implicitly or explicitly identifying important risk and protective factors (Conwell et al., 2002; Frey & Cerel, 2015; Pietrzak et al., 2010; Witte et al., 2006). Using Bronfenbrenner’s model, a sociocultural framework for midlife suicidality would investigate risk factors at both the micro and macro levels of involvement. To be more specific, to assess a particular midlife adult’s risk for killing themselves adequately, a professional counselor would need to know about the individual themselves (e.g., demographic data, situational information, diagnoses), the immediate environment that surrounds that individual (microsystem), and the social conditions under which the immediate environment operates (macrosystem). Furthermore, Bronfenbrenner’s model is particularly useful in that it incorporates cultural norms and values and provides clinicians with both primary (assessment and treatment of individuals) and secondary (assessment and treatment of environments) levels of intervention. A working knowledge of risk factors in all three of these systems should increase counselors’ abilities to adequately assess and intervene with potentially suicidal midlife adults. For this research project, Bronfenbrenner’s model also provides a framework with which to identify specific codes and even themes for data analysis. This will be further explored in Chapter 3.

**Joiner’s Interpersonal Theory of Suicide**

Thomas Joiner's 2005 book, *Why People Die by Suicide*, opens with a recounting of his father's gruesome death in 1990. The prologue of his book details how Joiner’s middle-aged father left home before dawn on a summer day, drove their minivan to a deserted parking lot, and killed himself. This personal experience with suicide led Joiner to study the phenomenon, including features that were often over-looked in prior empirical studies, and he is one of the foremost researchers in the field today. Joiner’s (2005) interpersonal psychological theory of
suicide provides a fitting theoretical conceptualization to examine the factors related to suicidal ideation and behaviors for midlife adults. Joiner stated that suicidal ideation is thinking about, considering, or planning for suicide completion. Suicidal ideation can range from a specific, concrete plan to a fleeting thought (Joiner, 2005). Suicidal behaviors are defined as self-initiated actions that include both an intention to die and physical injury wherein both intention to die and physical injury can vary in degree (Van Orden et al., 2010).

Joiner (2005) highlighted three factors as being the underlying causes of suicide within the general population. These three factors are perceived burdensomeness, thwarted belongingness, and acquired capability. More specifically, Joiner (2005, 2009) asserted that a conceptual interplay between perceived burdensomeness and thwarted belongingness contributes to suicidal ideation.

**Perceived Burdensomeness**

Perceived burdensomeness, one of two factors associated with suicidal ideation (Joiner, 2005), consists of two facets: individuals’ (1) self-hatred resulting from the belief that they are a problem to others because they are excessively flawed and (2) their beliefs that they are a liability to close friends and family and that they would be better off without them (Joiner, 2005; Stone et al., 2017; Van Orden et al., 2010). The first facet, consisting of self-hatred beliefs, can be deduced directly through individuals’ assertions that they hate themselves, or it may be communicated indirectly through feelings of uselessness (Van Orden et al., 2010). The second facet, which is the belief that they are a liability to others, is demonstrated when individuals state that family or friends are actually worse off because of their presence (Van Orden et al., 2010). Perceived burdensomeness is a dynamic cognitive-affective state, and individuals’ degree of perceived burdensomeness may vary across time (Van Orden et al., 2010). Given that perceived
burdensomeness comprises beliefs of self-hatred and of being a liability to others, perceived burdensomeness is likely related to midlife adults’ suicidal ideation because of the unique difficulties and responsibilities faced in this developmental stage.

Recalling Bronfenbrenner’s model, Joiner’s interpersonal theory would be articulated through the activities, roles, and interpersonal relations of the microsystem. For example, perceived burdensomeness is the view that one’s existence burdens family, friends, and/or society. This view produces the idea that “my death will be worth more than my life to family and friends,” and it represents a potentially fatal misperception (Joiner, Van Orden, Witte, & David, 2009). It is a myth that life insurance companies uniformly deny benefits to living relatives when the policy holder dies by suicide. Typically, if the policy has been in effect for more than two years, it is paid regardless of how the subscriber died (Dorfman, 2014). For midlife adults, the view that their death would unburden loved ones might stem from a potential payout from life insurance or an elimination of their debts upon their passing. An tragic example of this rationale is the July 2017 deaths of Glenn Scarpelli, age 53, and Patricia Colant, age 50, who jumped to their deaths from the Madison Avenue office building where the couple had worked (Cohen, Pagones, Fears, Lapin, & Musumeci, 2017). The couple left suicide notes describing how they “cannot live with” their “financial reality,” as they owed substantial back taxes to the Internal Revenue Service and additional debts of over $200,000 (Cohen et al., 2017).

Indeed, suicide notes often articulate feelings of burdensomeness as rationale. Joiner directly tested this theory in two studies of suicide notes, showing that raters detected more expressions of burdensomeness in 1) the notes of people who had died by suicide compared to the notes of those who intended to die but survived; and 2) the notes of those who died by violent means compared to the notes of those who died by less violent means (Joiner et al., 2002). In a
2006 study of psychotherapy outpatients, Van Orden, Lynam, Hollar, and Joiner (2006) demonstrated that perceived burdensomeness was a robust predictor of suicide attempt status and of current suicidal ideation. This result held even controlling for powerful suicide-related covariates like hopelessness (Van Orden, Lynam, Hollar, & Joiner, 2006).

**Thwarted Belongingness**

Thwarted belongingness is broadly defined as social isolation and is assessed by measuring individuals’ social connectedness (Joiner, 2005; Van Orden et al., 2010). Thwarted belongingness is unique from social isolation in that thwarted belongingness includes *perceived* as well as actual social isolation from others (Joiner, 2005; Van Orden et al., 2010). Specifically, thwarted belongingness includes both subjective social isolation (e.g., “These days, I feel like I do not belong”) as well as objective social isolation (e.g., “These days, I might have one satisfying interaction every day) (Joiner, 2005; Van Orden et al., 2006, 2010). Social isolation, in contrast, refers solely to the absence of positive social relationships. Thwarted belongingness is also a dynamic cognitive-affective state, which is influenced by individuals’ interpersonal environments, interpersonal cognitive schemas, and emotional states (Van Orden et al., 2010). Therefore, individuals’ thwarted belongingness varies across time and in degree, ranging from minimal social isolation (e.g., having social relationships but occasionally feeling lonely) to severe social isolation (e.g., having few to no social relationships) (Van Orden et al., 2010). Joiner (2005) elaborated that thwarted belongingness contributes to suicidal ideation because belongingness is an essential need for all humans. When the need is not being met, thwarted belongingness emerges and involves emotional and psychological pain, which can significantly contribute to the development of suicidal ideation (Joiner, 2005).
Joiner (2005) added that thwarted belongingness comprises two facets: loneliness and the absence of reciprocally caring relationships. Loneliness is defined as the cognitions and emotions associated with the lack of sufficient social connections (Van Orden et al., 2010). The loneliness facet of thwarted belongingness can be exemplified through an assertion of feeling disconnected or having shallow social interactions, particularly those in the microsystem. In counseling sessions or in other interactions, individuals experiencing an absence of reciprocally caring relationships may be evidenced by assertions about feeling a lack of support from others, in general, as well as during times of need.

A low sense of belongingness is the experience that one is alienated from others and not an integral part of a family, circle of friends, or another valued group. There is abundant evidence that this factor is implicated in suicidal behavior (Joiner, 2005). Suicide rates go down during times of celebration (e.g., when people pull together to celebrate) and during times of hardship or tragedy (e.g., when people pull together to commiserate) (Joiner, Hollar, & Orden, 2006). For instance, there was a low rate of death by suicide in the United States on September 11, 2001 (Joiner, 2009). Suicides also dip to their lowest rates in December, which is contrary to the myth that suicides increase around the holiday season (The Annenberg Public Policy Center, 2010). The holiday season is typically when individuals get together with family and friends to celebrate, so it seems that in a season of celebration, the rates would go down. Interestingly, the summer months are when suicide rates are at their highest (CDC, 2017b).

**Acquired Capability**

Joiner’s (2005) third factor, acquired capability, is a critical and essential factor for engagement in suicidal behaviors. Acquired capability comprises two facets: (1) an elevated physical pain tolerance and (2) a reduced fear of death (Van Orden et al., 2010). The first facet,
elevated pain tolerance, refers to becoming habituated to physically painful experiences and having a heightened ability to engage in increasingly painful, physically harmful, and lethally self-harming behaviors (Van Orden et al., 2010). Physical pain tolerance is developed because of individuals’ self-experience of physical pain. Physical pain tolerance varies in degree; it is method-specific so that physical pain tolerance associated with one method (e.g., cutting) can be high but can be low for another method (e.g., suffocation) (Van Orden et al., 2010). The physical pain can either be directly associated with suicidal behaviors, such as self-harm, or be developed through non-suicidal physical pain, such as physical abuse or invasive medical procedures (Van Orden et al., 2010). Research is consistent with this theoretical assertion that elevated physical pain tolerance could develop through non-suicidal physical pain. Findings indicate significant relationships between both suicidal and non-suicidal self-injury and suicide attempts (Guan, Fox, & Prinstein, 2012; Klonsky, May, & Glenn, 2013; Willoughby, Heffer, & Hamza, 2015).

Reduced fear of death is the second facet associated with acquired capability. Reduced fear of death refers to a decreased fear of death that develops from having been exposed to or observing numerous or repeated physically painful or fearful experiences, and it includes feelings of relief associated with these experiences (Van Orden et al., 2010). Specifically, reduced fear of death may develop through individuals’ witnessing physically painful experiences (e.g., physical abuse or trauma), actively engaging in physically painful experiences (e.g., inflicting physical pain or harm on another person or animal), or being involved in fearful experiences (e.g., exposure to combat or natural disaster). Individuals who witness, engage in, or are involved in physically painful or fearful experiences could develop a reduced fear of death because they habituate to these physically painful or fearful situations. Sadly, these situations become somewhat normalized (Van Orden et al., 2010). Reduced fear of death results in
individuals becoming increasingly able to engage in previously painful or frightening behaviors (Van Orden et al., 2010). Fear of suicide ranges from high fear to low fear, and fear of suicide must be nearly nonexistent for individuals to engage in suicide attempts (Van Orden et al., 2010). Having almost no fear of suicide can be expressed through individuals stating that they have the courage and capability to complete suicide and that they are “not afraid to die” (Selby et al., 2010; Van Orden et al., 2010).

Acquired capability consists of an elevated physical pain tolerance and reduced fear of death; thus, it can be gained over time and is relatively stable once established (Van Orden et al., 2010). The most direct route to developing the acquired capability is practicing, preparing for, or engaging in suicidal behaviors, with suicide attempts being the most extreme form of suicidal behaviors (Van Orden et al., 2010). However, acquired capability can also be established through other experiences and behaviors. For example, individuals who are subject to physical abuse and violence may develop an increased physical pain tolerance, which may result in increased acquired capability (Van Orden et al., 2010; Van Orden, Witte, Gordon, Bender, & Joiner, 2008). Specifically, women who experience domestic violence could be less frightened of physical harm and consequently may have an increased likelihood to engage in self-harm behaviors associated with suicide (Cavanaugh, Messing, Del-Colle, O’Sullivan, & Campbell, 2011; Devries et al., 2011). As another example, a military veteran who is wounded in action can develop increased physical pain tolerance from the sustained injury and also develop a reduced fear of death as a result of being in and witnessing combat (Selby et al., 2010; Van Orden et al., 2010).
Empirical Data Supporting Joiner’s Interpersonal Theory

The capability of engaging in suicidal behavior is separate from the desire to do so. According to Joiner’s theory (2009), the capability for suicidal behavior emerges in response to repeated exposure to physically painful and/or fear-inducing experiences. One way of acquiring the capacity, and the most reliable predictor of future death by suicide across the lifespan, is having a prior history of this type of behavior. The presence of multiple past attempts is an especially strong predictor of lethal suicidal behavior in adults (Christiansen & Jensen, 2007, Suominen et al., 2004). A 37-year longitudinal study indicated that the elevation in risk for lethal suicidal behavior, given a history of a previous attempt, persists over the lifetime (Suominen et al., 2004).

Further, empirical findings are consistent with Joiner’s (2005) assertion regarding the association of perceived burdensomeness and thwarted belongingness with suicidal ideation (Conner, Britton, Sworts, & Joiner, 2007; Joiner et al., 2002; Van Orden et al., 2008). Joiner (2005) posited that acquired capability is associated with suicidal behaviors, which has been supported within research. Specifically, results from Joiner et al.’s (2009) study suggested that community-based psychotherapy outpatients with greater numbers of suicide attempts had higher acquired capability than those with fewer suicide attempts or no suicide attempts. The theory further elaborates that the combined effect of perceived burdensomeness, thwarted belongingness, and acquired capability results in lethal or near lethal suicide attempts (Joiner, 2005).

Research with various samples offers empirical support for Joiner’s (2005) theory, specifically that perceived burdensomeness and thwarted belongingness have been associated with suicidal ideation in psychotherapy outpatient clients (Van Orden et al., 2006), inpatient
psychiatric patients (Monteith, Menefee, Pettit, Leopoulos, & Vincent, 2013), and individuals with substance use and abuse disorders (Conner et al., 2007).

Christensen, Batterham, Soubelet, and Mackinnon (2013) also examined suicidal ideation in relation to thwarted belongingness and perceived burdensomeness and explored the relationship between acquired capability and suicidal behaviors across three age cohorts: 20s, 40s, and 60s. For adults in their 40s, belongingness alone was not a predictor, unless it was paired with perceived burdensomeness. However, belongingness became a predictor in association with hopelessness or perceived burdensomeness (Christensen, Batterham, Soubelet, & Mackinnon, 2013). For plans/attempts and ideation, capability alone and/or the interaction of the ideation and capability were significant. For adults in their 60s, all three components were significant in predicting suicide ideation, both two-way interactions were significant, and the three-way interaction of perceived belongingness, thwarted burdensomeness, and hopelessness was significant (Christensen et al., 2013). Thus, Joiner’s (2005) model offers a fitting explanation for suicidal ideation and behaviors in midlife.

**Suicide in Midlife Adults**

The United States suicide rate for adults ages 45–64 had the largest absolute rate increase from 1999 to 2016 (from 13.2 to 19.2 per 100,000 people), and the greatest number of suicides (232,108) during the same period, according recent CDC data (Hedegaard et al., 2018; Stone et al., 2018). Table 7 compares 1999, the first year of the uptick in suicide rates in the United States, with the most recent year, 2016, for which data is available (as of August 2018; Curtin et al., 2016; Hedegaard et al., 2018). It should be noted that there is a significant lag time between the end of a reporting year and the statistical data being published. Typically, it takes 24–30
months for data to be reported. Table 7 is also broken down by age and sex the better to illustrate when the increase in the suicide rates has been most apparent: at midlife adulthood.

Table 7

Suicide rates by sex and age, 1999-2016

<table>
<thead>
<tr>
<th>Sex and age (years)</th>
<th>1999</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Rate</td>
</tr>
<tr>
<td>Female</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10-14</td>
<td>50</td>
<td>0.5</td>
</tr>
<tr>
<td>15-24</td>
<td>575</td>
<td>3.0</td>
</tr>
<tr>
<td>25-44</td>
<td>2,359</td>
<td>5.5</td>
</tr>
<tr>
<td>45-64</td>
<td>1,868</td>
<td>6.0</td>
</tr>
<tr>
<td>65-74</td>
<td>420</td>
<td>4.1</td>
</tr>
<tr>
<td>75 and over</td>
<td>469</td>
<td>4.5</td>
</tr>
<tr>
<td>Not stated</td>
<td>-</td>
<td>*</td>
</tr>
<tr>
<td>Male</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10-14</td>
<td>192</td>
<td>1.9</td>
</tr>
<tr>
<td>15-24</td>
<td>3,326</td>
<td>16.8</td>
</tr>
<tr>
<td>25-44</td>
<td>9,213</td>
<td>21.6</td>
</tr>
<tr>
<td>45-64</td>
<td>6,109</td>
<td>20.8</td>
</tr>
<tr>
<td>65-74</td>
<td>2,051</td>
<td>24.7</td>
</tr>
<tr>
<td>75 and over</td>
<td>2,549</td>
<td>42.4</td>
</tr>
<tr>
<td>Not stated</td>
<td>16</td>
<td>*</td>
</tr>
</tbody>
</table>

*Quantity zero. Missing values for age were not distributed prior to calculating rates.
-Figure does not meet standards for reliability or precision; based on fewer than 20 cases in the numerator.

Note: Suicide deaths are identified with underlying cause-of-death codes U03, X60-X84, and Y87.0 from the International Statistical Classification of Diseases and Related Health Problems, Tenth Revision (2008).

Nearly 45,000 suicides occurred in the United States in 2016, making it the 10th leading cause of death. Among the explanations offered for this recent trend among the middle-aged is one that attributes the increases to cohort effects (McIntosh, 1994; Phillips, Robin, Nugent, & Idler, 2010). Cohort effects consider both contemporary and historical socio-cultural contexts for a given group of people, recognizing that certain events have different implications for suicide according to the age at which that event occurs. It may be that the Baby Boomers, who occupied
the middle age range between 1999 and 2010, may have a unique suicide risk, higher than that of previous generations, that carries through the life course. A 2008 study was one of the first to sound the alarm regarding the uptick in midlife suicide rates for whites aged 40–64 years (Hu, Wilcox, Wissow, & Baker, 2008). Hu et al. found that the overall suicide rates increased by 2.7% per year in men and 3.9% per year in women from 1999 to 2005 and suggested multiple possibilities for explaining this increase, from cohort effects to prescription drug abuse to firearm availability (Hu et al., 2008). The researchers presciently concluded that “the latest trends suggest that the epidemiology of suicide has changed. Detailed analyses of recent data reveal largely unrecognized trends in suicide” (Hu et al., 2008)

Tara Parker-Pope (2013) reported that CDC officials have cited a number of possible explanations for the recent rise in suicides, including that during their adolescence, people in the Baby Boom generation also posted higher rates of suicide compared with other cohorts. She wrote, quoting the CDC’s Deputy Director, Ileana Arias, “It is the baby boomer group where we see the highest rates of suicide. There may be something about that group, and how they think about life issues and their life choices that may make a difference” (Parker-Pope, 2013). Indeed, Phillips (2014) concluded that while the suicide rates did show a decline in the last two decades of the 20th century, “patterns have started to reverse as the large Boomer cohort (particularly males) moves into older age ranges with traditionally higher suicide rates and with the development of increasing suicide rates among the middle-aged” (p. 158). Suicide rates vary with age, owing to biological or behavioral differences and the accumulation of social experiences associated with age. Thus, shifts in the populations’ age composition or in the age pattern of suicide can produce changes in overall suicide rates.
A 2016 CDC Data Brief reported national data for 1999-2014 that noted an increased rate of suicide against a backdrop of otherwise decreased morbidity and mortality (Curtin et al., 2016). While the rate increased steadily over this period, the average annual percent increase was greater for the second half of this period (2006–2014) than for the first half (1999–2006). Though the suicide rate increased for nearly all age groups, the increase was most striking among midlife adults (Curtin et al., 2016). For example, men aged 45–64 had the largest percent increase rate-wise (43%), increasing from 20.8 in 1999 to 29.7 in 2014 (Curtin et al., 2016).

Figure 5 displays the data in the CDC report, as well as data obtained via the CDC WONDER database, as it pertains to midlife adults and their rates of suicide by decade (Curtin et al., 2016, CDC Wonder, 2018).

**Figure 5. Suicide in Midlife in the United States by Age and Decade**

In the past 17 years, the suicide rates have increased by 30% according to the CDC (Stone et al., 2018). The most recent data analysis showed that 25 states had increases of more than 30%, and nearly all of those states are in the western and midwestern regions of the United
States (Stone et al., 2018). Historically, the western states have some of the highest rates of suicide, which could be related to the fact that they tend to be more rural and are more likely to have a gun in the home. Additionally, the midwestern and more rural states are still recovering from economic downturns and have been hit hardest by the opioid epidemic (Hedegaard et al., 2018; Stone et al., 2018). Though there is no single factor that leads to suicide, psychiatric concerns, relationship issues, and financial troubles tend to be top factors contributing to suicide across the country. The most comprehensive rationale for the uptick in midlife suicidality, called “deaths of despair,” was formulated by Case and Deaton (2015, 2017). It is discussed in the section that follows.

**Deaths of Despair**

The increase in midlife suicide was elucidated in 2015 by Princeton University professors Anne Case and Sir Angus Deaton. Their 2015 PNAS paper explored the patterns and potential causes of increased middle-age white mortality. They noted that between 1978 and 1998, the mortality rate for non-Hispanic whites aged 45 to 54 in the United States fell by 2% per year on average, which matched the average rate of decline in six comparison countries (France, Germany, the United Kingdom, Canada, Australia, and Sweden), as well as the average over all other industrialized countries (Case & Deaton, 2015). Starting in 1999, U.S. white non-Hispanic mortality stopped falling and instead rose by half a percent a year. This is a contrast to the comparison countries whose mortality rates continued to decline by 2% per year (Case & Deaton, 2015, p. 15078). The increase in midlife mortality among non-Hispanic whites also stands in contrast to the continued progress being made in the United States by black non-Hispanics and Hispanics, who are on average poorer than whites (Case & Deaton, 2015, p. 15078).
As an explanation for this increase, Case and Deaton reason that “[t]he change in all-cause mortality for white non-Hispanics 45–54 is largely accounted for by an increasing death rate from external causes, mostly increases in drug and alcohol poisonings and in suicide…In contrast to earlier years, drug overdoses were not concentrated among minorities” (Case & Deaton, 2015, p. 15078). Figure 6, excerpted from Case and Deaton’s paper (2015, p. 10579) displays the role played by suicide, alcohol-related liver mortality, and accidental drug overdoses in pushing mortality rates higher for white non-Hispanic Americans.

