Suicide of Older Adults: A Sad Ending to an Untold Story

By

Catherine May White

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Mount Saint Vincent University, Department of Family Studies and Gerontology

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Catherine May White

Approved:

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Deborah Norris, PhD

Thesis Advisor, Professor

Mount Saint Vincent University, Family Studies and Gerontology

_____

Jeanette A. Auger, PhD

Professor Emeritus and Adjunct Professor of Sociology

Acadia University, Department of Sociology

_____

Linda Caissie, PhD

Associate Professor

St. Thomas University, Gerontology

Abstract

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Many older adults enjoy healthy aging while others face a range of losses (health, companions, resources, meaning in life) that can result in social isolation, loneliness, and fear that one will become a burden. The challenge of accepting a declining quality of life, lack of a sense of purpose, and increased dependence on others may become too great, contributing to the risk for suicide. While risk factors and protective factors are identified, each suicide is different. There is a lack of consensus on how suicidal ideation arises and little existing research to illuminate the lived experience of how older adults move from ideation-to-action.

The purpose of this study was to create an opportunity for people over the age of 50 who have recently attempted suicide to share their personal experience. A better understanding of what leads older adults to attempt suicide may help to develop approaches to suicide prevention that better address their needs.

Narrative Inquiry was chosen as the methodology for this study as it lends well to sharing stories of lived experience and accounts of specific events or actions, specifically ones with a turning point. Four participants engaged in two interviews. The first provided each person the opportunity to share their story, with minimal prompts provided. The second allowed them to review the preliminary findings and clarify as needed.

Although the findings revealed alignment with the Interpersonal Theory of Suicide which posits that suicide is the result of simultaneous existence of thwarted belonging and perceived burdensomeness, accompanied by hopelessness, there was great diversity in the ways they did so. Some carried burden while others feared becoming a

burden. Thwarted belonging was evident in the ways participants evaluated their role in the family. Some were socially excluded from family events, while others felt a general lack and having something to offer in the world.

The Critical-Ecological Framework added an additional lens through which to view the findings. The intertwined ecological levels of the environment (microsystem, mesosystem, exosystem, macrosystem) added a depth of understanding that illuminated the challenges inherent with maintaining an exclusive focus on mental health issues as strictly an individual issue, as is often the case in mental health services. Participants wanted more than another prescription. They wanted to be included and valued, and to feel that they had something to offer. Mental health services could benefit from the knowledge that interventions such as social prescribing and occupational therapy could be a good fit for supporting people to supplement symptom management with finding meaningful activities in which to engage. Community responses to create welcoming, accessible and inclusive environments and opportunities for intergeneration participation could also be helpful.

In conclusion, there are many pathways to suicidal ideation, requiring a multi-pronged approach when it comes to prevention. The biomedical approach is not enough to support older adults who are considering ending their lives. People need a sense of purpose. Battling ideologies such as agism and helping people to overcome barriers to inclusion and find activities that are meaningful are required.

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Chapter 1: Introduction

Although themes of death and dying are common in the study of gerontology, suicide is seldom among the topics discussed. Death by suicide is generally considered a tragic outcome for people across the lifespan and around the world. It has been described as "perhaps the most puzzling and devastating of all human behaviors" (Millner et al., 2020, p. 704), one with immeasurable impacts on those left behind. It seems especially tragic for older adults who have navigated their way through a lifetime of challenges, only to arrive at a point where they no longer see life worth living.

Suicide is disproportionate among older adults, accounting for approximately 18% of suicides worldwide (Segal et al., 2018), and the overall number is growing in North America and abroad (Wadhwa & Heisel, 2020). Attempts made by older adults are more likely to be lethal (especially for men), with one in four attempts resulting in a suicide, as compared to 10 – 20 attempts for every one suicide in the general population (Van Orden & Conwell, 2016). Sadly, as Crestani and colleagues point out, "suicide in the elderly population is a phenomenon that is often ignored or neglected" (2019, p. 68). Furthermore, their suicide risk is often not identified in primary care settings, resulting in the lack of referral to specialized services (Simons et al., 2019). The Mental Health Commission of Canada (MHCC) confirms it is a very concerning issue for older adults (MHCC, 2019). Many older adults enjoy healthy aging, but, as they discuss, many others struggle as they face diminishing health, loss of loved ones, and decreased physical mobility and independence coupled with adjustment to life changes such as retirement,

changes in financial situation, and in some cases, transition into long-term care. This can result in social isolation, loneliness, and fearing one will become a burden to family with little to offer in return, all of which negatively impact mental health and overall quality of life (Wand et al., 2018a). The challenge of accepting a declining quality of life and increased dependence on others may become too great, contributing to the risk for suicide in older adults (Erlangsen et al., 2021).

In spite of this knowledge about contributing factors, there is no direct cause-and-effect relationship with suicide. Some authors report a sequential process whereby older adults experience multiple losses which lead to stress, depression, pain, and eventually, suicide (Franks et al., 2012), but many people face great adversity without ever considering ending their lives in this manner. As Wijngaarden et al. (2015) point out, "most elderly people who wish to die will wait until time fulfills their wish" (p. 257). They may consider suicide unacceptable, although, as they discuss, increasingly neo-liberal values such as autonomy and self-determination may be shifting the view. Another option, Medical Assistance in Dying (MAiD), is now legal in Canada (Patton & Dobson, 2021). Although it may be a viable choice for those who are suffering, there are strict criteria, and it is fraught with contention around religious beliefs, alignment with personal and family values, and equitable access.