![Figure 6. Mortality by cause, white non-Hispanics ages 45–54](image_url)

Whereas the mortality rate related to drugs, alcohol, and suicides has risen for middle-aged whites at all education levels, the largest increases are seen among those with the least education (Case & Deaton, 2015, p. 15079). Individuals with a high school diploma or less experienced an 81% increase in deaths from suicides and all-cause mortality rose by 22% for this group (Case & Deaton, 2015, p. 15080). Little change occurred in overall death rates for those
with some college education, and rates declined for those with a bachelor's degree or higher (Case and Deaton, 2015, p. 15080).

Case and Deaton (2015) use figures from the AIDS epidemic to put this number of mortalities into perspective (p. 15081). In terms of lives lost, had the white mortality rate held at its 1998 value, 96,000 lives would have been saved between 1998 and 2013. If it had continued to fall at the rate of decline seen in the two-decade period of 1978–1998, 488,500 deaths would have been avoided between 1999 and 2013. This is a figure comparable to the number of deaths caused by the AIDS epidemic in America (Case & Deaton, 2015, p. 15081).

Case and Deaton’s (2017) second paper found that the mortality increases are consistent with the distress that white, non-Hispanic midlife adults face: poorer physical health and mental health, social isolation, obesity, marriage (or lack thereof), lack of labor market opportunities, and weaker attachment to the labor market. Case and Deaton discovered a widening gulf among white non-Hispanics based on education level: those without a college degree experienced an increase in mortality, and those with a college degree experienced a decrease. Mortality rates of white non-Hispanics with no more than a high school degree, which were around 30% lower than the mortality rates of blacks in 1999, grew to be 30% higher than those of blacks by 2015, which is in line with recent literature pointing to lesser-educated whites’ losing ground to other groups in various life measures (Arias, 2016; Autor, Dorn, & Hanson, 2017; S. L. Brown & Lin, 2012; Cherlin & Seltzer, 2014; G. Hu et al., 2009; Meara & Skinner, 2015).

Case and Deaton (2017) found that both white non-Hispanic men and white women are facing a mortality crisis with what they refer to as “deaths of despair” (e.g., deaths by suicide, alcohol, and drugs; p. 11). It could be argued that even though they are counted differently for statistical purposes, to some extent, all deaths of despair are suicide, whether carried out quickly
(e.g., with firearms) or slowly using drugs and alcohol. White deaths of despair have increased in all regions of the country at every level of urbanization (Case & Deaton, 2017, p. 12). The epidemic spread from the Southwest, where it was centered in 2000, first to Appalachia and then to Florida and the west coast by the mid-2000s; it is now, unfortunately, nationwide (Case & Deaton, 2017, p. 12). A 2018 article released a study that included geographic maps of deaths of despair across the United States (Dwyer-Lindgren et al., 2018). The authors found that deaths owing to drug use and suicide increased in all counties in the United States; however, there were major differences among counties: mortality rates were alarmingly high in parts of Kentucky, West Virginia, Ohio, Indiana, and Oklahoma. In the hardest hit counties, such as those in Appalachia, there were increases of more than 5000% (Dwyer-Lindgren et al., 2018).

Case and Deaton (2017) noted mortality advancements from improved health care treatment of cancer and heart disease, as well as improvements from fewer people smoking. But these advancements have slowed, especially from heart disease mortality, and have been offset by deaths of despair (Case & Deaton, 2017, p. 14). While other wealthy countries, such as the United Kingdom, Germany, France, Sweden, Australia, and Canada, have continued to make progress in mortality rates, the United States has not. Instead of experiencing a decline in mortality rates of 1.9% per year between 1999 and 2014, rates for white non-Hispanics in the United States increased by 0.5% a year (Case & Deaton, 2017, p. 9).

A documented accumulation of pain, distress, and social dysfunction in the lives of working class white Americans took hold as the blue-collar economic heyday of the early 1970s ended and continued through the 2008 financial crisis and its subsequent slow recovery (Case & Deaton, 2017, p. 30; Meara & Skinner, 2015). Case and Deaton acknowledged the difficulty in proving causation between “deaths of despair” and factors such as unemployment. They pointed
to the literature (Autor et al., 2017; Cherlin, 2018; Cherlin & Seltzer, 2014; Meara & Skinner, 2015) to emphasize cumulative deprivation, rooted in the steady deterioration in job opportunities for people with low education (Case & Deaton, 2017, p. 29).

Autor et al. (2017) echo this, writing that contractions in the supply of economically secure adult men stemming from rising pressure spur a surge in male idleness and premature mortality (likely via deaths of despair). “This results in a decline in marriage and fertility, an increase in the fraction of mothers who are unmarried and who are heads of single, non-cohabiting households, and a growth in the fraction of children raised in poverty” (Autor et al., 2017, p. 17). Regarding this cumulative deprivation, Case and Deaton suggest how it might occur:

People moved away from the security of legacy religions or the churches of their parents and grandparents, towards churches that emphasized seeking an identity, or replaced membership with the search for connections. These changes left people with less structure when they came to choose their careers, their religion, and the nature of their family lives. When such choices succeed, they are liberating; when they fail, the individual can only hold him or herself responsible. In the worst cases of failure, this is a Durkheim-like recipe for suicide (Case & Deaton, 2017, p. 30).

Case and Deaton’s (2017) analysis is pessimistic about the future, concluding that short of a drastic turnaround, those who suffer in midlife are likely to be much less healthy in old age than are the current elderly. An additional finding also stands out: there appear to be two versions of America: one for people who got a college degree, and one for people who did not. This finding recalls a quote from author David Simon (2013), who remarked,
There are two Americas—separate, unequal, and no longer even acknowledging each other except on the barest cultural terms. In the one nation, new millionaires are minted every day. In the other, human beings no longer necessary to our economy, to our society, are being devalued and destroyed. (p. xx)

When individuals feel devalued, it is no wonder that they might turn to drugs, alcohol, and even suicide to numb a painful existence.

Conclusion

Midlife brings special opportunities and challenges. It often marks the pinnacle of one’s career. It also is a time when personal responsibilities and other burdens are the greatest. Balancing these opportunities against an ever-changing world can be difficult, particularly when one is struggling with a variety of internal and external risk factors. As a theoretical framework for this study about middle-aged adults attempting suicide, Bronfenbrenner’s bioecological theory is integrated with Joiner’s interpersonal theory. Both theories provide flexibility for the variable under consideration as well as philosophical grounding. Several gaps in the current research on this topic have become evident through this review of the literature. Specifically, the accounts of the lived experiences of midlife adults are missing from the current research, which consists mostly of statistics and demographic information. Thus, the use of qualitative methods can enhance understandings of the lived experiences of midlife adults considering suicide. An articulation of the methodology for this study follows in the next chapter.
CHAPTER 3: METHODOLOGY

The purpose of defining a methodology is to detail a template for working through the proposed study and coming to know the phenomenon of interest (Smith, 1997). Methodology begins with the assumption that investigators gather evidence based on the nature of the question and theoretical orientation (Pasick et al., 2009). Social inquiry is targeted toward various sources and the many levels that influence a given problem (e.g., policies, organizations, family, individual). Much of the research into suicidal behavior seeks to identify causes of the behavior in a linear cause-and-effect manner (Hjelmeland & Knizek, 2010). Quantitative—mainly deductive—methods are ideal for measuring the pervasiveness of “known” phenomena and central patterns of association, including inferences of causality. In contrast, efforts to understand this behavior typically use qualitative methods and focus on the meaning of the behavior for the individual. Qualitative—mainly inductive—methods allow for identification of previously unknown processes, explanations of why and how phenomena occur, and the range of their effects (Pasick et al., 2009).

The nature of suicide and the complexity of factors make it impossible to find any necessary or sufficient factor that causes it. Qualitative research about suicide helps us to understand why a particular person contemplated suicide and not simply why people wish to end their lives (Hjelmeland & Knizek, 2010). An example of such qualitative study is the work of David Lester, who read biographies of suicides and suicide notes, and discovered that the majority had experienced loss of a parent or parent surrogate and that many of those losses occurred during childhood (Lester, 1989). Lester’s qualitative research into the risk-factor of loss or interpersonal disconnectedness may generate hypotheses that are tested in quantitative research.
Hjelmeland and Knizek (2010) found that a current bias in the scope and methodology in suicidology has led to repetitious research. As examples of this bias, the authors point to the three main international suicidology journals and their use of qualitative methods by percent from 2005 to 2007. In the *Archives of Suicide Research*, 1.9% of the studies were qualitative, in *Crisis*, 6.6%, and in *Suicide and Life-Threatening Behavior*, 2.1% qualitative (Hjelmeland & Knizek, 2010). They argued that an increased focus on understanding is essential in advancing the suicidology field, and this is accomplished through qualitative research (Hjelmeland & Knizek, 2010). There is a dearth of studies exploring the perspectives of suicidal people from their own lived experiences. Webb wrote that “there is a fundamental flaw at the core of contemporary thinking about suicide; which is the failure to understand suicide as it is lived by those who experience it” (2010, p. 5). Understanding suicide goes beyond counting and comparing the cause of death statistics. Death by suicide ought to be considered on a continuum of suicidal experiences and behavior. This means that the field must shift towards hearing from those who are struggling with suicidality. Their stories are important and anyone with an interest in preventing suicide (e.g., everyone), must listen to the experiences of suicidal people in their own words in order to explore the meaning they have found and applied to their experiences.

Qualitative research is a necessary component to any study on middle-age suicide given that, to date, no qualitative studies directly address this population. Given the media attention that the uptick in the middle-age suicide rate has garnered (Bahrampour, 2013; Boyce, 2018; Cytrynbaum, 2013; Esposito, 2016; Greenfield Parker-Pope, 2013; Guoqing Hu et al., 2008; Phillips et al., 2010; Solomon, 2018), it is an aspect that needs further exploration in order to understand the experiences of those who have taken their own lives.
Glesne (2015) defined one of the purposes of qualitative research as learning about social phenomena, without generalizing or making causal conclusions. This project is aligned with this general purpose, as I investigated the phenomena of midlife suicide via individuals’ interactions on an online forum specific to suicidality in midlife. The phenomena under examination were the personal experiences of those who have grappled with suicide during midlife, as such phenomena align with the ontological and epistemological perspectives of qualitative research (Glesne, 2015). More specifically, these constructions are complex, variable products of our social worlds, and understanding them required a holistic, multi-faceted investigative approach.

This constructivist study sought to extend our understanding of the nature and meaning of the lived experience of midlife adults who are contemplating suicide or have done so. The remainder of the methodology section describes in detail how the study was constructed and conducted. Specifically, this chapter includes the methodological framework for both phenomenology and hermeneutic phenomenology. Figure 7 provides a representation of philosophical underpinnings, the selected methodology, and the methods used to inform and guide this study of suicidality in midlife adults.
In this chapter, the guiding process used for the methodology of this project that details van Manen’s (1990) research activities for conducting a hermeneutic phenomenology study is explained. Data sources, collection, and analysis are fully explicated in alignment within the hermeneutic phenomenology. Finally, key issues of quality for including criteria for trustworthiness and authenticity, as well as ethics, are discussed.

**Methodological Framework**

This study is nested within a constructivist paradigm positing that “…realities exist in the form of multiple mental constructions, socially and experientially based, local and specific, dependent for their form and content on the persons who hold them” (Guba, 1990, p. 27). The paradox for a researcher conducting a constructivist study is that a naturalistic approach must emerge, develop, and recognize context as opposed to being fully prescribed on the front end.
Yet, the prescribed intent of this chapter is to detail my thinking regarding the methodology and methods to be employed. Lincoln and Guba (1985) suggest that “…the design specifications of the conventional paradigm form a procrustean bed of such a nature as to make it impossible for the naturalist to lie in it— not only uncomfortably, but at all” (p. 225).

Given this inherent paradox in constructivist research, how does one go about designing a constructivist inquiry? Lincoln and Guba (1985) suggest 10 elements that form the foundation for this chapter: (1) determining a focus for the inquiry; (2) determining fit of paradigm to focus; (3) determining the “fit” of the inquiry paradigm to the substantive theory (theoretical framework) selected to guide the inquiry; determining where and from whom data will be collected; (5) determining successive phases of the inquiry; (6) determining instrumentation; (7) planning data collection and recording modes; (8) planning data analysis procedures; (9) planning the logistics; and (10) planning for trustworthiness (Lincoln & Guba, 1985, pp. 226-247).

The aim of this study was to understand how midlife adults contemplating suicide describe their experiences and rationale—their thoughts, feelings, assumptions, and/or situations— for ending their lives. This aim required an analysis of multiple constructs that have not yet been fully explored in the scholarly literature. Thus, my aim was to understand the phenomenon inductively. This gap suggested a bottom-up approach for fully understanding the perspectives and experiences of these midlife adults who struggle with suicidality. To begin the process of delineating the design strategy for this study, it was necessary to begin with my own philosophical posture and relate it to and within the context of this study.

A paradigm creates the context in which the theoretical elements are situated. Guba (1990) defines a paradigm as “…a basic set of beliefs that guide action, whether of the everyday
garden variety or action taken in connection with a disciplined inquiry” (p. 17). A paradigm is characterized by its ontology (the way things are or the nature of reality), epistemology (the way we know things), and methodology (how one acquires knowledge). For the purposes of this study, I borrowed from a constructivist paradigm as I examined multiple perspectives from the midlife individuals who have posted in a specific online forum to gain support, information, and validation. The constructivist paradigm provided a perspective that supports research in complex environments where knowledge is essentially the outcome of human expression. Thus, to gain a greater understanding, the outcome was dynamic and contingent upon the worldviews, experiences, and perspectives of the sources. Therefore, I made a theoretical claim that a constructivist lens was the most appropriate paradigm to understand fully the phenomena central to this study.

An essential element of communicating my design strategy is to articulate clearly the alignment between the philosophical underpinnings and chosen methodology (Lopez & Willis, 2004). Phenomenology, which explores the meanings and essence of human experiences, is frequently used for studies that seek to unearth understanding and meaning within the human sciences (Lopez & Willis, 2004). As such—and given that the aim of this study was to understand the lived experiences of midlife adults and suicidality—a methodology grounded in the fundamental tenants of phenomenology seems most appropriate. However, there is more than one school of phenomenology. Understanding the similarities and differences between phenomenological schools is necessary to ensure that the appropriate methodology is selected. In the review of the literature, two primary philosophical schools appeared within phenomenology (Lopez & Willis, 2004): phenomenology as largely influenced by Husserl’s descriptive tradition followed by Heidegger’s hermeneutic phenomenology with a focus on interpretation.
Phenomenology

The purpose for a phenomenological research study is to understand the nature of meaning in one’s everyday life (van Manen, 1990). It is the study of lived experiences that seeks to get straight to the pure vision of what an experience essentially is (Laverty, 2008). Phenomenology asks us to “…lay aside, as best we can, the prevailing understandings of those phenomena and revisit our immediate experience of them, [so that] possibilities for new meaning emerge for us or we witness at least an authentication and enhancement of former meaning” (Crotty, 1998, p. 78). Phenomenology is most often located within the constructivist paradigm (Wilding & Whiteford, 2005). Its philosophical underpinnings are predicated on an ontology that suggests the existence of multiple realities that are contextually bound, as well as recognition that understanding is more powerful than explanation in the social sciences because it stands more fully in the human world of self-understandings, meanings, skills, and tradition. Prediction is possible only in limited ways for human beings who are self-interpreting and subject to change from the very interpretations offered by research (Racher & Robinson, 2003, p. 475). In summary, this study is situated within the constructivist paradigm and is well-aligned with the methodological tradition of phenomenology.

Phenomenology surfaced as a way to challenge the dominant views regarding the nature of truth (Dowling, 2007). Phenomenology offered the promise of a new science that focused on the realm of being through personal experience (Laverty, 2008). Edmund Husserl is often considered to be the father of phenomenology (Dowling, 2007; Laverty, 2008). Husserl focused on creating a philosophy that recognized experience as a central feature of life: if experience is central, universal knowledge could be realized (Ehrich, 1999). Husserl’s phenomenological goals were heavily weighted towards epistemology because he regarded experiences as the
fundamental source of all knowledge (Racher & Robinson, 2003). The goal was to study things in an unbiased way, free of subjective interpretations and as they appeared. Therefore, the goal was to describe the phenomenon as it presented itself. Within the Husserlian tradition, four key concepts—consciousness, experience, phenomenon, and intentionality—have been delineated as the characteristics of phenomenology (Giorgi, 1997).

Consciousness refers to the totality of lived experiences (Giorgi, 1997) and can best be understood as “…co-constituted dialogue between a person and the world” (Laverty, 2008, p. 23). Giorgi claims that “within phenomenology, consciousness enjoys a privileged status because it cannot be avoided” and consciousness presents objects to us as a function of intuition (Giorgi, 1997, p. 241). Following these ideas, it is advisable for researchers to acknowledge the presence of consciousness rather than ignore it. The reason is that it may be significantly relevant, considering the role that consciousness plays in the meaning of objects in the abstract sense. In comparison, experience is the intuition of the more tangible objects such as a computer or a chair. Thus, for Husserl, experience refers to a narrower range of presences that carry reality with them (Giorgi, 1997). The distinction between intuition and experience is an important one for phenomenological research, as most human science research will tend to focus on intangible, abstract phenomena that are crucial to our understanding. Phenomenon, in phenomenology, refers to the presence of something as it is experienced (Giorgi, 1997). The focus is always the meaning of the object as it is given based on the experiences of the individual participants. In phenomenological studies of lived experiences, the experiences, as defined by all the participants, are considered as given, regardless of how marginal that experience may be.

Intentionality allows for greater understanding and clarifying conscious acts (Giorgi, 1997). Husserl characterized intentionality as consciousness, which allowed one to describe the
whole stream of consciousness or total meaning of an object (Giorgi, 1997). Husserl proposed that by directing one’s focus, one could develop a description of particular realities (Laverty, 2008). Thus, this total meaning, this reality, is always greater than the perspective or experiences of one participant. In this study, the participants’ lived experiences, midlife adults struggling with suicidality, as bestowed with meaning, is intentionality as intended by Husserlian phenomenology.

From a methods perspective, phenomenology is seen as an inductive, descriptive inquiry approach and strategy. Its goal is to produce accurate descriptions of the phenomenon being studied. The phenomenological method is a way of putting in place standards as a way of limiting bias. As such, phenomenological research encompasses three essential elements of method: reduction, description, and search for essences (Giorgi, 1997). A fundamental strategy for Husserl was phenomenological reduction, which allows one to be led back to the source of original meaning (Giorgi, 1997). Through the process of reduction, the phenomenon may be studied from a new perspective (Giorgi, 1997). Husserl devised a notion of reduction called bracketing, which requires the researcher to “…hold subjective private perspectives and theoretical constructs in abeyance and allow the essence of the phenomena to emerge” (Racher & Robinson, 2003, p. 471). In the social sciences, bracketing refers to the examination of a researcher’s own biases and prejudices surrounding the topic with the intent of setting those aside to allow for a more robust process of knowing.

Description is the process of giving “linguistic expression” to intentional objects of consciousness from within the perspective of phenomenological reduction (Giorgi, 1997, p. 243). For the phenomenologist, to describe is to articulate what is provided as it is and without assigning meaning. Thus, if participants indicate that they feel overwhelmed with the demands of
their lives, phenomenology does not try to interpret the *meaning* of what the participant said. Rather, it simply describes *what* the participant said with the intent that deriving full expression from multiple participants will elicit a rich description to provide an intrinsic account of a phenomenon.

The final strategy in the phenomenological research study method is to search for the essence of the phenomenon. Husserl suggested that to achieve this objective, imaginative variation must be used (Giorgi, 1997; Laverty, 2008). Giorgi (1997) wrote that

…free imaginative variation is a natural method for discovering essences. As the name implies, the method means that one freely changes aspects or parts of a phenomenon or object, and one sees if the phenomenon remains identifiable with the part changed or not. Ultimately, the use of the method depends upon the ability of the researcher to awaken possibilities. (p. 244)

Through the process of imaginative variation, what is essential becomes evident (Giorgi, 1997). With this technique, the researcher removes one theme, then another theme, and so on in order to discover which themes are essential and which are not essential (Giorgi, 1997; Moustakas, 1994).

**Hermeneutic Phenomenology**

The philosophical underpinnings for hermeneutic phenomenology were established through the works of Martin Heidegger and Hans-Georg Gadamer. Like phenomenology, hermeneutic phenomenology is concerned with human lived experiences as well as with providing a scientific approach that is non-reductionistic (Laverty, 2008). At the core, hermeneutic phenomenology is about knowing, learning, and understanding the meaning of one’s everyday experiences. In Heidegger’s view, “consciousness is not separate from the world
but is a formation of historically lived experiences” (Laverty, 2008, p. 24). Heidegger emphasized understanding one’s history—how one has become situated in the world—because it is through social, historical, and cultural contexts that one develops an understanding of the world. Essentially, for Heidegger, nothing could be fully understood without acknowledging one’s background. Through this background, one determines what is “real” (Laverty, 2008, p. 24). Another characteristic of hermeneutic phenomenology is the concept of co-constitutionality. Persons and their world co-constitute each other, providing a way of understanding and creating meanings from the phenomena we study. Other philosophers describe hermeneutic phenomenology as a philosophy of the unique and a human science which studies persons and the uniqueness of human beings (van Manen, 1990, p. 6–7). Van Manen explained that phenomenology is the “…philosophy of the personal, the individual, which we pursue against the background of an understanding of the evasive character of the logos of other, the whole, the communal or the social” (van Manen, 1997, p. 7).

Interpretation is a critical part of the hermeneutic phenomenological process. Heidegger stressed that “…every encounter involves an interpretation influenced by an individual’s background …” (Laverty, 2008, p. 24). A hermeneutic phenomenologist seeks to provide descriptions that capture the essence of lived experiences and then provide interpretation of those experiences through rich and thick textual descriptions (van Manen, 1997). A core concept for hermeneutic phenomenology is the hermeneutic circle, wherein the interpretative process is fully realized. Heidegger conceptualized the hermeneutic circle as an ontological issue that illustrates reciprocity in recognizing that our knowledge is a function of historical experiences and being in the world (Mantzavinos, 2016). The hermeneutic circle is essentially a metaphor for the circular process that occurs when one moves from the whole to its parts and then back again to the whole.
For example, a person brings his or her social and historical knowledge into a research study, and that knowledge is defined as “pre-understanding,” which cannot be eliminated but only corrected or modified (Clark, 2008; Mantzavinos, 2016). This pre-understanding is a necessary condition for moving through the hermeneutic circle and, thus, bringing an understanding of the whole, which provides a coherent and meaningful knowledge of the phenomenon being studied. As new knowledge is acquired, that knowledge is brought into the hermeneutic circle, which suggests that understanding and interpretation continue to evolve (Debesay, Nåden, & Slettebø, 2008). This circularity is seen as a process that enables a person not necessarily to understand better but rather to understand in novel or “different ways” (as cited in Debesay et al., 2008, p. 58). Figure 8 is a representation of the hermeneutic circle, as adapted from Bontekoe (1996, p. 4) and DeGrezia and Scrandis (2015, p. 152).

![Hermeneutic Circle Diagram](image)

*Figure 8. Depiction of the hermeneutic circle*

Gadamer advanced Heidegger’s work but with a greater focus on the concepts of meaning and universality (Mantzavinos, 2016). Understanding and interpretation, which are bound together, represent a continuously evolving process (Laverty, 2008). Gadamer developed
the concept of horizon, which he defined as a range of vision that included everything that can be seen from someone’s vantage point. Interpretation, therefore, is a fusion of horizons where a dialectic interaction occurs between the participants and the text (Laverty, 2008). Central to this concept is the recognition that we all have “historically-effected consciousness,” as one’s horizon is determined by one’s situatedness in time and place (Crotty, 1998). This concept has particular relevance for a study on midlife suicide as Bronfenbrenner’s (1979) bioecological model of human development informs us that the chronosystem may be a key area of developmental influence.

Given the above description and explanation, hermeneutic phenomenology was selected as the primary methodology for this study for several reasons. First, the study required that unique consideration be given to each participant’s (or poster’s) social and historical context, underscoring that generational location matters. Hermeneutic phenomenology seeks to capture historical reference in one’s lived experience by recognizing that it is impossible to separate people from their past. Second, hermeneutic phenomenology does more than merely describe a person’s lived experience: it tries to understand the whole person as co-constituted by a person and his or her world. In the case of this study, the goal is to understand midlife adults who have struggled with suicidality and how they are situated within their world. Moreover, this approach goes beyond mere description by providing an interpretation of one’s experiences, which, Heidegger would suggest, cannot be fully realized through description alone. Finally, the methodological traditions and corresponding framework of hermeneutic phenomenology provided methods that are congruent with the research objectives and the constructivist research paradigm. Through the inductive process of this approach, themes cumulate as multiple voices are heard and experiences interpreted. As such, hermeneutic phenomenology is well suited to
this study as it allows understanding of people and their meanings and interactions with others and their environment, reflecting my intent to pursue a rich exploration of the lived experiences of midlife adults who have struggled with suicidality.

Van Manen’s Hermeneutic Phenomenology

Max van Manen (1990, 1997) introduced a phenomenological process of reflection and analysis that may be used as a guide for conducting phenomenological research. This approach outlined six activities, among which a dynamic interplay contributes to “animate inventiveness and stimulate insight” (van Manen, 1990, p. 30). These six research activities (van Manen, 1990, pp. 30–33) are described below.

1. Turning to the nature of lived experience. For researchers, this activity is predicated on a commitment to dedicating themselves to the inquiry and understanding that this is a study about the lived experiences of human beings in social, political and historical context (van Manen, 1990, p. 31). As I am the primary researcher for the study, this activity required that I contemplate my own experiences, biases, and pre-understandings as they pertain to midlife adults as they grapple with suicidality and incorporate my personal understandings into this reflection.

2. Investigating experience as we live it rather than as we conceptualize it. Inherent within the hermeneutic phenomenological approach is an understanding that the researcher investigates experiences as they are lived to collect data from the participants (van Manen, 1990, p. 31-32). For this study, I identified understanding the lived experiences of midlife adults as they navigate this developmental period in the context of suicidality against a national backdrop of a rising suicide rate. Thus, the focus was on these experiences and I, as the researcher, worked towards orienting myself on this topic to capture fully the essence of those experiences.
3. Reflecting on the essential themes. The aim of hermeneutical phenomenological reflection is to grasp essential meaning through a process of reflection, clarifying and identifying the structure of meaning of one’s lived experiences (van Manen, 1990, p. 32). Development of the themes is a critical component to this research approach as it provides interpretation and a structuring of the experiences (van Manen, 1990, 1997). This process is used to capture fully the focused experiences of midlife adults who struggle with suicidality and their desire to search for support online.

4. Describing the phenomenon through the art of writing and rewriting. Human science research is a form of writing, and text is the essential goal of the research process (van Manen, 1990, p. 32). Writing is an iterative and recursive process for hermeneutic phenomenological research (Levers et al., 2008). This approach was taken in this study as writing allows for “…some aspect of our lived world, of our lived experience, reflectively understandable and intelligible” (van Manen, 1997, p. 125).

5. Maintaining a strong and oriented pedagogical relation. Van Manen recognized the task placed upon researchers to maintain their focus and strength in terms of the topic being researched. This allows for rich and deep descriptions and for interpretations of the lived experiences to be as fully described as possible.

6. Balancing the research context by considering parts and whole. As the research study unfolds, it is easy to get lost in the parts and lose sight of the overall goals and research questions. Van Manen cautions the researcher to balance the parts to the whole and be mindful of contextual givens throughout the entire study (van Manen, 1990, p. 33). Conceptually, this process is like the hermeneutic circle (see Figure 8).
Table 8 displays the six steps as outlined by van Manen (1990, p. 30-31) and the activities related to each of these steps in this hermeneutic phenomenological research study.

### Methodological structure (van Manen, 1990)

<table>
<thead>
<tr>
<th>Steps suggested by van Manen</th>
<th>Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Orientation to the phenomenon which seriously interests us and commits us to the world</td>
<td>Positioned clinically to encounter individuals struggling with midlife suicide or who have been touched by the phenomenon; Deep research interest in the phenomenon</td>
</tr>
<tr>
<td>Immersion and investigation of the phenomenon under study</td>
<td>Choosing a data source with rich textual descriptions from individuals in the study’s purview</td>
</tr>
<tr>
<td>Reflecting on essential themes</td>
<td>Using a holistic approach to develop themes</td>
</tr>
<tr>
<td>Describing the phenomenon by using the art of writing and rewriting</td>
<td>Writing and rewriting to achieve the best description of the phenomenon</td>
</tr>
<tr>
<td>Establishing and maintaining a strong relation to the phenomenon</td>
<td>Checking the contents of the transcripts and finding their relationships in the analysis</td>
</tr>
<tr>
<td>Aligning the research with continuous components</td>
<td>Movements from the whole to part and from the part to whole</td>
</tr>
</tbody>
</table>

### Unobtrusive Measures

Unlike the research methods used in many hermeneutic phenomenological studies, there will be no direct interviews with participants or face-to-face research. Instead, I am using unobtrusive methods to study the lived experience of midlife adults who struggle with suicidality. Unobtrusive measures, such as unsolicited narratives and secondary data analysis, have been used for over a century in suicidology. Use of these methods is traditional because of the stigma that death by suicide often carries. Many studies have been conducted with secondary analyses of official statistics on suicide, a renowned example being Durkheim’s 1897 book,
Suicide: A Study in Sociology. By examining statistics in terms of locations, weather, age, gender and religion, Durkheim (1897) concluded that social stability is a protection against suicidal tendencies in populations. From this unobtrusive analysis, Durkheim created the concept of anomic suicide, as described in Chapter 2, which is a product of social instability and disintegration and quite different from the theories at the time which posited that suicide was a consequence of mental illness. Another example is Phillips and Zhang’s (2002) report in The Lancet on suicide rates in China from 1995-1999. The missing data from official statistics used in this report tells us more about China’s censorship, laws, and the stigmatization than it does about actual suicide rates. Vigilance and critical evaluation are essential when analyzing any type of unobtrusive research data; however, identifying missing or distorted data also can reveal interesting information and lead to unexpected findings.

Further, a body of research has been built around the use of suicide letters as a viable data source (Lester, 1989). A collection of suicide notes found in the 1950s led to an analysis of the experiences of those who died by suicide (Shneidman & Farberow, 1957; Shneidman founded the American Association for Suicidology and launched the practice of psychological autopsy, an examination of the factors contributing to a completed suicide). Gregory (1999) followed this up by comparing genuine and simulated suicide notes to determine in what ways they might be similar and dissimilar. He found that the two types of suicide notes differed with respect to five language components and revealed the extent to which individuals internalize the decision to die. Gregory’s findings are likely to be of interest to authorities when the reason for death is equivocal, to families trying to make sense of their loss, and to clinicians wanting a better understanding of the factors that influence an individual’s decision to die. These studies are
examples of the appropriateness of unobtrusive research techniques to generate new theory by analyzing pre-existing data.

Unobtrusive measures can provide insight into the subjective experiences of life under a variety of circumstances and the meanings the authors ascribe to them. Considering the stigma that often surrounds suicide, it may be difficult to obtain candid responses in a face-to-face format or in solicited, researcher-driven interviews. Hookway (2008) writes that using online resources, such as blogs, provides “a very useful technique for investigating the dynamics of everyday life from an unadulterated first-person perspective” (p. 107). Berg (2007) put it simply: “Unobtrusive indicators provide access to aspects that are simply unreachable through any other means” (p. 239).

Personal stories are frequently shared online, often in real time, given the ubiquity of technology. Given the increase in popularity of sharing personal experiences in this way, research into online communities is now commonplace (Morison et al., 2015). Existing qualitative research has involved examination of personal narratives produced by individuals and shared via social media platforms, blogs, and other types of online spaces (Barker, 2008). These online accounts can provide researchers with an understanding of what it is like for the author of the personal narrative.

Unobtrusive research techniques may not be as highly valued in some academic disciplines as more traditional methods, but they are extremely valuable tools that do not disturb data. Use of online communication is also free from reaction bias that can arise when individuals are aware that they are being researched. The use of unobtrusive measures allows researchers to collect stories of struggle, particularly those of a controversial or sensitive nature, without the usual interaction that exists between researcher and participant (O’Brien & Clark, 2012). It is the
authors of posts, blogs, or texts who determine the content of their story, not the researcher. Other advantages of unobtrusive methodology include repeatable results, easier access to data, and the fact that permission from subjects is not always necessary. Unobtrusive methods are relatively inexpensive, a significant advantage in the current overall financial state of academia, and they are also appropriate for longitudinal studies that follow activities over time. As opposed to interventionist research, unobtrusive methods are non-reactive: that is, subjects are not interrupted, their time is not taken up, and they are not prompted to disclose sensitive or potentially distressing information.

There are some drawbacks, as with any methodology. For example, the extent to which the findings presenting in this project apply more generally to midlife individuals who struggle with suicidality in the United States is unknown. A strength of this methodology is that it enables the voices of those who live or have lived with suicidal thoughts to be heard; however, we cannot know how similar these individuals are to those who struggle but have no idea that SuicideForum.com and its subforums even exist, or if they would post if they did know. This methodology does not provide an opportunity to check or clarify with posters what they may have meant in their transcripts. Thus, despite having the exact words, I may not always have understood their meanings.

Interpreting the transcripts from the 2014 Antiquitie’s Friends Forum through the lens of van Manen’s hermeneutic phenomenological approach is sound even though unobtrusive measures were employed. In a 2009 article with Catherine Adams, Max van Manen explored the complexity of physical, temporal, imaginal, and virtual experience, including the writing space, the space of the text, and cyber space, all of which may provide a conduit to a writerly understanding of human phenomena. They write, “In online text spaces—discussion-boards,
email, blogs—we come to know the other through writing alone. Relation is not perturbed or infected by visuality or orality, physical presence or vocal discourse. We do not meet the other’s eyes; rather, we read and are read by the other’s text. We move and are moved by word alone” (van Manen & Adams, 2009, p. 17). They go on to say that “[w]riting online forces us into a mode of pure relation. We sense the other through their text. We are touched by and desire to touch the other through the text we write. Once we have met a person face-to-face and we know their gestures, we will read their text differently. The text will now be read against the carnal qualities that make up this person” (van Manen & Adams, 2009, p. 17). The transcripts from the forum allow analysis from a pure relation, and the unobtrusive measures employed prevent the researcher from contaminating this relation, yielding richer text and quality analysis.

**Data Collection and Recording**

The human instrument is the source of data collection in constructivist studies (Lincoln & Guba, 1985). Thus, if a researcher lacks accuracy in recording responses during data collection or asks leading questions, the quality of the data may suffer (Lincoln & Guba, 1985; Marshall & Rossman, 2010). Moreover, it is imperative that the researcher, as the human instrument, be able to demonstrate trustworthiness as well as show an ability to be adaptable to an indeterminate situation (Lincoln & Guba, 1985). In this study’s research paradigm, the goal is to provide an environment in which the participants are comfortable to express themselves freely and structure the dialogue as they need it so that their views can be expressed and heard. Between work and family obligations, Institutional Review Board requirements, and the stigma surrounding mental health, financial, and interpersonal issues, suicidal midlife adults are often hard to reach by those interested in researching their experiences (Abrams, 2010). The online forum has the advantage of anonymity and the ability to speak candidly from behind a screen. It is a non-intrusive way to
collect qualitative data on the subject under examination. Another advantage in this type of collection is that large amounts of data can be reviewed quickly so that I as the researcher have the opportunity and privilege to better understand the meanings and perceptions that people hold and how they interact with others in a microcosm of society.

This study’s data source is an anonymous online resource and message board called Suicide Forum (www.suicideforum.com). Suicide Forum will be used to gain an understanding of the experiences of those who are struggling with suicidal thoughts or are sharing their prior history. Specifically, the forum entitled “Antiquitie’s Friends,” a forum for the middle-aged, will be used for this project. Suicide forum is a pro-living, peer-to-peer support forum for people in crisis with the basic tenets “Do no harm. Promote no harm.”

The features of Suicide Forum that that users may appear to find most valuable are convenience, accessibility, anonymity, honesty, and acceptance. At the same time, it must be acknowledged that the virtual world has introduced a dramatic change into our cultural understanding of reality. Through this project, I hope to gain a more definitive understanding of this reality, given that it can be either a potential space for personal development, growth, and support or a venue for psychic retreat (Lingiardi, 2008). In other words, the virtual world has been envisioned as a “funhouse mirror, trapping the wary and vulnerable in pseudo-reality” while at the same time offering others an opportunity for positivity and growth (Malater, 2007).

The shame and isolation that often accompany suicidal thoughts and behaviors make Internet forums an attractive source of social support. Contributors appear to vary widely in the level of their desire to engage in a suicide attempt or to recover after an attempt. The benefits for contributors and visitors are involvement in something that is similar to group therapy, without such barriers to access as time and geography.
I did not post to the forum and viewed the forum only to conduct an analysis of the content, having registered with the site under a pseudonym to access the message boards and forums. User names, handles, pseudonyms, and any other identifying information will not be used in this study; the data was deidentified prior to analysis. All threads from the “Antiquitie’s Friends” forum for the calendar year 2014, with at least two posts (a query or initial message and a reply), is included in the analysis. Each thread was converted into an Adobe PDF file and then uploaded to ATLAS.ti, a qualitative analysis software program, which is described in detail in the following section.

**Computer Assisted Qualitative Data Analysis Software**

Qualitative researchers have the potential to become overwhelmed by large amounts of textual data. For this reason, Computer Assisted Qualitative Data Analysis Software (CAQDAS), specifically the ATLAS.ti program, is used for organization and data management. While CAQDAS does not perform analysis, it can “serve as an able assistant and a reliable tool” (Yin, 2009, p. 128). Additionally, CAQDAS may increase closeness with the data, due to the number of ways to access and interact with various whole and partial data files (Silver & Lewins, 2014). When data are organized and easily referenced, analysis is a more straightforward practice; connections between different postings and their resulting codes and themes are well grounded and solidly constructed.

To use ATLAS.ti, I will begin by creating the research project called a Hermeneutic Unit. Midlife Suicide will be the name assigned to the hermeneutic unit for this project, serving as an electronic container for everything related to this study. There are 21 threads in Antiquitie’s Forum in 2014. To stay organized, I will upload every thread, including attachments to threads, to ATLAS.ti to store the data and simplify the analytic process. Using an open coding method, I
will code each primary document within the hermeneutic unit line-by-line and systematically analyze for thematic patterns across cases. The coding function in ATLAS.ti includes highlighting the transcribed text to be coded within the primary document and labeling the text using open coding, code in vivo, or code by list. Open coding is the process of breaking down, examining, comparing, conceptualizing, and categorizing data (Silver & Lewins, 2014). For this project, open coding will be used and assigned codes that accurately captured the highlighted text. As labels are created for the codes, key concepts emerge from the review of related literature. After coding several threads, the “code by list” function of ATLAS.ti is employed to enable researchers to quickly code a selection that uses a previously assigned code. If the “code by list” function is used, reoccurring themes across the cases will evolve for further analysis (Yin, 2009).

As the posts of contributors to “Antiquitie’s Friends” from 2014 are reviewed, the data will be coded and significant statements that are pertinent to this study (e.g., risk factors, perceptions of burdensomeness, biological/physical changes) will be highlighted. After this step, these codes will be explored in depth to determine the meaning from the poster’s perspective.

**Data Analysis**

This study uses three primary theories/approaches to analyze the research data: van Manen’s phenomenologically oriented method, Bronfenbrenner’s bioecological theory of human development, and Joiner’s interpersonal theory of suicide. Van Manen’s (1990) hermeneutic phenomenological method of inquiry discovers and delineates the structure, the meaning, and the essentiality of the lived phenomena of the humans and experiences under examination. Bronfenbrenner’s (1977, 1979) ecological theory of development offers a holistic lens to examine the relevant variables that influence human experiences of midlife suicidality, such as
the risk factors and protective factors (Bronfenbrenner & Ceci, 1994). Joiner’s (2005) interpersonal theory of suicide is capable of explaining phenomena associated with suicidal behavior, such as perceived burdensomeness, thwarted belongingness, and acquired capacity (see also Joiner et al., 2009). The following section delineates the ways the phenomenologically-oriented approach and the theoretical framework will guide my data analysis.

**van Manen’s Hermeneutic Phenomenological Approach**

Van Manen’s (1990) hermeneutic phenomenological reflection will inform the analysis of the postings in Suicide Forum’s Antiquitie’s Friend message board. This reflection is guided by the intricate alliance of the fundamental essences of lived experiences; lived space, lived body, lived time, and lived relation (van Manen, 1990). In writing about sources of lived experiences, van Manen posits that diaries, logs, journals, and other methods are not only of therapeutic value, but also contains reflective accounts of human experiences that are of phenomenological value (van Manen, 1990, p. 73). He explains, “The point of phenomenological research is to “borrow” other people’s experiences and their reflections on their experiences in order to better be able to come to an understanding of the deeper meaning or significance of an aspect of human experience, in the context of the whole human experience” (van Manen, 1990, p. 62).

To help gain insight into the meaning of a phenomenon, van Manen (1990) developed a process of “reflectively appropriating, of clarifying, and of making explicit the structure of meaning of the lived experience” (p. 77). The five steps of reflection are: (1) conducting thematic analysis, (2) finding meaning, (3) unearthing thematic aspects, (4) uncovering thematic account, and (5) verifying incidental and essential themes (van Manen, 1990). These steps are explained in detail below:
1. Conducting thematic analysis. Themes are the empirical constituents that form a specific experience (van Manen, 1990). It is crucial to grasp the notion of themes in the context of discovering the essence of lived experience. Van Manen (1990) offered perspectives that exemplify various phenomenological essentials of the experience of themes as developing lived meanings: theme as the yearning for making sense, as the meaning we can derive from something, as the opening of oneself, as the course of perceptive creation, uncovering, revelation. Van Manen (1990) argued that theme is the instrument for unfolding the notion. Following van Manen’s perspective in uncovering lived meanings from participants’ posts, a theme that may be related to the meaning of getting older or midlife changes might be derived from expressions such as “feeling caught in the middle” and “my body no longer looks or feels like my own.” Identifying lived temporality might be derived from expressions such as the following: “At 52 I am too young to retire, yet I do not want to work at my dead-end job for another 13 years.” “I would love to switch careers but at this point in my life, I would not make enough money to support my family if I started from the bottom again.” From statements such as these, a theme might be developed. Further, attaining thematic insights is a product of the factors of “invention, discovery, disclosure” (van Manen, 1990, p. 88). Identifying the themes, uncovering the similarities and differences among them, and listing them under different categories would be an example of this product.

2. Finding meaning. The way to find meaning or make sense of an experience is to uncover things that appear to be revealing, important, and specific, and to let the theme surface (van Manen, 1990). When reviewing posts to message boards and threads, I must pay the utmost attention to words, expressions, and statements, identifying the existential meanings of space, body, time, and relation in participants’ experiential account.
3. Unearthing thematic aspects. The way to go about unearthing thematic aspects is to reflect on the threads of words, expressions, and statements participants have made. What are the common themes? What seems to be different among these themes? In this study, several participants may discuss transitional issues with their families or careers. Others might express frustration with life always being so difficult for them and wondering if the future will be any better. What exactly do these things mean for the posters, both now and in the future, or the essence in this lived time for these participants? According to van Manen (1990), no concepts or single remark can unravel the unknowingness of the experiential account. Thematic expressions can indicate only a facet of the experience. Reaching the mystery of the experience is both intriguing and taxing, yet this mystery contains a rich source of meanings that is worth the uncovering effort.

4. Uncovering thematic statements. When a person talks about an experience, there are indeed some deeper aspects about this experience that can be uncovered. Van Manen (1990) recommended three ways to discover thematic statements: (1) the wholistic approach, (2) the selective approach, and (3) the detailed approach. These approaches suggest the identifying of themes from words, phrases, or statements participants make and unearthing the principal meaning from these figures of speech. In this study, participants have used various expressions to describe their aging experiences. One of the ways of uncovering the themes of these experiences was to identify the principal meaning among the themes. I have used the four lived existentials as a means of identification.

5. Verifying incidental and essential themes. After identifying several themes, the next step is to determine which themes were essential to the phenomenon and which were simply incidental. Culling the themes helps to discover the important elements that constituted the
phenomenon. For example, the biological/physical experience of going through menopause or losing one’s hair is associated with the aging process during midlife and a sign of transition. The key issue was to examine the meaning of going through these changes for the participants. Determining the incidental and essential qualities of themes is a complex matter, as van Manen (1990) argued that themes that seem to hold essential meanings are usually influenced by historical or cultural properties. For instance, in American culture, people tend to promote youthfulness rather than old age, particularly for females. Thus, it is important to discover the meaning of going through menopause or hair loss as related to this period of development and their effect on their feelings of suicidality. Specifically, the parameters of the lived existentials of space, body, time, and relation as they relate to these biological/physical changes, as well as other aspects, are explored.

**Bronfenbrenner’s Bioecological Theory of Human Development**

Bronfenbrenner’s bioecological theory of development will facilitate the exploration of the interactions that have taken place in the life world of the midlife posters. The interactions on Suicide Forum play a part in the experience of these participants, particularly in the sense of a community for individuals struggling with suicidality at this life stage. Meanwhile, the ecological developmental lens helps to examine the risk and protective factors that encountered the developmental processes of each person on the message board. One example might be the following participant post: “I try to surround myself with positive people who make me feel better about myself.” From the risk factors and protective factors perspective, this participant operated from his previous experience in protecting himself from encountering negative people, who drain energy and diminish one’s mood. This participant has noticed that other people and supports help to place him or her in a healthy frame of mind.
Joiner’s Interpersonal Theory of Suicide

As this study uses van Manen’s (1990) hermeneutic phenomenology method, Bronfenbrenner’s bioecological theory of human development (1979), and Joiner’s interpersonal theory of suicide (2005), there are elements from each that have contributed to the overall analysis of the data. An example post for review follows:

I am 55. There I said it. It looks awful to me. Things have changed so much from just two years ago. I had more energy and enthusiasm. I smiled. My knees hurt sometimes, don't know why. I have trouble finding words or remembering things. There was a time when my mind was so sharp. Words and memories were vivid. Now I find myself trying desperately to remember someone's name from 20 years ago or a word to describe something. My therapist says this is normal aging, but is it? I have problems belonging. I go to college and they are all too young, I go to the Senior Citizens Center and they are all older than me, some have children my age. I am on disability, which is a trap btw, so I don't work anymore. I have been a member of a church for coming on 3 years and made one sort of acquaintance. There it is all families and older retired people. Again I fall through the cracks. Where do I belong?

The example contains statements related to belongingness (e.g., too young for the Senior Center; too old for college) and burdensomeness (e.g., disability) that are related to factors within the microsystem and mesosystem. Individual risk factors are also present, such as age, physical ailments, and depression. As more statements are reviewed and analyzed, commonalities may appear among the contributors’ experiences. From these commonalities, codes will be developed. In the examination of codes, primary codes and subcodes will be delineated, and those codes will be used to formulate thematics for this study.
Researcher’s Perspective

Suicide is often thought to be a tragedy that befalls the young. Sadly, however, it is their parents who are often most at-risk. As a counselor who works primarily with adolescents, young adults, and their families, I discovered that several midlife adults in my community who seemed to be thriving on many levels had taken their own lives. Other times, parents will call under the auspices of confirming their child’s appointment, only to discuss their own struggles and ask for assistance themselves. I have come to learn that this is not simply a problem in my community, in Pittsburgh, or even in the United States. This is happening in other Western, modern countries whose citizens are oft regarded as well-off compared the rest of the world. For example, the United Kingdom’s Office for National Statistics released an annual summary of data on deaths by suicide and the data shows that in 2016, people between ages 40 and 44 had the highest prevalence of suicide, a rate of 15.1 deaths per 100,000 people (Office of National Statistics, 2016). Split by gender, the highest prevalence was for men aged 40 to 44 (23.7 deaths per 100,000 in 2016) and for women between the ages of 50 and 54 (6.4 deaths per 100,000 in 2016) (Office of National Statistics, 2016).

My observation in formulating this study is that society is uncomfortable with making the individual tragedies of suicide into a case for collective change. Considering suicide as a problem of the young allows us to tell ourselves a simplified story in which despair is a passing personal crisis rather than an endemic condition. It seems more palatable for suicide to be related to naivety and immaturity and to excessive emotional acting out. It isn’t always so. Middle-aged people are wrestling with the same social and economic changes as young people, often in situations where there will be no change for the better. Placing the emphasis (and fiscal priorities) on young people and suicide allows us to think in terms of the race yet to be run. To
address those in middle age who are at risk of dying by suicide would require us to do something about what makes people feel they have already run their race and lost. I wanted to shed light on those stories, those middle-aged adults who have struggled or who are struggling with suicidality. My ultimate goal in doing so is not only to educate those in the helping professions but also to advocate for more suicide prevention resources to be spent on this part of the lifespan and to make meaningful change to decrease the suicide rate.

**Openness**

Qualitative researchers must separate personal “preunderstandings, frameworks, and theories regarding the motivation and nature of the question” (van Manen, 2014, p. 224). Van Manen refers to this as “openness” and is a type of bracketing or hermeneutic reduction that seeks to overcome “one’s subjective or private feelings, preferences, inclinations, or expectations that may seduce or tempt one to come to premature, wishful, or one-sided understandings of an experience” (p. 224). The researcher seeks to isolate his or her experience of the phenomenon from the transcripts.

Researchers who are oriented to the phenomenological approach acknowledge the philosophical influence of constructivism in their research design. Social constructivism attempts to understand the meaning individuals give to certain experiences (Creswell, 2013). Researchers expect to find a “complexity of views” that generates a pattern of meaning (Creswell, 2013, p. 24). Finlay (2011) reminds researchers who are also clinicians to practice reflexive acknowledgement of the researcher’s involvement. Any interpretation of data is based on personal understanding of the experience. The lens that is adopted by the researcher may be very broad and open or narrow and closed. As the researcher, interpretations of the data are subject to that lens. Finlay (2011) guides researchers to “disentangle our perceptions and
understandings from the phenomenon being studied” and “to recognize that interpretation cannot be exorcized from the ongoing revelation of the thing under scrutiny and should probably be acknowledged” (p. 113). The researcher determines how and in what way personal understandings influence the study (Creswell, 2013).

Assumptions and Biases

As the sole investigator in this inquiry, I must be sensitive to my own assumptions and biases. The fact that I am a clinician who frequently works with suicidal individuals, as well as a soon-to-be midlife adult (i.e., I am either a late Generation Xer or early Millennial depending on the birth year cut-off!) who may share a cultural background with many of the individual participants, may pose challenging to maintaining an objective stance. For example, I might assume that I am familiar with a cultural reference, and my understanding may lead me to want to interpret meaning as I believe that I “know” what someone else means. Because my bias can cloud my observations, advice and second opinions from seasoned colleagues, as well as from my dissertation chair, are a necessity.

On the other hand, my experience in working with many suicidal individuals provides me with some insight about the myriad of factors that goes into a decision to live or die. Further, my cultural background and age help me to relate to their difficulties, particularly in terms of juggling many obligations and responsibilities.

Key Issues of Quality

Rigorous qualitative research has the potential to yield findings that reflect the research experience and have value in other settings. However, research quality is often equated with practices consistent with a quantitative understanding of reliability and validity. Because of the contrasting epistemologies underlying positivist and interpretivist paradigms, qualitative
researchers argue that experimental designs and researcher disconnectedness do not enhance the quality or usefulness of their research. Although the tactics will differ from its quantitative counterpart, qualitative research must reflect efforts to enhance quality in research. Thus, in the sections that follow, I define my understanding and use of trustworthiness, authenticity, voice, and ethics as they pertain to this study and the strategies used here.

**Trustworthiness**

Trustworthiness refers to the methodological elements of a study, such as how the data were collected and analyzed. For constructivist studies, trustworthiness ensures that the data analyzed are truthful and accurate (Lincoln & Guba, 1985). Under a post-positivist/quantitative lens, researchers typically think of issues of reliability and validity as measures of trustworthiness. Under a constructivist lens, and as a substitute for conventional thought on issues of reliability and validity, Lincoln and Guba offer credibility (internal validity), transferability (external validity), dependability (reliability), and confirmability (objectivity) as their equivalents. Moreover, others reinforce this suggestion, indicating “…trustworthiness of a research report lies at the heart of issues conventionally discussed as validity and reliability” (Seale, 1999, p. 266). This study establishes trustworthiness within each of these areas identified by Lincoln and Guba.

A constructivist researcher wants to ensure that his or her results are credible. Lincoln and Guba (1985) suggest that the most crucial technique for establishing credibility is through member checks. Essentially, this can be an informal and formal process for researchers to make sure that they are capturing the full essence of a participant’s voice. Researchers’ analyses, categories, interpretations, and conclusions are reviewed with the participants to ensure that their reconstructions are adequate representations (Lincoln & Guba, 1985). A second technique for
ensuring credibility is prolonged engagement with the participants and the data (Lincoln & Guba, 1985). For this study, the goal of prolonged engagement will be achieved through the iterative and ongoing process of reviewing a year’s worth of postings to the forum (as well as looking at the prior year) to get a feel for the culture of the message board and the individual participants.

Regarding transferability, Lincoln and Guba (1985) are very clear that it is not the role of the constructivist researcher to provide a study that can be transferred to other contexts. Indeed, the nature of a constructivist study is that it is unique and bounded to the social phenomena being studied. A constructivist researcher’s role is to provide a “thick description” or richness of what is happening so that readers can draw their own conclusions on the possibility of transferability to their own unique situation (Lincoln & Guba, 1985). In Chapter 4, thick descriptions of the results from this study will be provided to help to satisfy the transferability requirement of a constructivist study.

Dependability is seen as an alternative to reliability. For qualitative studies of a constructivist nature, the way a researcher thinks about dependability is very different than the concept of reliability in a quantitative study. As opposed to striving for consistency, the constructivist researcher wants a rigorous process that is logical, traceable, and documented (Schwandt, 2007). Audit trails are detailed so that they will allow for verification of the researchers’ steps taken through the study. To this end, an audit trail of the entire study will be kept, demonstrating the rigor of the process. Some of the salient actions of the audit trail will include the acceptance of this proposal, submission through the Duquesne University Institutional Review Board’s (IRB) Mentor System, and the uploading of data to ATLAS.ti, among other actions. While this study uses data publicly available on the World Wide Web, it still required Expedited approval from the IRB.
Confirmability is another trustworthiness criterion used in constructivist research—as a way of checking the process of the inquiry. Lincoln and Guba (1985) recommended the audit trail as the primary method by which a researcher could establish confirmability. By means of the researcher’s maintaining detailed accounts of how the data were collected, organized, and analyzed, the reader has a clear picture into the thoughts of the researcher. As mentioned above, the audit trail was a primary approach to ensure both dependability and confirmability. Reflexive journaling may also be incorporated throughout the study as it provides “broad-ranging application” for all areas of establishing trustworthiness and can provide a foundation for researchers as they evaluate and make decisions during the process (Lincoln & Guba, 1985, p. 327).

Authenticity

In 1989, Lincoln and Guba added another dimension to their philosophy on trustworthiness (Lincoln & Guba, 1989). It was suggested that a fifth criterion, authenticity, be added that reflected a demonstration of “…a range of different realities” (Seale, 1999, p. 469). As such, five states or criterion were established that are foundational to the concept of authenticity: fairness, ontological authenticity, educative authenticity, catalytic authenticity, and tactical authenticity (Lincoln, 2005). Fairness represents the concept of balance, suggesting that all participants’ views are represented in the text. Educative authenticity is defined as “…the increased awareness and appreciation of the constructions of other stakeholders” (Lincoln, 2005, p. 72). Ontological authenticity refers to a heightened awareness of one’s own assumptions and constructions (as researcher and participant). Catalytic authenticity is defined as “…a criterion that is judged by the prompt to action generated by inquiry efforts” (Lincoln, 2005, p. 72). Finally, tactical authenticity is defined as “…the ability to take action, to engage the political
arena on behalf of oneself or one’s referent stakeholder or participant group” (Lincoln, 2005, p. 72). Authenticity will be demonstrated in this study by presenting all views of midlife suicidality and the factors and experiences related to suicidality to advance our understanding of the phenomenon behind the recent increase in the suicide rate among midlife adults. Additionally, authenticity requires dissemination of the results to advance public policy and counselor education. Table 9 describes how the authenticity criterion was satisfied.

Table 9

*Description of Five Quality States of Being for Trustworthy Criterion of Authenticity*

<table>
<thead>
<tr>
<th>States of Being</th>
<th>Description</th>
<th>Criteria Satisfaction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fairness</td>
<td>Balanced view</td>
<td>Process provided an outlet for posters’ stories.</td>
</tr>
<tr>
<td>Ontological authentication</td>
<td>Increased awareness of one’s own assumptions</td>
<td>Research had a greater awareness of the experiences of midlife adults struggling with suicidality.</td>
</tr>
<tr>
<td>Educatice authentication</td>
<td>Increased understanding of written constructions</td>
<td>Researcher had a greater understanding and appreciation of the multilayered constructions of the lived experiences of midlife adults who are or who have experienced suicidality.</td>
</tr>
<tr>
<td>Catalytic authentication</td>
<td>Stimulate action generated by inquiry efforts</td>
<td>Call to action for caregivers and educators to recognize potential risk factors and identify areas of improvement.</td>
</tr>
<tr>
<td>Tactical authentication</td>
<td>Empowering others to act</td>
<td>Clinicians, counselor educators, students, and interested stakeholders will feel empowered to support those who are struggling and advocate for comprehensive suicide prevention programs.</td>
</tr>
</tbody>
</table>
Voice

Voice is a multilayered problem in constructivist-located inquiries, as described by Lincoln and Guba (1985). Given the emergence of more constructivist research in today’s context, voice refers to something very different than in other types of studies. For a constructivist located inquiry, voice refers to the researcher as a participant whereby the researcher and participant/contributors are co-creating a narrative. It is recognizing that I am the instrument and, thus, that the researcher’s voice is inescapable in the process. For this study, I detailed Gen Xers narratives while recognizing and bringing awareness, through the process of reflexivity, to the self as a member of this generational cohort.

Ethics

Being a constructivist researcher requires being sensitive to the ethical considerations that are inherent in studies that require human participation. Some may argue that conducting this type of research depends on the interpersonal skills of the researcher, and the ability to discern what information is relevant and which is noise (Marshall & Rossman, 2010). Creswell (2009) identifies several ethical issues in the key stages (data collection, data analysis and interpretation, and writing and dissemination) of the research study that should be considered as part of the overall study design. As an example, one of the initial ethical considerations at the data collection stage is receiving approval from my dissertation committee and submission to my university’s Institutional Review Board.

Conclusion

The aim of this study was to examine the lived experiences of midlife adults who are or who have struggled with suicidality, and who are seeking assistance and support from their peers via an online forum for those with a similar history of suicidality. Findings from this study may
underscore the important public health challenges associated with middle-aged suicidality. When public health quantitative data are considered with the qualitative experiences of individuals on the Suicide Forum, they may indicate where additional effort is needed to educate counselors and other helping professionals more fully about suicide prevention and available services for this specific population. In response, targeted community-based programs may be created or changed to meet the mental health and interpersonal needs of this population. In the chapter that follows, the results of this study are reported.
CHAPTER 4: RESULTS

The intent of this project was to understand the lived experience of midlife adults struggling with suicidality and to gain a better understanding of the factors contributing to the increased rates of suicide among this group. This study was driven by the guiding research question: How do midlife adults contemplating suicide describe their experiences—their feelings, thoughts, assumptions, and/or situations in terms of ending their lives? To answer this question, a hermeneutic phenomenology approach was employed to capture unobtrusively the experiences of the phenomena under examination. Four categories were constructed using a dialectic process, meaning an iterative process between the data and me (van Manen, 1990). This process encouraged thoughtful analysis of the data that ultimately led to descriptive themes (Lincoln & Guba, 1985). As described in the literature review, the theoretical framework for this project was constructed with Bronfenbrenner’s biocological model (1977) and Joiner’s Interpersonal Theory of Suicide (2005). Further, van Manen’s phenomenological method (1990) was employed to organize and structure the data, as well as to provide a lens through which the lived experiences of these individuals may be understood.

Suicide Forum – Antiquitie’s Friends

As described in Chapter 3, the data source for this project is an anonymous online resource and message board, Suicide Forum (www.suicideforum.com). The support forums on the site contain over 120,000 discussions and threads and more than 1.4 million replies. The main priority of Suicide Forum is to provide resources to help individuals facing mental health challenges and to offer positive, pro-living support in a safe, non-religious affiliated environment. The support forums offer insight possible only for those who have dealt with similar difficulties. This allows all who visit and post to the forums to speak anonymously in a
safe environment without fear of judgment or harassment. Specifically, I used material from the retired forum “Antiquitie’s Friends,” which was for middle-aged people struggling with suicidal thoughts or sharing their prior experiences with suicidality. In 2016, among several changes that the Suicide Forum made to its website, postings from the Antiquitie’s Friends Forum were migrated to the archive and new forum topics were created. I accessed and used the archived posts for 2014. My unobtrusive data collection yielded rich textual data from 304 posts and 21 unique threads from the Antiquitie’s Friends forum in 2014. The titles of the threads and the number of posts in each thread are included in Table 10.

Table 10

_Suicide Forum, Antiquitie’s Friends Forum, 2014_

<table>
<thead>
<tr>
<th>Thread</th>
<th>Thread Title</th>
<th>Posts in Thread</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>So who's single, over 55, alone here with no friends or family?</td>
<td>55</td>
</tr>
<tr>
<td>2</td>
<td>Anyone want to live to 100?</td>
<td>41</td>
</tr>
<tr>
<td>3</td>
<td>Almost 50 and struggling</td>
<td>29</td>
</tr>
<tr>
<td>4</td>
<td>Redundancy at 40, struggle</td>
<td>28</td>
</tr>
<tr>
<td>5</td>
<td>Childless and proud</td>
<td>20</td>
</tr>
<tr>
<td>6</td>
<td>Member profiles</td>
<td>13</td>
</tr>
<tr>
<td>7</td>
<td>You ever feel like it’s not worth the hassle?</td>
<td>13</td>
</tr>
<tr>
<td>8</td>
<td>Sort of funny, sort of sad</td>
<td>12</td>
</tr>
<tr>
<td>9</td>
<td>Feeling old today</td>
<td>11</td>
</tr>
<tr>
<td>10</td>
<td>Freaking out</td>
<td>11</td>
</tr>
<tr>
<td>11</td>
<td>Motivation needed!</td>
<td>10</td>
</tr>
<tr>
<td>12</td>
<td>Why are some people so nosy</td>
<td>10</td>
</tr>
<tr>
<td>13</td>
<td>Female newbie hoping to make friends</td>
<td>9</td>
</tr>
<tr>
<td>14</td>
<td>Every time I look in the mirror</td>
<td>7</td>
</tr>
<tr>
<td>15</td>
<td>Little advice needed please?</td>
<td>7</td>
</tr>
<tr>
<td>16</td>
<td>Running out of time</td>
<td>6</td>
</tr>
<tr>
<td>17</td>
<td>Why is it so hard</td>
<td>6</td>
</tr>
<tr>
<td>18</td>
<td>Turned 40 a while ago</td>
<td>5</td>
</tr>
<tr>
<td>19</td>
<td>Facades</td>
<td>4</td>
</tr>
<tr>
<td>20</td>
<td>Problems – an early morning ramble</td>
<td>4</td>
</tr>
<tr>
<td>21</td>
<td>Oh my aching back</td>
<td>3</td>
</tr>
</tbody>
</table>

_Total all 2014 threads_ 304
Organization of Results

Data collection is an iterative and recursive process. I considered emergent themes with respect to the theoretical models that frame this study, specifically Bronfenbrenner’s bioecological model (1977) and Joiner’s Interpersonal Theory of Suicide (2005). The 2014 transcripts were uploaded to the Atlas.ti program, and each post was then read several times with the intent of identifying units of data and coding as such. The project code book is included in Appendix B. The codes were created by both the theoretical underpinnings for this project and other topics pursuant the literature review. This process yielded a set of codes for each thread that were used in a thoughtful analysis of the data, leading ultimately to the emergence of descriptive themes (Lincoln & Guba, 1985). Data was collected over a period of six months, resulting in a within-thread analysis of all 21 threads and subsequently, a cross-case analysis between threads. During that time, I continuously moved from data collection to data analysis, which allowed me to follow an inductive process of data analysis.

Drawing from van Manen’s thematic analysis and hermeneutic phenomenological method, themes were developed that represented “the structures of experience” for the study participants (Manen, 1990, p. 79). Additionally, Moustakas’ (2004) suggestion “… to determine what experience means for the persons who have had the experiences and are able to provide a comprehensive description of it …” (p. 13) was considered as part of the data analysis process. I found this process especially meaningful as I engaged with the transcripts to understand the lived experience of suicidality for midlife adults and what it was like for the individuals posting to the forum in 2014.

The results of this inquiry are organized according to 4 major categories based on the theories used and the 12 themes gleaned from the analyzed data. The four major categories are
Biopsychosocial Considerations, Mental Health Concerns, Connectivity, and a Desire to End Pain. Each category is presented and described in the sections that follow along with its emergent thematics and cross-case comparisons. The categories and main themes of all transcripts in this project are summarized in Table 11.

Table 11

Organizing Categories and Themes

<table>
<thead>
<tr>
<th>Category</th>
<th>Theme</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Biopsychosocial Considerations</td>
<td>1.1 Physical decline/health</td>
</tr>
<tr>
<td></td>
<td>1.2 Economic risk</td>
</tr>
<tr>
<td></td>
<td>1.3 Family conflict</td>
</tr>
<tr>
<td></td>
<td>1.4 Grief and loss</td>
</tr>
<tr>
<td>2. Mental Health Concerns</td>
<td>2.1 Psychiatric illness</td>
</tr>
<tr>
<td></td>
<td>2.2 Clinical care</td>
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<td>2.3 Stigma</td>
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<td>2.4 Personality traits</td>
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<td>2.5 I’m not doing well</td>
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<td>3. Connectivity</td>
<td>3.1 Loneliness</td>
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<td>3.2 Thwarted belongingness</td>
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<td>3.3 Perceived burdensomeness</td>
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<td>3.4 Online connection</td>
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<td>4. Desire to End Pain</td>
<td>4.1 Frustration with life</td>
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<td>4.2 Prior attempt</td>
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The categories and themes explicated in this chapter fully describe the lived experiences of each poster’s individual, shared, and co-created constructions. As part of the trustworthy consideration for this study, thick description is used to capture fully the essence of those experiences. Thick description is achieved by drawing quotes from the transcripts, my input/background knowledge, and the supporting literature. Each category and theme is
described to provide a deep understanding of these lived experiences, and Table 12 lists the 4 categories and 12 themes with representative quotes from each theme as identified in the data analysis.

Table 12

*Categories, Themes, and Examples from Data Analysis*

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<thead>
<tr>
<th>Category</th>
<th>Theme</th>
<th>Example</th>
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<tr>
<td>1.Biopsychosocial Considerations</td>
<td>1.1 Physical decline/health</td>
<td>Getting old sucks! I am only 55. But I feel 90 or how I imagine 90 would feel. I hurt my back in the spring picking up a microwave at Big Lots. Took a long time for the pain to go away. Doc said to strengthen my back, or it would happen again.</td>
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<td>1.2 Economic risk</td>
<td>Re-training? Financially I can barely afford food and paying bills right now. I can be as flexible as I can regarding salary, now even searching for jobs below my most recent remuneration which is exactly what I did not want to do because when you're desperate you will accept anything.</td>
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<td></td>
<td>1.3 Family conflict</td>
<td>My family does not care anything about me. I have become bitter and angry and hateful. I know that I share some of the blame for alienating my family, but I have done so because of the way they treat me (or rather ignore me).</td>
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<tr>
<td></td>
<td>1.4 Grief and loss</td>
<td>My dad, who raised me on his own for 5 years, ended up eaten up with cancer. When it reached his brain, he was no longer &quot;my&quot; daddy (if that makes sense). He needed me to make all decisions on his treatment, or if he made a decision (like no more chemo), he relied on me to tell the</td>
</tr>
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</table>
2. Mental health concerns

- **2.1 Psychiatric illness**
  
  I was diagnosed years ago with dysthymia. As far back as I can remember as a child I have felt what I think of in my mind as melancholia. It is a romanticized way of thinking of my depression. I have always romanticized things while at the same time feeling jaded. I have never fit in and always felt different. I was socially inept. This has a lot to do with my upbringing and with my genetics.

- **2.2 Clinical care**
  
  Had to suspend my counseling sessions for the time being, which is a shame because right now I need it the most. Trust issues always emerged during my counseling sessions, even towards my therapist at times.

- **2.3 Stigma**
  
  I could never reveal what I do on here if I left even a hint of who I really am. I have a pretty good case of social anxiety that has plagued me since I was a child so I'm paranoid about that stuff anyway.

- **2.4 Personality traits**
  
  I'm not really anxious with surface socializing either. I'm just unwilling to get close to people for fear of getting hurt.

- **2.5 I’m not doing well**
  
  I always presumed I would be dead by now and wish I still was.

3. Connectivity

- **3.1 Loneliness**
  
  I put my lawyer down as next of kin. Hurts doing this but lets those who
need to know or might do what the situation is. I made a will after I lost my husband over twenty years ago. My lawyer suggested it as then I had something to leave. I had no close relatives, only cousins I hadn't seen in years. My lawyer said unless I was happy for them to inherit I should choose someone, so I put down someone I was fond of at the time.

3.2 Thwarted belongingness

I have lived here for 12 years and I don't have any friends or social life. I have tried, but now have given up.

3.3 Perceived burdensomeness

The idea of not being able to do anything except be alive and probably cost other people money and time holds zero appeal for me.

3.4 Online connection

You will meet some wonderful people on the forum and friendships here can and do last, some of us have even met in real life.

4. Desire to End Pain

4.1 Frustration with life

I am feeling worthless, depressed, etc anyway, so a significant age birthday is just another thing to bring me down. I don't want to make it to Saturday - I would rather just go before then - if that makes sense.

4.2 Prior attempt

55, married once, widowed, no kids, 55 (56 next month), some family (younger sisters). I don't like the idea of the next 20-25 years. I had few friends to start with (sort of the loner type), and less now that I can easily talk about suicide attempts, psych wards, depression and other meds.
Biopsychosocial Considerations

According to Bronfenbrenner’s model, individuals develop in the context of one or more microsystems, such as family, peer group, or workplace, and in turn, these microsystems cluster together into a group of microsystems also called a mesosystem, which is nested in the macrosystem (e.g., culture). This bioecological theory embraces a person-in-environment perspective by focusing on the individual and the context in which the individual functions. The individuals posting in the Antiquitie’s Forum in 2014 were strongly influenced by their family, work, and community contexts. The main themes that seemed to appear repeatedly are those related to a decline in physical abilities and health, economic instability, family conflict, and grief and loss.

Decline in physical abilities and health. Over three-quarters of the posters described a decline in physical abilities and overall health in midlife. While specific age was not typically provided, many discussed how their bodies at 48, 52, 57, and 60 feel “different” (e.g., slower, painful, achy) from how their bodies felt in prior years. Conversations about age and ailments—“Oh my aching back!”—unified posters who all self-identified as midlife adults. The posters seemed eager to lament their decline in health, memory, and other abilities to those who might empathize with this experience. From having to downsize the bag of cat food typically purchased to forgetting names of people, the posters freely discussed their struggles with the aging process. At the same time, the posters wondered how much worse they would possibly feel as they continued to age and whether or not they wanted to experience a worsening of their ailments. Unfortunately, there was no discussion about things were potentially getting better as they moved into old age, as research has demonstrated that older adults (ages 65+) are reportedly happier than midlife adults who are often caught in the midst of multiple responsibilities.
(Thomas et al., 2016). The overall sentiment was to “hang in there” and to validate the experiences of the other midlife adult posters.

Given the focus on appearance and youth, including sexual performance, in Western culture, there was surprisingly no discussion of perceived declining attractiveness, feeling invisible in public spaces, or sexual impotence. Instead, the discussion was about how the posters themselves feel about their midlife physical and mental changes and not the perception of others. This omission may be owing to the virtual space the forum offered, in which physical appearance and superficial attractiveness are irrelevant. It is also possible that to many of the posters, improving their physical and/or mental health and interpersonal relationships was higher on the priority list than being perceived as attractive or youthful.

**Economic risk.** Roughly a third of the threads included posts that referred to economic risk. Some posters were unemployed, having left the workforce because of downsizing, firing, or caring for others or themselves. Other posters mentioned that they were underemployed, finding a job with less financial security or less prestige than prior positions. Job loss in midlife—and the subsequent change in socioeconomic status—seems to have been associated with increased suicidal thoughts in this forum, as also found in the research on economic insecurity mentioned in Chapter 2. It is uncertain if, for the posters, this association is causal or merely correlated. Job loss might confer vulnerability by increasing the impact of stressful life events. It may indirectly cause suicidality by increasing the risk of factors that are known to precipitate suicide (e.g., mental illness, financial difficulties). Alternatively, confounding factors that predict both unemployment status and suicide risk may demonstrate a non-causal association.

Unemployment payments, Social Security disability checks, and other social support payments may prevent individuals from sliding into abject poverty after job loss. Most posters
were grateful for the social safety net while also feeling that there is a stigma in not working and “collecting a check” even though the posters universally validated the experiences of others. There seemed to be an acknowledgement that the longer individuals are out of work, the more likely they seem resigned to this new normal. People whose resumes have a sizeable gap—whether from layoffs or from stepping out of the workforce to care for self or others—often have a substantially harder time finding another job. This might contribute to a sense of hopelessness about improving one’s financial lot.

Lower incomes might also result in the interruption of treatment for pre-existing mental illness as households reallocate their limited resources to such necessities as food and housing. Many might lose their current health care plan and be placed on Medicaid. Medicaid is a safety net for low-income individuals who need access to health care. However, many mental health clinicians do not accept Medicaid given that reimbursement is significantly lower. Additionally, if client with Medicaid does not show-up for a session, the program rules prohibit clinicians from charging a fee to recoup their time. Given the effects of lack in mental health care, job loss and its subsequent stressors can affect the suicide risk of all household members, not just the individual who suffered the job loss.

The transcripts show that there seem to be several ways that unemployment might influence suicidality. Sudden job loss may be a profound psychological shock that may lead some to develop maladaptive coping rituals, such as drinking. It may lead others to develop depressive symptoms and/or anxiety-related symptoms; as one poster commented, “My personal finances get slimmer each week that goes by.” Similarly, prolonged unemployment and frustration with job seeking can challenge an individual’s conception of self-worth: “I feel like I am a criminal at times who must answer every single detail, including my high school
qualifications. I have over 15 years’ experience and these dickheads question a job seeker on their high school years and certificates? Are they pulling our legs? What is this world coming to?”

In response to one of the posts discussing recent unemployment, a supportive peer wrote,

Dear Job Market gambler Rocknroller. Understand that you should not at all feel any ounce of self-doubt that you are not trying. That this is in any way your fault. Some unaccountable scum are the ones that have plunged many into this state of unemployment. The greater con is they want to make the average person believe that they need to tighten their belts and try harder. It is the equivalent of being robbed. Having everything taken and being told it is your fault so you deserve this follow up beating with the blame/shirker baseball bat. The loss of a job can be very psychologically damaging, Job loss features highly in the downward plunge into depressions and suicidality. There are some reasons for that, which you can shore yourself up against. The first is loss of purpose. So you need to fill your day with some purpose…

It seems that many of the posters were in an economically risky position that was having a deleterious effect on their overall wellbeing. Their job loss conferred a loss of self-esteem and self-worth for many. If their mental health was already precarious, these struggles seem to have increased with the stressor of unemployment.

**Family conflict.** About a quarter of the threads contain posts describing family conflict. These posters discussed non-existent, dysfunctional, or completely hostile relationships with family members. Conflicts stemmed from various sources: the result of a divorce, children having moved away, or the death of a parent, with a consequent battle between relatives. Some of the posters seemed distressed that they were no longer close or even on speaking terms with
family members. However, many rationalized that the emotional cutoff was necessary because a family member was “toxic” or that they felt rejected first, so their reaction was justified. It seemed that for some the emotional cutoff might have been helpful in the short-term, perhaps even empowering. Unfortunately, the frequent use of this strategy may have resulted in pushing others so far away that they experienced more negative moods (e.g., anxiety, depression, hopelessness) and interpersonal problems (e.g., loneliness, isolation).

It seems that the midlife adults in the forum grew up with the belief that family was supposed to be loving and supportive. However, that is the ideal and many people do not grow up in a healthy environment. Thus, many were resigned to the current state of their familial relationships and displayed little insight into how the relationships might be improved.

The subject of one thread was a lengthy discussion about the decision to remain childless. Some of the posters were concerned that they could not take care of a child when they were struggling themselves; others simply had no desire to be a parent. However, there seemed to be a connection between having a conflictual relationship with their own parents and their own desire not to procreate. One poster explained:

Don't have children, don't want children, don't particularly like children, nothing personal against the people who do, but that's not for me, no thanks, no way, no how. Unless of course I were to somehow end up with children by accident in spite of my conscious efforts to avoid such an unfortunate situation, in which case I would love them with all of my heart and give them everything that my own heartless selfish parents never gave to me, but only out of guilt and obligation, not because I have any inclinations at all to raise miniature versions of myself through which I can hopefully live vicariously through or brag about their accomplishments as though I somehow had something to do with them.
or in the hopes that they might support me in my helpless golden years because I was too shortsighted to make any long term plans for my own future care.

It seems that when some individuals do not feel loved by their own families, they fear that they will repeat those patterns of behaviors if they have families of their own.

**Grief and loss.** Loss is inevitable in mid-life, and grief is a natural step in the healing process. The reasons for grief are many, such as the loss of a loved one, the loss of health, or the letting go of a long-held dream. Some grief stems from common losses, such as the death of a friend or family member, or the breakup of a relationship. Other losses seem less obviously catastrophic, such as children moving out of the home, the death of a pet, the move to a smaller home, loss of physical ability, or a change in financial security.

One poster described her recent losses of her pet and her “man-friend” writing that “I thought I could hang on as long as I had my darling dog, but I just lost her too this weekend. I also lost my man-friend of 12 years (well, I can't call him a boyfriend!) a couple months ago and don't see a replacement in my future. He finally gave up on me and my problems and was very mean about it.” This woman lost her boyfriend because of her mental health struggles and the companionship he had provided. She believed that she would be ok because she had the love of her beloved dog. Sadly, the dog passed away and she found herself grieving, very much struggling over these huge losses.

Dealing with a significant loss is usually one of the most difficult times in a person's life, but most people can find a way to move on. However, some of the posters seemed stuck in their strong feelings of grief that may be labeled as complex grief. Grief is a normal, expected set of emotions that can occur after the loss of a loved one. However, some people experience a more significant and longer-lasting level of grief. This is known as complicated or complex grief.
Complicated grief shares many symptoms with major depressive disorder, the psychiatric disorder most commonly associate with suicidality. Complicated grief may lead to depression or worsen depression in those who are already experiencing it. Some of the symptoms include difficulty accepting that your loved one is gone, inability to focus on other aspects of life, feeling as if your life no longer has meaning, and trouble trusting others. It seems that for the posters discussing issues of grief and loss, their feelings and behaviors are related to the complex type. This requires more than time to get through; it requires clinical intervention.

Other posters discussed multiple losses that compounded overtime and contributed to a sense of hopelessness and suicidal thoughts. For example, losing a spouse or partner during a crisis event may leave middle-aged adults with unfamiliar responsibilities and roles, experiencing financial hardship, and/or dealing with grieving children. A person in this example may grieve the future plans that will not come to fruition after all. Another midlife adult may have actively encouraged their children to become independent, but the experience of letting go can be more painful than expected. This new empty-nester feels lonely and misses the constant companionship. They have gained their identity mainly from their role as parents and are asking themselves who they are in the wake of this transition.

“Role-exit” is a term coined by Helen Rose Fuchs Ebaugh in her 1988 book *Becoming an Ex* and defined as “the process of disengagement from a role that is central to one’s self-identity and the reestablishment of an identity in a new role” (p. 1). For many of the posters, after disengagement from one role, they have become unmoored. They do not yet know what their new role ought to be; they seem to be aimless and ungrounded. Without a new role to step into, their self-concept in threatened and they feel unstable, diminished from their loss.
Table 13 summarizes the four themes concerning the biopsychosocial considerations related to midlife suicidality. Although there is variation among the themes in this category, similarities are evident as well. The most common were physical decline and health concerns in this developmental stage. Another common theme was economic risk, referred to with such concerns as unemployment, underemployment, and an inability to support one’s self with or without government assistance. Other posters discussed family conflict and/or a decreased involvement in family life. Finally, about a third of the threads expressed feelings of loss and grief related to the passing of loved ones, life span transitions, or the loss of a job and/or status.

Table 13

*Cross Thread Comparison: Biopsychosocial Considerations*

<table>
<thead>
<tr>
<th>Thread</th>
<th>Physical Decline/Health</th>
<th>Economic Risk</th>
<th>Family Conflict</th>
<th>Grief and Loss</th>
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Mental Health Concerns

As this is a study about midlife suicidality, it is unsurprising that mental health concerns appear in nearly two-thirds of the forum’s threads. As mentioned in Chapters 1 and 2, the exacerbation of an underlying mental health condition is a primary stressor for suicide, particularly major depressive disorders and/or substance abuse (Mann, 2003; Mościcki, 1995; O’Boyle & Brandon, 1998). Research also demonstrates that mental disorders in midlife are more prevalent than previously reported, possibly because of stigma associated with mental health concerns and the fluctuating nature of mental illnesses (Stone et al, 2018; Takayanagi, 2014). The main themes that appeared about mental health concerns are those related to psychiatric disorder, clinical care, stigma, personality traits, and a feeling of “I’m not doing well.”

Psychiatric disorders. Approximately two-thirds of the threads discussed diagnosed mood disorders (bipolar disorder or a depressive disorder), anxiety disorders (mainly social anxiety or panic disorder), or symptoms related to obsessive compulsive disorder or post-traumatic stress disorder. While much of the literature indicated that substance abuse was a main factor in suicidality, the posters refrained from discussion of substance abuse on the forum unless it was in past tense (e.g., “I’m trying to rebuild my life after alcoholism”). It is possible that posters who self-medicated through drugs and alcohol felt shame about their use and subsequently held back from mentioning that aspect of their lives.

People who struggle with mental health issues or addiction often feel pushed to the outskirts of society and may lose touch with their community and family and experience profound loneliness and isolation. Without social ties, struggling individuals are less likely to reach out for treatment. Individuals who are addicted to substance are more likely to be
depressed and may hide their drug use from health care providers to avoid stigma and drug shaming. The mental health consequences of isolation can fuel additional drug use, leading to further isolation, and ultimately a destructive pattern that is difficult to stop.

The posters discussed the mental health symptoms and deficits that arise from psychiatric illness; they lamented the interference illness has caused in their life plans. Some posters believed that their psychiatric disabilities limited their ability to take advantage of opportunities consistent with what they considered a “good” quality of life, resigning them to a lesser fate. Psychiatric disabilities permeated into aspects of the posters’ lives such as employment difficulties (symptoms or side effects may make it difficult to work), housing (affordability, type of housing), education (difficulty focusing or completing tasks), and parenting to name a few.

Other posters pointed to their mental health symptoms and diagnoses as the reason they were posting in the first place. As one poster explained, “I have a pretty good case of social anxiety that has plagued me since I was a child so I’m paranoid…The internet is a safe window to the world for someone who suffers from social anxiety. I even avoid making phone calls because of my social phobia.” Others described their psychiatric illnesses, particularly depression, as their constant companion and longest relationship of significance. Many of the posters spend their time alone because being around other people is so difficult. They feel judged and instead of facing their world, they withdraw to avoid stigmatization. Unfortunately, this is often a two-way street — those struggling with psychiatric illness often withdraw from society and society, in turn, withdraws from them.

**Clinical care.** Participation in talk therapy and taking psychiatric medication were mentioned in 3 of the 21 threads. In these posts, forum members were ambivalent about the mental health care provider community. For example, one poster commented that she “had an
hours long anxiety attack yesterday. Called the psychiatrist and he upped my Klonopin. Sure hope it helps....” Others lamented that whenever they discussed their symptoms worsening, their medications were often increased. The transcripts seemed to indicate that the practice of prescribing medication before (or without) talk therapy was suboptimal clinical practice. As one woman said, “Wish I’d been given therapy before anti-depressants when first diagnosed. Diazepam was NOT a good idea, took me a year to get off them.” (Diazepam is more commonly known by its brand name, Valium, a benzodiazepine that can be highly addictive.)

Talk therapy was endorsed as something positive and helpful, even if difficult. A poster remarked that “[a]ctually having someone to talk to, who won't be freaked out by me, helps.” A poster in recovery from alcoholism wrote, “Hi…will reach 5 years sober on April 20th this year - bumpy journey, but worth it. Now seeing therapist to sort out mental issues, that is proving difficult, but got to keep trying.” Unfortunately, some posters had to “stop therapy” as they “can no longer afford the fees” either because of changes in employment or insurance, or simply lack of income. Conversely, there were accompanying stories of spending a lot of money on therapy appointments and not improving as they had hoped. There was an acknowledgment in the transcripts that there are many types of providers and clinical approaches, and many posters encouraged their peers to continue to find a therapist that would be a good fit for the individual.

The transcripts indicated that the type of provider posters tried to avoid was those professionals who endorse authoritarian attitudes toward their severely depressed and suicidal clients. Coercive treatments like inpatient commitment or ultimatums about medication compliance are sometimes mandated in cases where they may not be necessary. This robs the clients of power over their own treatment. From the clinical view, conversely, decisions about client care can have serious life-or-death consequences. A client’s death by suicide has a
significant emotional impact on the client's family, his or her social network, and the clinician. When a client of a mental health professional dies by suicide, clinical, ethical, and legal questions may arise about the adequacy of the clinician’s evaluation and about the sufficiency of his or her training to perform such evaluations. Thus, clinicians often err on the side of caution, and this seemed heavy-handed to many of the posters on the forum because it seems more about the clinician’s protection from liability than client wellbeing.

**Stigma.** Analysis of the transcripts revealed the presence of stigma connected with mental illness. There seemed to be a fear of being labeled as crazy and forced into a psychiatric hospital. Thus, the individuals on the forum seemed to hide their ongoing struggles and even their suicide attempts in order to avoid mental health services. Ascribing a stigma to mental illness is not only an individual problem but also an issue for family, friends, neighbors, and others who people the lives of those with mental illness. Owing to the violent aspect of suicide (it is the taking of a life after all!), it is assumed that “normal” people cannot attempt or even consider suicide. Therefore, passive and active suicidal ideation should, in common thinking, be related to severe mental illness.

Stigmatizing views about mental health conditions does not seem to be limited to uninformed members of the public; they are often shared by those experiencing symptoms related to mental illness. Individuals who would benefit from mental health services may not opt to pursue them or may fail to participate fully once they have begun. One of the reasons for this disconnect is stigma: namely, to avoid the label of mental illness and the harm it brings. The posters to the forum valued the anonymity the website provided, which enabled them to discuss their suicidality without negative consequences. They reported that the forum is the only place that they could freely talk about their experiences without judgment because the other
participants had experienced similar issues. One poster summed it up: “This is such a sensitive (emotional) topic, I think that's why most people are reluctant to reveal too much. You just never know who's out there and what they're up to.”

Stigma also seems related to media portrayals of those with mental illnesses. Televised portrayals of mental disorders often show people as violent, nonsensical, or completely debilitated. It is no wonder that those struggling with mental health concerns do their best to hide it from family, friends, and the provider community.

Additionally, some posts discussed social stigma for lifestyle choices; for example, there were repeated references on the forum concerning the choice to be childless and the stigma resulting from that choice. A few of the midlife posters discussed their decisions about procreating: some were unwilling to pass on their genetics, others simply never wanted to parent, and another was concerned with the number of people already on the planet. Yet, nearly all talked about the judgment they had experienced from others who have procreated and lamented that the expectation seems to be that people should parent and that only the “selfish” choose to be child-free.

**Personality Traits.** The personality trait discussed in the forum was introversion (or low extroversion in personality assessment parlance). Other specific personality traits were unmentioned in forum posts for the year 2014. Intuitively, this makes sense as many of the participants were turning to Antiquitie’s Forum to fulfill their need for human interaction and connection. Introverts tend to stay home more and have smaller social connections. For many introverts, having significant downtime between social interactions is necessary to function and have a well-balanced life. Some of the posters discussed their introversion as owing to an anxiety disorder (e.g., fear of having a panic attack in public) or a mood disorder (e.g., too withdrawn to
engage in conversation). Others retreated to their own space because that is the only space they could control and would not feel judged for being different in some way. Others may label their experience as perfectionistic, a more acceptable label in their view than something that needs intervention. Yet, they struggle still. A woman wrote about purchasing a new appliance:

I know it sounds silly (especially to my mother), but these kinds of things set me on edge. My anxiety was up just over the thought of dealing with the delivery and now that the idea of problems is a reality, I am stressed, upset and depressed. I can't deal with any little upset. I am a perfectionist and I know that this is silly because nothing is perfect, but I can't help it. I have read many books on anxiety and depression, etc., and I understand that I need to change my way of thinking and I do try, but every time I seem to be making some progress, something always happens. I am truly miserable most of the time. There are little moments here and there when I laugh and talk with a coworker, but those times aren't really enough to make me feel whole. I am so alone and wish for a normal life.

Extroverts occupy most social spaces and the societal expectations of individuals to connect is high. Many posters who are introverts have become isolated and alone—even when they don’t want to be. Introverts who are depressed end up struggling silently and are not getting the help they so desperately need. This is a risk factor for suicidality as those who isolate themselves are often are depressed, and depression is a risk factor for suicidal behavior.

I’m not doing well. A less frequent theme was an expression summed up as “I’m not doing well.” This was expressed in just three threads, but it is included because there seemed to be a realization by these posters that they were struggling and needed additional support from their peers on the forum. One poster, in receiving birthday wishes from another, replied “Thanks, but not doing very well at all... can’t stop the tears...or the memories...sad.” Other posters rallied
to validate and offer support. One peer wrote, “I will never judge you. But I hope you can see, people are thinking of you. Stand strong, stay safe, do not feel alone, try to find contentment in your own company instead. You are in my thoughts. Let's be alone together.”

When people share what they are going through, how they feel, and what they are experiencing, they are not asking for it to be made better. For whatever reason, just telling someone makes them feel a little less alone. It's human nature to want to share and to have someone who understands and empathizes with what they are going through. When people struggle, they deeply desire connection to know that they not without support. It is a human need to want someone to acknowledge how bad the hurt is and to be allowed the space to talk without an offer to fix the situation or an expectation of immediate improvement.

It seems that this is a benefit of the suicide forum—likeminded individuals who have or have had similar experiences just responding to the words of their peers. It is true that some did offer advice or helpful suggestions (this will be discussed later in this chapter), but most simply provided encouragement and support to people, even those who say that they are not ok. The posters acknowledged that it is typical to not feel ok at times. However, the support of the forum, the empathy of the members, and the resources provided are helpful tools to make it through one more day.

Table 14 summarizes the themes related to mental health concerns relayed in the forum posts for 2014. “Psychiatric disorders” was the most common theme in this category which aligns with the literature review and clinical knowledge that some psychiatric disorders are common among those contemplate or die by suicide.
Table 14

Cross Thread Comparison: Mental Health Concerns

<table>
<thead>
<tr>
<th>Thread</th>
<th>Psychiatric Disorders</th>
<th>Clinical Care</th>
<th>Stigma</th>
<th>Personality Traits</th>
<th>I’m not doing well</th>
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Connectivity

In The Principles of Psychology (1890), William James wrote about man’s social self and the desire to be looked upon favorably by others:

No more fiendish punishment could be devised, were such a thing physically possible, than that one should be turned loose in society and remain absolutely unnoticed by all the members thereof. If no one turned around when we entered, answered when we spoke, or minded what we did, but if every person we met ‘cut us dead’ and active as if we were non-existent things, a kind of rage and impotent despair would before long well up in us, from which the cruelest bodily torture would be a relief (p. 293–294).
The need to belong is fundamental for humans, and when this need is unmet, it has a negative effect on well-being. One poster, in discussing a multitude of health problems that were affecting her, commented:

Christmas is coming, which always makes me sad. No family or friends to be with. No community activities except Christmas Eve services at churches. I enjoyed sending presents and cards, but that's about it. I miss my parents. I am 55 years old and still miss my parents. I wonder if that will ever change?

Many posters turned to Antiquitie’s Forum to find connection and support from other midlife adults struggling with suicidality. Thus, connection is one of the major categories of this study with over two-thirds of all threads containing posts about connectivity. The four themes related to this category are: loneliness, thwarted belongingness, perceived burdensomeness, and connection online. The themes of thwarted belongingness and perceived burdensomeness stem from Joiner’s Interpersonal Theory of Suicide, one of the theoretical underpinnings for this study.

**Loneliness.** In over one-third of the threads, posters openly discussed feelings of loneliness and a lack of meaningful connection with others. There is a deep, human desire to have close, sustaining relationships with others. However, the posters also expressed a feeling of constraint due to pressures (e.g., financial, relational, medical) that keep them resigned to an unhappy, lonely existence. One poster sketched the outlines of how her world was mired in loneliness, remarking that she was

61. no kids. never been married. I sort of adopted children of my heart. That’s what I called them. But they are gone from my life now. I have a couple of friends. I see one of them twice a year. Another one will talk with me as long as we only talk about her. And
then another who is very physically ill who i try to help. I have an elderly mother who atm is not in good health. But am hoping she will make a good recovery. 9 times out of 10 when my phone rings it’s a telemarketer or a wrong number. So I do think I am alone.

The posters expressing loneliness on the threads described emotional suffering and the pain of feeling separate from others; and in some cases their loneliness stemmed from mental health disorders. It can be difficult to make meaningful connections when there is a desire to hide one’s symptoms from the world. They may make jokes about their plight, but the hurt remains, as posted by this forum member:

I realized that I don't need a girlfriend/wife. Depression has been my loyal partner for over 11 years! She's always been by my side, every day and she's very possessive. She won't let me get close to anyone else nor get rid of her from therapy and medication!

:laugh: I love you too depression! Come here and give me a kiss!

Loneliness is presently seen as a public health crisis, as long-lasting loneliness not only makes one sick; it can kill. When a feeling of being alone and disconnected persists for extended periods of time, alone time may transition into loneliness. Persistent loneliness, as experienced by many of the posters, lead to difficulty with sleep, low energy, substance abuse, feeling hopeless, and physical ailments. Emotional isolation is ranked as high a risk factor for mortality as smoking 15 cigarettes per day (HRSA, 2019). For the many posters on this forum, lonely seemed synonymous with different or separate. They felt different because of their age, life circumstances, mental health conditions, employment status, and lack of meaningful relationships, and many did not believe that they were an integral part of their families or their communities. Thus, they searched and found an online forum of likeminded individuals so they could have a sense of connection, not feel so alone.
**Thwarted belongingness.** Thwarted belongingness, an unsatisfied need to belong via interactions with others and a feeling of being cared about (Joiner, 2005, p. 96), was common to the posters and was discussed in about half of the forum’s threads. Thwarted belongingness occurs when an individual perceives a lack of connection to others. This is related to loneliness in that the individual has attempted to make connections in numerous social settings. Yet, they have been dissatisfied with the result or have felt rejection from family members or peers. There is overlap in these two themes but for those who have tried to connect repeatedly and remain alone it seems that they are more likely to “give up” on having meaningful connections. The post below exemplifies this sentiment (my emphasis added):

> I adopted many 'godchildren' over the years and accepted that they would move on.
> Haven't had one for a while. There were a few young people who thought a woman on her own would benefit them financially. I've been like you to o with friends. As long as we talked about them or I could do something for them fine. When I needed to talk they were busy. Have been in tears this a.m., normally keep them at bay. Tried phoning a suicide hotline. After 22 minutes THEY ended the call politely. *No reason I know of other than the person felt as everyone does about me.*

Trying to connect with others and being turned away, dismissed, or discouraged was a common theme in the transcripts. Feeling thwarted or rejected often leads to increased social withdrawal which may have the effect of limiting who is able to help and to support the struggling individual. Indeed, if someone does intervene and offer to help those who are socially withdrawn, such persons might turn down the help, as they might feel like they are a burden. One poster summed up that relationship writing: “Even when there is somebody around (from my experiences), most people really aren't comfortable hearing about that type of pain and anguish.
Especially if it’s for an extended time or something that deserves being repeated many times. As a result, the isolation deepens.” This poster has tried to connect but has been unable to do so outside of the role of victim. They want to connect as a human, as an equal, and not that of someone who needs patronized or infantilized. The theme of perceived burdensomeness is discussed in the next section.

**Perceived burdensomeness.** Perceived burdensomeness is the perception that one is a burden and that this state is permanent and stable (Joiner, 2005, p. 98). An interplay exists between perceived burdensomeness and thwarted belongingness that contributes to suicidal ideation (Joiner, 2005, 2009). Indeed, the threads coded for perceived burdensomeness overlapped with thwarted belongingness in all but one thread. Posters not only want to connect with others, they want to contribute to the relationship in ways that are fulfilling and mutually beneficial.

One post from a parent who had finally finished paying off a daughter’s college debt posited that his usefulness to his child was probably ending:

> Just feeling more useless and out of date. I really do not serve a lot of purpose at all anymore, and this morning was just a reminder that soon will have even less real use. I do not really work—just some part time freelance that takes me too long to do. Kids do not “need” me anymore for the most part—it is more hassle to come visit than anything really I suspect.

Now that his daughter did not need him financially, he viewed his role in her life as burdensome. With a debt to pay on her behalf, he felt connected and beneficial to her world. Without the looming bill, he does not believe that she will think the relationship is valuable and is, conversely, a burden.
Life events such as unemployment, illness, and relational conflict can contribute to an increased perception of burdensomeness. In addition, the construct of burdensomeness can encompass a midlife adult posters’ feelings of being unimportant to their family, friends, and society, and their perception that they are expendable. For individuals feeling burdensome, particularly when combined with thwarted belongingness, death may be considered a solution to their problems (Joiner, 2005, p. 98). One poster’s comments exemplified this thought: “The idea of not being able to do anything except be alive and probably cost other people money and time holds zero appeal for me... I plan on dying in a boating accident or in a homemade spaceship or something.”

It should be noted that the key word in the theme “perceived burdensomeness” is the world “perceived.” This perception may be faulty, particularly with individuals who are struggling with psychiatric illness or substance abuse. People want to feel like they belong, and their lives have meaning. To be a drain on others is seen as shameful to posters. I think that is why they are so eager to connect with their peers online and to provide support to their peers, even when struggling themselves.

**Connection online.** Census figures have indicated that among all United States households, 89% had a computer, which includes smartphones, and 81% had a broadband Internet subscription (Ryan, 2016). Accordingly, participation in online discussions boards and chat rooms has become commonplace over the past two decades as more people have become comfortable seeking information from online resources and sharing information online. The Internet is also a resource for meeting health information needs, as well as for the very human need for support; increasingly, social relationships are formed in this environment and dependence on social networks increased. Individuals are turning to online message boards and
forums instead of joining face-to-face groups as a means of contacting other people in similar situations who can provide communication and connection (White & Dorman, 2001).

An anonymous online forum, such as Suicide Forum, provides an opportunity for people experiencing similar difficulties and struggles to come together in a virtual space. The anonymity gives participants an extra layer of comfort in their exchanges, given the inherent stigma of suicidality in our culture. Combining this stigma with the likelihood that those who are experiencing depression, anxiety, trauma, and suicidal thoughts isolate themselves from others, the online forums provide a safe space for connection without real-time obligations.

Suicide Forum is an online community that converges around suicide and suicide prevention. The Antiquities’ Forum is composed of members who develop and maintain caring relationships derived from facing similar challenges. The forum creates friendship-based relationships beyond the topic of suicide; the ability to discuss nonmedical issues such as family and social life are fostered as well. Indeed, in every thread a member responded to the initial post and offered some forum of support, feedback, or shared experience.

Given the category of connection in this study and the resultant themes, this forum provides access to social support, or even simply the perception of social support, to act as a buffer to help people cope with stressful events and painful lives. Obtaining social support is particularly important for struggling individuals who may need acceptance and validation during difficult times and to combat feelings of loneliness. One of the interesting findings of this study was that Antiquitie’s Forum provided frequent displays of emotional support and encouragement, as well as helpful suggestions and messages of appreciation. The types of responses in each of the threads are displayed in Table 15.
Unlike on other types of online forums where individuals may flame or disrespect one another, the communication on SuicideForum.com consists primarily of helpful interpersonal interactions that provide comfort, advice, and encouragement to those who need it. The 2014 posts in Antiquitie’s Forum yielded friendship-based relationships beyond conversations about suicidality and fostered an ability to discuss personal issues, such as relationships, family, and attempted forays into social activities. Connection through this forum seemed to encourage communication and empathy among people with shared experiences, enhancing their lives.

The four themes related to this category—“loneliness,” “thwarted belongingness,” “perceived burdensomeness,” and “connection online”—are displayed in Table 16.
Table 16

Cross Thread Comparison: Connectivity

<table>
<thead>
<tr>
<th>Thread</th>
<th>Loneliness</th>
<th>Thwarted Belonging</th>
<th>Perceived Burden</th>
<th>Connection Online</th>
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Desire to End Pain

This category encompasses two themes—"frustration with life" and "prior suicide attempts." Though smaller than the other categories, it was an important one to include because the experiences of those who have survived an attempt and/or those who are contemplating suicide are rarely articulated in the literature. Table 17 contains a cross-thread comparison of the themes in this category, as described in detail following the table.
Table 17

*Cross Thread Comparison: Desire to End Pain*

<table>
<thead>
<tr>
<th>Thread</th>
<th>Frustration with Life</th>
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**Frustration with life.** Nine threads discussed an overall frustration with the posters’ current lives. Individuals often experience frustration when they are blocked from reaching a desired outcome. Frustration is not necessarily bad as it can be a useful indicator of the problems in a person's life (and hence a motivation to change). However, for the posters in this forum, frustration often resulted in anger, resentment, or depression. Many posters discussed feeling resigned to their fate or that they want to just give up because they did not see any reason to exist. One poster commented:
I can't think of one reason why I exist on this earth. What is the point of going to work everyday except to pay my bills and buy my food to live. But there is nothing else—just existence. I often feel like I am just taking up space and should just go.

Another, bemoaning both frustration with life and the people in it, shared on the forum that

[I]ife is a continuous boxing match as far as I am concerned. I don't feel like fighting anymore. I feel betrayed, belittled, bullied and really worthless. Betrayed by the job market. Belittled by my previous boss. Bullied in life. Worthless for all of the events that lead me to have suicidal thoughts once again and this time going beyond the fear of surviving it.

Yet another simply wondered if life is worth it and wrote, “I'm just finished with everything. The hassles at work. Not worth it. Traffic, not worth it. Car needs repair, not worth it. Life, not worth it.”

For a few of the posters, suicidal thoughts seem almost comforting because they were an alternative to feeling frustrated and out-of-control. The idea of ending their lives when they wished to do so seemed to be an empowering fantasy that gave them a degree of control. Some may have even imagined scenarios in which they might be appreciated in death in a way they were not while alive. Perhaps in death, their family members would finally acknowledge their importance to their lives, or an ex-lover would think wistfully of happy memories of them. The posts responding to those feeling frustrated with life and writing of suicidal thoughts encouraged their peers to persevere. Respondents also implored the frustrated to seek professional assistance and to find other ways cope with these strong feelings.
**Prior suicide attempt.** Perceived burdensomeness and thwarted belongingness may instill a desire for suicide. However, although these two feelings are necessary, they are not enough to ensure that desire will lead to a suicide attempt, per Joiner’s theory. For this to occur, the acquired capacity for lethal self-injury must be present (Joiner, 2005). A history of suicide attempts has been found to be a strong predictor of future suicidal behavior, including death by suicide. Individuals with past suicide attempts experienced more serious forms of future suicidality, as compared to others who did not have a history of suicidality. Crucially, this association was not accounted for by other variables (e.g., psychiatric disorders, family history) (Joiner et al, 2005). Two of the threads discussed prior attempts openly; more expressed chronic suicidality with no prior attempts. One post that discussed a prior attempt seemed open to a future attempt, once the poster’s mother passes away from brain cancer:

> I'm a complete recluse. I can't decide if I care or not though. I too tried to kill myself at 20...and 19 and 30. I did go to the library and got the right pills and more but such a young body is strong you know, and it ain't so easy to die. I too wish I'd died the first time. I guess I can say that I've completely given up. I've tried and tried to make some use of my extraordinary intelligence but my mental illnesses keep getting in the way. Even my support worker says he's never seen anyone try as hard as me to fight their way back. Unfortunately, it's like Sisyphus, you know? Push the rock up and it just keeps falling back down. At some point you just have to say, fuck the damn rock. I'm not doing it anymore. So now I kind of just sit here in a passively suicidal way, just letting the time tick away because I figure life is short and it has to end eventually, if I just sit here doing nothing. Also, I'm waiting for my mom to die of brain cancer because she's the only one
who would be completely devastated if I killed myself. I figure once she's gone, I'm off the hook with the problem of it irreparably hurting anyone.

Posts discussing prior attempts, particularly the ones that indicated ongoing frustration with life, were met with responses offering ideas for coping, messages of support and validation, and suggestions for professional assistance. The themes in this section—frustration with life and prior suicide attempt—overlapped in six threads with the themes of perceived burdensomeness and/or thwarted belongingness. Per Joiner’s theory (2005), this combination is highly indicative of suicide risk. In nearly a third of the threads, the model as it appears in Figure 9, seems to resemble Joiner’s theory precisely.

Figure 9. Intersection of themes

The posters who discussed their frustration with life and/or their prior attempts seemed to be prey to a sad resignation that their lives would be unhappy and that suicide might be their only escape. Indeed, they might even begin to see death as a welcome reprieve or as a beautiful way to end a miserable existence. Such would indicate that the individual no longer fears death and has the acquired capacity to make a serious suicide attempt. As a clinician and through this research, I am concerned about these individuals who are most at risk for a suicide attempt.
Van Manen’s Lived Existentials

According to van Manen (1990), four lifeworld themes, or “existentials,” are “helpful as guides for reflection in the research process: lived space (spatiality), lived body (corporeality), lived time (temporality), and lived human relation (relationality or communality)” (p. 101). The four existentials can be differentiated, but not separated, and they form a unity for the lived world (van Manen, 1990). Table 18 provides a glance at the significant quotations from the transcripts that are exemplars of each lived existential.

Table 18
Van Manen’s Lived Existentials and Quotations of Significance

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<th>Lived Existentials</th>
<th>Quotations of Significance</th>
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<tbody>
<tr>
<td>Lived Space</td>
<td>But there is nothing else – just existence. I often feel like I am just taking up space and should go.</td>
</tr>
<tr>
<td></td>
<td>I stay here in my unit, waiting and not living. I am not even a shadow of my former independent self (that person seems to be long gone).</td>
</tr>
<tr>
<td>Lived Body</td>
<td>I'm 54 and I'm a shell of the person I used to be.</td>
</tr>
<tr>
<td></td>
<td>I seriously lack both physical and mental strength to cope with an uncertain future</td>
</tr>
<tr>
<td>Lived Time</td>
<td>I sit here and wait to see if will feel sick today or not and how sick.</td>
</tr>
<tr>
<td></td>
<td>I waited three and a half years and though it is not grandiose or a palace, its’ a nice little place.</td>
</tr>
<tr>
<td>Lived Relation</td>
<td>Sigh, Christmas is coming, which always makes me sad. No family or friends to be with. No community activities except Christmas Eve services at churches.</td>
</tr>
</tbody>
</table>
I have been unable to make lasting friendships and have been estranged from my family for years. I essentially have no friends and no family, no one to turn to when times are bad...no one to celebrate with when times are good.

The four existentials underscore what van Manen calls the “life world,” and what supports our understanding of the lived experiences. This understanding provides a richness of meaning for the phenomenon being studied, specifically, the lived experiences of midlife adults struggling with suicidality.

Chapter Summary

The impetus for this study was to understand why suicide is on the rise for those in midlife. The results reported in this chapter emerged from 21 transcripts posted in 2014 on the Antiquitie’s Friends forum on SuicideForum.com, from which 304 posts were analyzed. The themes that surfaced in the posts were grouped into four main categories: (a) biopsychosocial considerations; (b) mental health concerns; (c) connectivity; and (d) a desire to end pain. The four categories were created by an analysis of the data through the theoretical framework identified for this investigation. Of the four categories of themes that emerged as a description of the posters’ experiences, the themes that demonstrated the greatest degree of homogeneity was related to connectivity: almost every thread contained posts seeking a connection online that posters were not receiving in person. It seems that for most of the forum participants, the site was a safe space to create new relationships and receive support and validation. In other categories, there were instances in which the posters’ experiences resonated with one another. Some examples include the loss of identity, financial stability, or decline in health (biopsychosocial considerations), living with a psychiatric disorder and navigating the mental health system.
(mental health concerns), and being frustrated enough with life to contemplate suicide (desire to end pain). The next and final chapter includes a summary of the dissertation and discussion of the findings. The implications for counseling theory, research, and practice are provided, along with a discussion of future research directions.
CHAPTER 5: DISCUSSION

The rates of midlife suicide have been increasing for more than a decade (Curtin, Warner, & Hedegaard, 2016; Stone et al., 2018). It is a major societal problem that suicide rates for people in middle age are higher than for other age groups in the United States and rates are continuing to rise. Understanding why suicide is on the rise in this age group is just as important as—if not more so—knowing who is choosing to die and how. This qualitative study contributes to the current quantitative research by augmenting the understanding of midlife individuals who have struggled with suicidality, and the factors related to the uptick in completed suicides nationwide. The results of this inquiry emerged from the online posts of midlife adults who had contemplated or were contemplating suicide, and who were seeking assistance and support from their peers via an online forum shared by those with similar interests, concerns, and/or history of suicidality. These posts were organized into four categories with 12 themes to describe, illuminate, and provide understanding for the research questions.

This dissertation includes four chapters thus far: Introduction, Literature Review, Methodology, and Results. Chapter 1 presents the background and significance of the problem, the purpose, the chosen methodology that guided the study, the informing theoretical frameworks, and the significance of the study. Chapter 2 provides an extensive review of the literature regarding generational research, which framed the background of the study, as well as literature about suicidality, risk factors, and protective factors. Chapter 3 explains my philosophical posture, and describes the paradigm, methodology, and methods used in this study. Chapter 4 provides a description of the organizing themes, which offer understanding into the essence of the lived experiences of the study’s subjects. The current chapter discusses preliminary findings and new information that emerged during the study. The first section
revisits the research questions and summarizes the findings. The discussion is framed within the four primary categories of themes that surfaced in the analysis of the posts: (a) biopsychosocial considerations; (b) mental health concerns; (c) connectivity; and (d) a desire to end pain.

For each of these four areas listed above, I draw conclusions from the data and offer hypotheses and questions for further research. Hypothesis generation is inherent to qualitative research (Levers, 2002). The experiential nuances that can be observed through qualitative methods provide opportunities for researchers to “enhance understanding of phenomena, inform relevant questions, and generate new hypotheses” (Levers, 2002, p. 30). Finally, implications for counseling research and practice are considered, limitations of the inquiry are noted, and recommendations for future research are proposed.

**Interpreting Finding 1: Biopsychosocial Considerations**

The first major category of findings organizes the themes related to the various biopsychosocial considerations that midlife adults encountered in their experience of suicidality. The most common themes were (a) physical decline/health issues and b) economic risk. Other themes also surfaced, including family conflict and grief and loss; however, the discussion will be limited to the two themes mentioned above. Good health is a prerequisite for successful aging and necessary to complete life plans. Even the healthiest of midlife adults may experience graying hair or hair loss, wrinkles and age spots, and hormonal changes. Many forum posters discussed their physical changes (e.g., changes in strength) as well as acute or chronic illnesses. There seemed to be resignation among the midlife adults on the forum that taking care of their health was another item on the endless to-do list, and commiseration was frequent on the forum.

Perhaps because this was an online forum and not a face-to-face group, the superficiality that often dominates conversations about midlife aging was not present. Many women
experience the American double standard of aging: Men who are graying are perceived as distinguished and sexy, while women who are graying are viewed as past their prime. However, virtual space flattens these distinctions. The conversations about physical changes and health were about how posters felt in their bodies and the shared experience of midlife aging.

Economic risk through unemployment and underemployment was another common theme for the posters. Lack of financial stability is associated with depression, substance abuse problems and marital turmoil, all of which are linked to suicide risk. In the United States, where a large portion of the population accesses healthcare through employment, this connection may be even stronger than in countries where the government finances healthcare for all. Individuals working part-time may not have access to health insurance; and Medicaid, the health insurance program for low-income individuals, has specific qualifications for receiving benefits. Midlife adults do not qualify for Medicare, the health insurance program for seniors, until age 65. Stressors such as the loss of a job or a home can result in shame, humiliation, or despair. This may precipitate suicidality in those who are already vulnerable or do not have resources (e.g., savings, close family) to draw on for support.

The findings of economic risk from this study align with Case and Deaton’s (2017) study that the mortality increases in midlife are consistent with the distress that many midlife adults face: poorer physical and mental health, social isolation, obesity, marriage (or lack thereof), and a lack of labor market opportunities. Widespread increases in unemployment, usually in the context of unstable or declining economic opportunity, are strongly linked with increases in suicide rates. These links between unemployment and suicide are especially strong for working-class non-Hispanic white men, but they show up in other groups as well, including women and persons of color. Unemployment may also contribute to relationship instability. For example, an
unemployed, middle-aged man with minimal prospects may have difficulty attracting a lasting romantic partner.

It was surprising that there was little mention of religion or spirituality. There was zero mention of politics or affiliation with political parties. Individuals posting on the forum likely channeled the spirit of Florence Hartley’s 1860 book, “The Ladies’ Book of Etiquette and Manual of Politeness.” Hartley warned her readers to avoid mentioning subjects or incidents that can in any way “disgust your hearers” (or, in the case of the forum, the readers). On a forum where people are trying to connect based on a shared experience, the last thing that many want to do is to alienate those who may be a support.

**Interpreting Finding 2: Mental Health Concerns**

For the midlife adult posters, the category of mental health concerns was prevalent in their discussions. The theme of psychiatric illness was referenced frequently, and the other themes in this category—clinical care, stigma, personality traits, and not doing well—are subsidiary to this theme. Stone et al.’s (2018) quantitative investigation discovered that nearly half of midlife adults who died by suicide did not have a diagnosed psychiatric illness. It is likely that Stone et al. (2018) underestimates the prevalence of psychiatric illness because those individuals were not receiving treatment and were not diagnosed. Cavanagh et al. (2003) found that psychological autopsy studies suggest nearly 90% of people who die from suicide suffer from a diagnosable mental disorder. It is also likely that given the methodology used in psychological autopsy, the interviews with those in decedents’ lives, as well as the documentation discovered (e.g., letters, text messages, social media posts, attendance records) are viewed through a lens geared toward ascribing the suicide to an underlying mental disorder.
This qualitative investigation found that nearly two-thirds of the threads referred to a psychiatric illness (e.g., depression, anxiety) or significant mental health symptoms (e.g., isolation, chronic sadness, unresolved grief). I think that 66% is a better representation of those who struggle with mental health concerns and who contemplate ending their own lives. Though most people who die by suicide have a potentially diagnosable and treatable mental health condition, most people with a mental health condition do not die by suicide. Suicide is never the result of one cause but rather a combination of common risk factors, often in the context of stress and interpersonal distress with access to lethal means.

Many psychological risk factors converge to contribute to suicidality. One important psychological risk factor is the loss of youth and its attendant hopes and dreams for future successes. During midlife, many experience a growing realization that they have gone about as far as they ever will, and that their professional and personal goals may fall short of their expectations. They might never be a great writer, be an entrepreneur, have a happy marriage, or have children. For some, this knowledge may be accepted in stride. For others, this is an indication of inadequacy that may serve as added fuel for low self-esteem, depression, or suicidal ideation.

The other themes in this category are related to psychiatric illness. For example, midlife adults with a history of trauma may mistrust their counselor or may be fearful that any expression of suicidality will land them in the hospital involuntarily (which they may or may not be able to afford). Midlife adults with psychiatric illness are often caught in a stigmatizing bind: they struggle with the symptoms and disabilities that result from the disease, and they are challenged by the misconceptions about mental illness. In four of the threads, the posters seemed to recognize and internalize societal stigma. This internalization or self-stigma may undermine
any sense of self-efficacy which might then worsen prospects of recovery. It will often prevent individuals from seeking professional help or reaching out to potential supports. For many, this forum undoubtedly served as a way for midlife adults struggling with suicidality and mental health concerns to dip their toe into helpful waters to seek connection in a low-risk (e.g., anonymous, free) environment.

**Interpreting Finding 3: Connectivity**

*Democracy in America*, Alexis de Tocqueville’s astute picture of American life, has been celebrated for its accuracy since its publication in 1835. Sadly, the following words from de Tocqueville no longer offer an illustration of American social life and interconnectedness:

As soon as several of the inhabitants of the United States have taken up an opinion or a feeling which they wish to promote in the world, they look out for mutual assistance; and as soon as they have found each other out, they combine. From that moment they are no longer isolated men, but a power seen from afar, whose actions serve for an example, and whose language is listened to (de Tocqueville as cited in Mayer & Lawrence, 1988, p. 516).

The themes of the third major category, connectivity, were highly relevant to the forum posters. The forum created a sense of community that many of the posters are lacking in their “real” world. Many of the posters seemed lonely and did not feel a sense of belonging in communities; thus, they sought out an online resource to mitigate their loneliness. This finding aligns with a 2018 survey by health insurer Cigna, which found that only around half of Americans (53%) have meaningful in-person social interactions (e.g., extended conversation, quality time) on a daily basis. The study also found that 43% of American adults sometimes or always feel that their relationships are not meaningful and that they are isolated from others.
(Cigna, 2018). This data is alarming! The social nature of humans requires connection, which is lacking in many of the posters’ lives, and the forum is a proxy for meaning from connections in real life.

Indeed, in 2000, Robert Putnam predicted a decline in social connectedness in his book *Bowling Alone* and cautioned that the Baby Boomers and Generation Xers would be less connected and would face a more lonesome old age than their parents or grandparents in the Greatest Generation. He wrote, “…it is hard to believe that the generational decline in social connectedness and the concomitant generational increase in suicide, depression, and malaise are unrelated” (Putnam, 2000, p. 265). The uptick in the national suicide rate began in 1999; one year prior to the release of Putnam’s prophetic tome.

Margolis and Verdery (2017) discovered a recent surge in “kinless” older adults, first noting that family members provide the majority of social support for most older adults as they age. However, not all individuals have living family, and those without living close kin reported higher rates of loneliness and chronic disease. In analyzing current demographic data on kinship, Margolis and Verdery (2017) made projections through the year 2060, by which time the number of older adults without kin is projected to increase to nearly 15%. One of the demographic changes that has increased the cohort of kinless adults is the rise of “grey divorces”—that is, divorces in midlife—which doubled among midlife adults between 1990 and 2010 (Brown & Lin, 2012; Moore, 2018). Divorce and remarriage often strain inter-generational relationships: support for divorced parents, stepparents, and remarried biological parents may not be present as it would for married, biological parents.

Given the prevalence of loneliness and thwarted belongingness by the posters in the forum, it became clear that online connection was providing access to social support. The theme
of online connection was present in over two-thirds of the threads. Posters discussed how much the forum had helped them, and they, in turn, had offered words of advice, encouragement, and even tough love to their forum peers. It seems that these midlife adults used the forum space to act as a buffer from ongoing mental health issues, including suicidality, and stressful life events. Obtaining social support is critical for struggling individuals who may need acceptance, validation, and the ability to combat crushing feelings of loneliness and thwarted belongingness.

**Interpreting Finding 4: Desire to End Pain**

Antiquitie’s Forum was for midlife adults struggling with suicidality, and many of the posters had either attempted or considered attempting suicide. The fourth and final category, a desire to end pain, was dominated by the theme of “frustration with life.” The theme of “prior suicide attempt” was found in just two threads, probably because many posters simply did not want to discuss prior attempts online. This frustration with life seems to come from an emotional state in which individuals are not achieving what they desire (e.g., romantic relationship, close friendships, financial security, good mental health). It seemed that many of the intentions or desires of the midlife adults on the forum had been thwarted, resulting in a deep frustration that affected their overall sense of self (e.g., “I can’t seem to do anything right”). The result is a deep dissatisfaction with one’s own life and a belief that things may not ever get better, and suicide may be a very real alternative to remaining alive, in pain, from unmet needs. A third of the transcripts aligned between this category and the themes thwarted belongingness and perceived burdensomeness, demonstrating that disconnection from others leads individuals to believe that they have no place in the world. Being alone is a painful experience; people need people. When this need is unmet, people look for answers to end their pain.
This theme reminded me of a story recounted in Joiner’s (2005) book describing a report from the 2004 Chicago Tribune about train conductors who run into suicide victims. The author of the piece, Jon Hilkevitch, wrote that almost always, suicide victims peer into the locomotive cab in their final moments: “they stare right into the eyes of the engineer, perhaps reaching for a last human connection” (Hilkevitch, 2004, as cited in Joiner, 2005, pp. 133–134). Another piece by Tad Friend (2003) concerned individuals who jump off the Golden Gate Bridge in San Francisco, California. Dr. Jerome Motto, who was part of a coalition to have barriers to prevent people from jumping, described reading a patient’s letter after the patient died by suicide by jumping off the bridge. The note said, “I’m going to walk to the bridge. If one person smiles at me on the way, I will not jump.” Even after they make the decision to die, people still want to be seen and perhaps even helped.

Revisiting the Research Question

The results from this study provided insights into the phenomenon of struggling with suicidality as a midlife adult in 2014. These posts describing the forum participants’ lived experiences provided the starting point that essentially breathed meaning into the phenomenon being studied (van Manen, 1990). The result was 4 main categories—biopsychosocial considerations, mental health concerns, connectivity, and a desire to end pain—with 12 themes that described and provided meaning for those lived experiences. In Chapter 4, which describes the findings, I was able to analyze the output of the lived experiences of the posters and reveal further insights that pertain to my guiding question: How do midlife adults contemplating suicide describe their experiences and rationale for ending their lives? In short, they described their experiences as largely isolating; thus, owing to their lack of connection with others, ongoing mental health concerns, and other psychosocial considerations, they may
contemplate an irreversible solution to end their suffering.

According to van Manen (1990), four lifeworld themes, or “existentials” are “helpful as guides for reflection in the research process: lived space (spatiality), lived body (corporeality), lived time (temporality), and lived human relation (relationality or communality)” (p. 101). The four existentials can be differentiated but not separated, and they form a unity for the lived world (van Manen, 1990). While midlife adults posting in the same thread of SuicideForum.com shared a common virtual location along with the four existentials in many ways, it is also important to recognize the differentiated aspects of the four existentials as they are applied to the posters’ transcripts of their lives.

Lived space (spatiality) is defined as felt space and is difficult to describe, as it is “largely pre-verbal; we do not ordinarily reflect upon it” (van Manen, 1990, p. 102). The spatiality of the study participants was their private life online. The lived space in which one finds oneself can influence the way one feels. Despite this, spatiality in this study was differentiated by the unique context for each poster. The theme related to economic risk relayed how downsizing or isolation affected the posters’ sense of space, which influenced their sense of self. As an example, in Thread 12, one poster described himself as taking up space on Earth while another in Thread 1 admits to reclusion in his own private world where it is safe. A poster in Thread 16 described her feelings when an ex “sold their home out from under them” and compared that with how she felt now in a small space of her own, not subjected to the whims of another. These examples depict how lived space can affect one’s feelings about suicide.

Lived body (corporeality) refers to the fact that we are always bodily in the world (van Manen, 1990). In addition to physical presence, corporeality can be thought of as a reality of
our identity. The individuals who posted in Antiquitie’s Forum perceived it as their collective identities as middle-aged members of society. Their identities became differentiated as they began to reflect on themselves and their unique position in the world. This differentiation was reflected in the theme related to biopsychosocial considerations wherein posters expressed beliefs about their aging bodies and how they function now compared to how they have functioned in the past. Sixteen of the 21 threads analyzed contained some reference to decline in physical abilities and advanced age. Comments like “I feel so old and tired,” “these lines on my face get clearer,” “I’m only 55 but I feel 90. I wonder how 90 will feel,” and discussions about physical ailments pepper the threads. Many of the posters seemed able to express beliefs about their personal identities as they experienced the aging process and began noticing lines and aches where once there were none.

Lived time (temporality) refers to subjective time and represents “our temporal way of being in the world” (van Manen, 1990, p. 104). Van Manen (1990) refers to “the temporal dimensions of past, present and future that constitute the horizons of a person’s temporal landscape” (p. 104). In line with Heidegger’s philosophy (Racher & Robinson, 2003), it is a recognition that we cannot separate ourselves from our past. Thus, the encounters of midlife adults with this hermeneutic process involve an interpretation that largely has been influenced by their history and experiences. Moreover, Gadamer recognized that a person may not only be influenced from past experiences but also may have a broader range of vision that expressly recognizes both the present and future, which is known as one’s horizon (Laverty, 2008). Thus, the horizon for the posters included the temporality of past and present experiences and their visions of the future. In the frustration with life theme, participants openly discussed their life experiences of pain and struggle, and wondered if life was worth living. The assumption
that life might never improve for the participants greatly affected their worldview and ways of being in the world. For example, why try to form romantic relationships when they have been unsuccessful for so long? Why try to seek employment when they have been laid off or fired repeatedly? These life experiences affected the forum posters and shed insight on the notion that we cannot separate ourselves from our past. The past sticks to us as memories, both pleasurable and painful, that we weave into our daily interpretations of our lived world.

Similarly, we have expectations and visions of our future. For many on this forum, visions of the future were not always bright. As an example, one poster mentioned looking forward to starting therapy with a new counselor with the hope of finally working through their mental health issues. Then, another poster commented about the belief that therapy does not work and that psychiatric medication is worse than the actual illness. This second poster believed that, because past treatment did not work, it would never work. Both examples highlighted the temporality of our future in the broadest form of subjective time.

Finally, lived other (relationality) refers to the lived relation that we maintain in connection with others (van Manen, 1990). It is essentially the act of being relational. As we interact with others, this interaction develops the self and exposes us to a larger sense of purpose—the communal sense of belonging. Relationality for the study participants refers to their lived relationships with individuals on the forum and off the forum. Part of being relational suggests that we are constantly forming opinions and learning about others as well as ourselves in the wake of these relations. Van Manen (1990) suggested that as we meet others we “develop a conversational relation which allows us to transcend our experience of the other” (p. 105).

The posters commented frequently about their perceptions of the people in their lives—
family, friends, neighbors, and coworkers—as well as the importance of these relationships, absent or not. Most of the posters spoke of relationships that were of great value to their quality of life. They also spoke of negative relationships that had caused them great pain and turmoil, and had contributed to a sense of disconnection from others. It seemed that many of the midlife adults posting used the forum as a way of being relational. Figure 10 offers a visual model of van Manen’s four existentials.

Figure 10. Visual model of the four existentials.

The four existentials underscore what van Manen calls the “life world”, and what supports our understanding of the lived experiences. This understanding provides a richness of meaning for the phenomenon being studied: specifically, the lived experiences of
midlife adults struggling with suicidality. As mentioned above, the four existentials can be
differentiated, but not separated, for one to fully understand the meaning.

**Hypotheses Generated**

This section reviews the major hypotheses that emerged from this inquiry. Most of the
hypotheses are tied to the themes that embody the results of this investigation and, thus, are
related to the lived experiences of midlife adults struggling with suicidality. The following
hypotheses emerged from this discussion:

1. Individuals who are more closely connected with others are less likely to experience
   suicidality and/or to die by suicide.
2. The degree to which midlife adults are positively connected and integrated within their
   community and social networks has an inverse relationship on their feelings of
   loneliness, thwarted belongingness, and perceived burdensomeness.
3. Individuals struggling with mental health issues in midlife tend not to replenish their
   social connectedness. Forming new and deep friendships in midlife is rare, and a
   depletion of friends leads to loneliness and thwarted belongingness.
4. Online forums foster a sense of community in the virtual world that may be lacking in
   real life. This encourages empathetic behaviors because posters seek to nurture and
   support others who have struggled with similar issues.
5. Mental health clinicians (e.g., counselors, counselors-in-training, social workers,
   psychologists, psychiatrists) need comprehensive training throughout their professional
   lives to conduct suicide risk assessments, and treatment planning and referrals for
   midlife adults.
6. Mental health clinicians must be aware of resources in their communities to connect
struggling individuals. Counselors have a responsibility to their clients not only to be clinically competent but also to be aware of the programs and resources available locally and online.

**Implications for Counseling Practice**

The role of the professional counselor is to work with suicidal people and their families in a clinically competent manner. Competent professionals who may diagnose, treat, or appropriately refer to a higher level of care may help reduce the number of suicides. Professional counselors can help prevent suicide in a variety of ways, such as teaching coping and problem-solving skills, identifying and supporting people at-risk, providing crisis intervention, and treating people at-risk for suicide or preventing re-attempts. For example, crisis intervention approaches provide support and referral services, typically by connecting a person in crisis (or a friend or family member of someone at risk) to trained volunteers or professional staff via telephone hotline, online chat, or face-to-face care. Crisis intervention approaches are intended to affect key risk factors for suicide, including feelings of depression, hopelessness, and subsequent mental health care utilization (Gould, Munfakh, Kleinman & Lake, 2012). Crisis interventions can put space or time between an individual who may be considering suicide and harmful behavior.

Treatment for people at risk of suicide can include various forms of psychotherapy delivered by counseling professionals to help individuals who have mental health problems and other suicide risk factors with problem-solving and emotional regulation. Treatment that employs collaborative (e.g., between patient and provider) and/or integrated care (e.g., having links between such caregivers as psychiatry and counseling services) can help engage and motivate patients, thereby increasing retention in therapy and decreasing suicide risk (Archer, Bower,
Gilbody, et al, 2012; Gilbody, Bower, Fletcher, Richards & Sutton, 2006). To prevent re-attempts, follow-up contact and diverse modalities are employed to engage recent suicide attempt survivors in continued treatment (Inagaki, Kawashima, Kawanishi, et al, 2015). Treatment may focus on improved coping skills, mindfulness, and other emotional regulation skills, and may include individual counseling and/or group therapy. For those who have attempted suicide, approaches that engage and connect them to peers and providers are especially important because many attempters do not present to aftercare: 12%-25% re-attempt within a year, and 3%-9% of attempt survivors die by suicide within 1 to 5 years of their initial attempt. (Inagaki, Kawashima, Kawanishi et al., 2015).

**Clinical training and continuing education.** Providing competent care to suicidal people and their families requires ongoing clinical training and continuing education. Unfortunately, training for mental health professionals in working with suicidal people seems to be lacking—not only in terms of how to deal with suicidal patients but also concerning how to process a patient’s death (Anderson, 2015). In an article in *The Atlantic*, Paul Quinett, a professor in the Department of Psychiatry and Behavioral Science at the University of Washington School of Medicine, said, “I think most of us believe that when we hire a licensed mental-health professional, that they've had training in how to assess and manage suicidal patients, when in fact, the majority do not” (as cited in Anderson, 2015). Providing competent suicide prevention and treatment ethically and legally requires professional counselors to have comprehensive, ongoing training.

Training for suicide assessment and treatment ought to begin in graduate training programs because it is an important clinical skill for counselors. However, when Wachter Morris and Barrio Minton (2012) studied 193 professional counselors, results showed that 67% of these
counselors indicated no crisis preparation course in their curriculum and, upon graduation, rated their self-efficacy as merely adequate in assessing suicide. Additionally, 31% of these counselors self-assessed at only minimal self-efficacy in collaboration skills for crisis intervention, and 30% self-assessed similarly for suicide management and intervention (Wachter Morris & Barrio Minton, 2012). Students want and need preparation for crisis and suicide: 32% of the participants in this study recommended increased curricular attention to this important issue, advising graduate programs to increase instruction about suicide and crisis in their course work (Wachter Morris & Barrio Minton, 2012). As evidence of student preparation, graduate programs in counseling with accreditation from the Council for the Accreditation of Counseling and Related Education Programs (CACREP) must provide instruction in eight core areas. Per the 2016 CACREP standards, four of these core areas include standards for preparation in crisis management: Professional Counseling Orientation and Ethical Practice, Human Growth and Development, Counseling and Helping Relationships, and Assessment and Testing (CACREP, 2016). For example, the core area of Human Growth and Development has a curriculum objective to include the “effects of crisis, disasters, and trauma on diverse individuals across the lifespan” (CACREP, 2016, p. 11). Addressing suicide risk across the lifespan, such as in midlife as illuminated in this study, would better prepare counselors-in-training for their careers, which may include work with suicidal individuals.

Ongoing training in the assessment and treatment of suicide is necessary to stay abreast of the research and current data, even for experienced, licensed clinicians. Research does not influence practice nearly often or fast enough and legislators, are taking notice of this discrepancy. In the Commonwealth of Pennsylvania, approximately every four hours, one person dies by suicide (America Foundation for Suicide Prevention, 2019). To stem the tide, on
July 8, 2016, Governor Tom Wolf signed into law the Matt Adler Suicide Prevention Continuing Education Act. This legislation requires licensed professional counselors and other mental health professionals in Pennsylvania to complete a minimum of one hour of continuing education in the assessment, treatment, and management of suicide risk in order to renew their professional license (General Assembly, 2016). Other states like Washington and Massachusetts have similar legislation. Even without this legislation, counselors have an ethical responsibility to put the welfare of the client first. Adhering to this ethical demand means that counselors ought to seek competence regardless of licensure requirements or programmatic demands.

**Boundaries in the counseling relationship.** Boundaries are fundamental to the counseling process. Boundaries are set and maintained by the clinician according to accepted professional standards and are intended to provide a “therapeutic frame which defines a set of roles for the participants in the therapeutic process” (Smith & Fitzpatrick, 1995, p. 499). Within the professional literature, cautionary tales abound warning therapists to avoid crossing therapeutic boundaries. In my own counselor education programs, I learned that boundary crossings ought to be avoided from a risk management perspective and congruent with ethical codes. In a 1994 article, Lazarus (1994) wrote that well-intentioned ethical guidelines can become transformed into artificial boundaries that undermine clinical effectiveness. Rigid roles and strict codified rules of conduct between therapist and client can obstruct treatment. He notes that “anxious conformists” are unlikely to prove significantly helpful to a broad array of clients when risk management take precedence over humane interventions. Lazarus (2007) warned that “genuinely caring and skillful clinicians, anxious to steer clear of any action that could be construed as an ethics infringement, may provide a sterile and artificial relationship that lacks much of what helps it to be a clinically effective one” (p. 406).
When discussing boundaries within counselor education programs, it seems that the topic centers on what clinicians ought not to do before they fully understand their role as professional counselors. Often missing in this commonplace understanding of boundaries is a consideration of culture and context within the therapeutic relationship. I believe that culturally competent practice necessitates a broader understanding of therapeutic boundaries than the somewhat narrow and limited view commonly espoused. Boundaries are complex, involving much more than managing risk, especially when working with suicidal clients. A client who is in crisis or contemplating suicide may not show up for session. A typical policy in an agency or private practice might be to call the client and leave a message. Some practices may charge a no-show fee without any follow-up. However, in my experience working with suicidal clients, I have stretched, adapted, and flexed the therapy boundaries in order to individualize the treatment to best meet my clients’ needs. This may mean that I call my client and express my concern over the missed appointment as I was looking forward to seeing him or her. I may also send a text (yes, most of my private practice clients have access to my mobile phone) or an e-mail reiterating my concern, desire to help, and offer to reschedule.

The ACA Code of Ethics (2014) Section A.1.a states, “The primary responsibility of counselors is to respect the dignity and promote the welfare of clients.” I take this primary responsibility seriously and hold it as part of my identity as a counselor. I have done things for clients, on behalf of clients, and with clients because of our close boundaries, actions that from a traditional mainstream viewpoint I “should” not have done. These “transgressions” include attending funerals, accompaniment to Alcoholic Anonymous meetings, answering my phone at odd hours, texting support before job interviews or exams, forwarding articles or quotes that remind me of them, and more. I believe that I owe a duty to help my clients due to the
therapeutic relationship, even outside of the therapy hour. While these things may be a deviation from traditional therapy, it was indeed therapeutic.

The research findings in this project demonstrate that people are craving human connection. They want to be heard and understood. For some clients, their counselor might be the only person who truly knows them. Treating the counseling relationship like any other professional relationship with hard and fast rules and little variability is not in the best interest of the client. In fact, it may lead the client to surmise that their counselor does not care or is abandoning them too. As a profession, I believe that counseling must return to its humanistic roots to deeply connect with our clients. This may require the profession to redefine our collective ideas about boundaries.

**Researcher’s Impressions**

As a researcher, I have my impressions gleaned from this project. I was heartened by the empathy and compassion most of the posters showed to strangers on a message board whom they have not met in person and might not even know their real name. Empathy makes it possible to resonate with others’ feelings. Posters expressed happiness when they vicariously shared “wins” of other posters and they felt with posters sharing suffering as their pain resonated. Additionally, many posters expressed compassion toward others on the message board sharing feelings of warmth, concern, and care for the other, as well as a strong motivation to improve the other’s wellbeing.

Many of the posters were seeking connectedness online and had expressed being thwarted in their sense of belonging in their “real” lives. However, these same posters were quick to support their peers on the forum and give them the feedback that they were lacking. I suspect that helping others with their words of encouragement, their empathy, and their
compassion gave these posters a greater sense of purpose. Their lives had meaning because they were able to contribute positively and powerfully to another human being, giving them a sense of belonging and usefulness.

**Limitations of the Research**

With any investigation, there are limitations. One limitation is that the sample size and selection were limited as this study focused on one suicide message board out of the many forums from 2014. It could be that a larger sample or different forum would yield different results.

An additional limitation is due to my use of unobtrusive measures to collect my data due to the sensitivity of the topic. It can be difficult in unobtrusive research projects to account for context or go beyond what is directly perceived or observed. In a face-to-face interview, the researcher can ask what situations or events led up to some occurrence, but this level of personal interaction is impossible in unobtrusive research. While it can be difficult to ascertain *why* something occurred in unobtrusive research, we can gain a good understanding of *what* has occurred. My interpretations of the data were based on the transcripts authored by each poster on the Forum. I did not interact with the Forum or the posters. Thus, I was unable to ask for clarification or further explanation of any statement posted; my findings are based on my interpretations rather than those of the posters.

Research in the online space is a relatively new phenomenon. I do wonder what it would have been like to solicit feedback from the posters or participate in the forum as a researcher. I suspect that if individuals knew that they were being studied, they would interact differently in the forum.
**Recommendations for Future Research**

Several recommendations for future research emerged from the findings of this study. A first, broad question for consideration is: How might communities increase their overall connectedness at all stages of life? A second important question for future consideration follows: How can professional counselors build stronger rapport and better meet the needs of at-risk midlife adults? Future studies may proceed by examining assessments and interventions that might be more accurate and result in better outcomes. Incorporating online resources in the therapeutic process may prove worthwhile to clients. Message boards and websites like SuicideForum.com may be an opportunity for individuals to form a support group that is unhindered by mobility or geography. Not only can they overcome the physical limitations of face-to-face support groups but are offered at no cost, 24 hours a day, and are available when the forum participants need it most.

Several other questions have emerged from discussing the results from this study. The following questions provide direction for continuing to examine the factors that enhance or detract from wellbeing among midlife adults:

1. To what extent do racial and cultural values within the broader American demographic influence the ways that people are socialized to think about midlife?
2. To what extent are mental health disorders untreated in the midlife adult population?
3. What barriers exist that prevent midlife adults from seeking counseling services? and
4. How do differences in gender, race, religion/spirituality, and socioeconomic status factor into a midlife adult’s sense of connectedness?
5. How do online communities create a holding environment for individuals to engage in social connectedness?
Examining these questions will help to ensure that midlife adults find meaningful connection with others and lessen their risk for suicide and other bio-psychosocial problems. Professional counselors are well-placed to intervene at multiple system levels to improve the quality of life for at-risk midlife adults. The goals are not only to improve quality of life for specific clients but also to promote well-being for vulnerable people everywhere. This may involve going beyond the boundaries of the clinic or private practice office to address organizational, community, and political issues that influence individuals’ social, emotional, and economic well-being. Counseling practice skills are broadly applicable and can be used to advocate with public authorities, organizations, community representatives, politicians, and others who lack awareness of the ongoing issues our lonely society faces.

**Conclusions**

The intent of this inquiry was to illuminate the guiding research question: How do midlife adults contemplating suicide describe their experiences—their feelings, thoughts, assumptions, and/or situations for ending their lives? To answer this question, I analyzed all posts on SuicideForum.com’s Antiquitie’s Friends forum for midlife adults from the year 2014, the same year Robin Williams died by suicide and which was a high-watermark for suicide in the United States. The results of this study reflect their experiences with suicidality—that it is a largely isolating experience. The findings demonstrate that online forums like the one examined help form a caring community of people in similar situations who express empathy and support for others. Posters came together online through the common bond of suicidality in midlife, which gave them connections and information both as individuals and as members of a collective. This research also identified how social support from those with similar experiences help people make sense of their own situations. Finally, participants gained access to other social resources that
added value to their lives, such as personal relationships that developed into friendships, both on and off the message board.

To decrease the rate of midlife suicides, increasing social connections and strengthening existing relationships is necessary. Given the loneliness epidemic in the United States, reaching out to and sharing ourselves with others, both in our professional and personal lives, affirms others’ worth and dignity. There is value in creating groups, communities, and sites that promote integrated ways for people to interact and gain the human connection they may be lacking.

The results from this study may be used to inform and guide professional counseling practices, influence research geared to boundary crossings and risk, and teach counselors-in-training appropriate interventions with suicidal people. There can be considerable variation in counselors’ experiences with suicidality, and a good first step is to listen to suicidal individuals’ thoughts and ideas about what they are experiencing and what type of support is necessary. This recommendation can be applied across all levels of the community from family member to professional counselor to neighbor. Professional counselors, physicians, and all clinicians who are in contact with midlife adults have an opportunity to continue to ask their patients questions about how and with whom they are spending their time and about the quality of their interpersonal relationships in order to better understand their world and prevent deaths by suicide.
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208


211


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238


Educational Philosophy and Theory, 41, (1), 10-21


APPENDIX A

Duquesne University IRB Approval Letter

To: Jayna Bonfini
From: David Delmonico, IRB Chair
Subject: Protocol #2018/11/20
Date: 01/11/2019

The protocol 2018/11/20. MIDLIFE SUICIDE: EXAMINATION THROUGH AN ECOLOGICAL AND INTERPERSONAL LENS has been verified by the Institutional Review Board as Exempt according to 45CFR46.101(b)(4): Existing Data & Specimens - No Identifiers on 01/11/2019.

If applicable, the consent form and/or recruitment flier have been stamped and are attached to this email or are accessible via Mentor. Please use these stamped versions to distribute or display.

Exempt status means there is no specific expiration date, and you are not required to file annual reviews or termination reports. However, any unanticipated problems, adverse effects on subjects, or protocol deviations must be immediately reported to the IRB Chair before proceeding with the study.

Further, any changes to your study requires the filing of an amendment and is subject to the approval of the IRB Chair. You must wait for approval before implementing any changes to the original protocol. Changes to your protocol may affect the exempt status of your research.

Please contact me if you have any questions regarding this study.

Best wishes in your research,

David Delmonico, Ph.D.
Institutional Review Board, Chair
irb@duq.edu
## APPENDIX B

### Project Code Book

<table>
<thead>
<tr>
<th>Code</th>
<th>Definition</th>
<th>Group Designation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acquired Capacity</td>
<td>Acquired capability is becoming fearless, pain-tolerant, and knowledgeable about dangerous behaviors (Joiner, 2005, p. 47-48). When this is combined with perceived burdensomeness and thwarted belongingness, suicide becomes “attractive” and accessible (p. 47)</td>
<td>Joiner</td>
</tr>
<tr>
<td>Chronosystem</td>
<td>The chronosystem represents environmental events, transitions, and sociohistorical conditions of an individual’s development. Environmental events are natural events such as hurricanes, tornadoes, and earthquakes. Sociohistorical circumstances are large socially historical events in that person’s life.</td>
<td>Bronfenbrenner</td>
</tr>
<tr>
<td>Clinical care</td>
<td>Access to and receiving Effective clinical care for mental, physical, and substance abuse disorders</td>
<td></td>
</tr>
<tr>
<td>Connectedness</td>
<td>Family, friend, and community support</td>
<td></td>
</tr>
<tr>
<td>Coping skills</td>
<td>Skills in problem solving, conflict resolution, and nonviolent ways of handling disputes</td>
<td></td>
</tr>
<tr>
<td>Cultural protective factor</td>
<td>Cultural beliefs that discourage suicide and support instincts for self-preservation</td>
<td></td>
</tr>
<tr>
<td>Desire for life to end/frustration</td>
<td>Comments such as &quot;when will it end&quot; or expressions of frustration with ongoing mental health issues</td>
<td></td>
</tr>
<tr>
<td>Distraction</td>
<td>Methods to keep one’s mind occupied to avoid negative thoughts or maladaptive behaviors</td>
<td></td>
</tr>
<tr>
<td>Economic Risk</td>
<td>Loss of income or savings due to unemployment, reduction in benefits, or other means</td>
<td></td>
</tr>
<tr>
<td>Encouragement response</td>
<td>Response from other User encouraging initial poster to keep going/seek help</td>
<td>Response</td>
</tr>
</tbody>
</table>

245
<table>
<thead>
<tr>
<th>Exosystem</th>
<th>The exosystem refers to social settings in which an individual does not have an active role influence his or her experiences. The exosystem is a more distal context that may not directly include an individual but may significantly impact them (Bronfenbrenner, 1979).</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Conflict</td>
<td>Heightened conflict between family members; familial discord and/or estrangement</td>
</tr>
<tr>
<td>Firearms</td>
<td>Easy access to lethal weapons</td>
</tr>
<tr>
<td>Grief/loss</td>
<td>Mourning the death of a loved one or the loss of an important relationship (e.g., divorce)</td>
</tr>
<tr>
<td>Helpful suggestions</td>
<td>User providing suggestions and resources to other users</td>
</tr>
<tr>
<td>I'm not doing well</td>
<td>Self-reports that poster is unwell or struggling</td>
</tr>
<tr>
<td>Lived Body</td>
<td>Lived body</td>
</tr>
<tr>
<td>Lived Relation</td>
<td>Lived Relation</td>
</tr>
<tr>
<td>Lived Space</td>
<td>Lived space</td>
</tr>
<tr>
<td>Lived Time</td>
<td>Lived time</td>
</tr>
<tr>
<td>Loneliness</td>
<td>Feeling of being alone or cut-off from others</td>
</tr>
<tr>
<td>Macrosystem</td>
<td>The macrosystem involves the broader culture (e.g., values, laws, customs) in which individuals live. The macrosystem refers to the consistencies in the form of systems at the level of the subculture or the entire culture (Bronfenbrenner, 1981, p. 26).</td>
</tr>
<tr>
<td>Mesosystem</td>
<td>The mesosystem is a system of microsystems and captures the idea that individuals develop by interacting with others within multiple settings in their microsystem (Bronfenbrenner, 1981, p. 23). The mesosystem involves linkages between microsystems such as family and community.</td>
</tr>
</tbody>
</table>
The microsystem is a pattern of activities, roles, and interpersonal relations experience by a person (Bronfenbrenner, 1979, p. 22). Within the microsystem, the individual has direct interactions with parents, children, peers, coworkers, and others.

Current or prior military service

Perceived burdensomeness is the perception that one is a burden and the perception that this state is permanent and stable, and death is a solution to the problem (Joiner, 2005, p. 98)

Impulsive or aggressive tendencies

General messages that provide a quote or saying meant to support

Attempted suicide at least once in the past

Factors that buffer individuals from suicidal thoughts and behavior

History of mental disorders, particularly clinical depression

A socially constructed category of identification based on physical characteristics, ancestry, historical affiliation, or shared culture

Religious beliefs that discourage suicide and support instincts for self-preservation

Respondent expressed that he/she has also experienced the same feeling/event
<table>
<thead>
<tr>
<th>Term</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stigma</td>
<td>Unwillingness to seek help because of the stigma attached to mental health and substance abuse disorders or to suicidal thoughts</td>
</tr>
<tr>
<td>Substance Abuse</td>
<td>History of alcohol and substance abuse</td>
</tr>
<tr>
<td>Support response</td>
<td>Response telling poster that the user is there for them, able to listen</td>
</tr>
<tr>
<td>Thank you</td>
<td>Thank you for kind words, for sharing, for encouraging</td>
</tr>
<tr>
<td>Thwarted Belongingness</td>
<td>Thwarted belongingness is an unsatisfied need to belong via interactions with others and a feeling of being cared about (Joiner, 2005, p. 96)</td>
</tr>
<tr>
<td>Tough love response</td>
<td>Response that seems firm or provides other members with a “reality check” about what is necessary to be well.</td>
</tr>
</tbody>
</table>