With over seven hundred million people over the age of sixty-five in the world as of 2019, and the number expected to double to 1.5 billion by the year 2050, the United Nations observes that "all societies in the world are in the midst of this longevity

revolution" (United Nations, 2019, n.p.). As the overall number of older adults increases, and suicides continue to increase (Obuobi-Donkor et al., 2021), if major changes are not forthcoming, the number of suicide-related deaths is likely to keep pace. Suicide is everyone's business. As Monette points out, "we're all going to be seniors one day and we're going to want those protections for ourselves if nothing else" (Monette, 2012, p. E886).

Theoretical Perspectives

A variety of theoretical perspectives have been developed to support an understanding of suicide. Historical reports credit sociologist Emile Durkheim as the first person to advance a theory of suicide (Durkheim, 1897). Durkheim's work identified altruistic (over-integration to a group; suicide for the benefit of a group), egoistic (limited social integration), anomic (inadequate moral regulation, inattention to social norms) and fatalistic (excessive moral regulation; not meeting self-imposed standards) as perspectives that explain suicide (Auger, 2019; Zhang, 2019), suggesting there is a range of causes. Further, his theory identified social integration (presence of social ties) and moral regulation (alignment with social norms) as key protective factors (Durkheim).

Many of the newer theoretical understandings draw on this early work, but integrate a focus on the transitions that occur in the *ideation-to-action framework* (Klonsky et al., 2017). For example, Thomas Joiner's *Interpersonal Theory of Suicide* posits that suicide is the result of simultaneous existence of thwarted belonging and perceived burdensomeness, accompanied by hopelessness, and the acquired capability to

take action (Van Orden et al., 2010). This theory adds an additional layer of complexity that helps us to understand that it is more than the presence or absence of belonging and burdensomeness that must be considered. As discussed by Smith and Cukrowicz (2010), suicide is difficult and contradicts long-held values of self-preservation, so making it a viable option requires a significant shift. Holmes and Holmes (2005) quoted a suicide note that was quite revealing in this regard: “I do not fear death as much as I fear the indignity of deterioration, dependence, and hopeless pain…” (p. 51). As Van Orden and colleagues (2016) clarify, the persistent nature of thwarted belonging and increased burdensomeness coupled by the belief that improvement is out of reach leads to hopelessness about the future. The capability for suicide is then acquired by developing a higher pain tolerance and lower fear of death, sometimes by engaging in painful or provocative activities such as non-suicidal self-harm (Van Orden et al., 2016). As other authors confirm, experiences of trauma, drug use, and self-harm could contribute to building the pain tolerance necessary to establish the capability to take lethal actions (Brokke et al., 2022).

The *Integrated Motivational-Volitional Model* also incorporates the ideation-to-action framework. It suggests that suicidal ideation arises from feelings of defeat and entrapment accompanied by *volitional moderators* including access to means, fearlessness about death, and impulsivity (O'Connor & Kirtley, 2018). Another example, *The Three-Step Theory*, suggests that suicidal ideation results from the combination of pain (usually psychological pain) and hopelessness. In this theory, connectedness (most

often social connectedness) is seen as a key protective factor against escalating ideation. In the absence of meaningful connectedness, progression from suicidal ideation to an attempt is attributed to genetic disposition, acquired attributes such as habituation to the idea, and practical considerations such as access to means, all of which contribute to increased capacity (Klonsky & May, 2015; Klonsky et al., 2021).

Other frameworks and theories also appear in recent literature. The *Stress-Diathesis model* posits that negative life events (known as diatheses) can predispose one to suicide, if certain situational stressors are present (Conejero et al., 2018). Brown and Schuman (2021) have drawn on Finkel's *I-cubed model*, focusing on instigators (environmental contexts), impellors (current situations) and inhibitors (factors that may decrease suicide attempts). As Stanley et al. (2016) discuss, Baumeister's *Escape Theory* focuses on escaping the negative emotions that may arise from negative self-perception, while Shneidman, in his *Psychache Theory*, attributes intolerable psychache (psychological pain such as shame, fear, or guilt) as the cause of suicidal thoughts and behaviours. Zhang (2019) proposed *Strain Theory*, identifying four sources of psychological strain (conflicting values, reality versus aspiration discrepancy, relative deprivation, and deficient coping) that may lead to suicidal ideation.

Although these theories draw on overlapping theoretical constructs that date back years, empirical testing of them is in its infancy. Their lack of consensus suggests that more research is needed. Millner and colleagues (2020) offer the critique that in suicide theories, cause-and-effect linkages are particularly hard to operationalize, and suggest

that current research has been guided by "theories containing vague constructs and poorly specified relationships" (p. 704), pointing to the fact that existing theories are verbal in nature (rather than mathematical), and thus imprecise. For example, they critique Joiner's *Interpersonal Theory of Suicide*, and report that in some literature, both thwarted belonging and perceived burdensomeness are identified as necessary precursors to suicide, while elsewhere, one or the other will suffice as creating sufficient risk. They also point to the challenges with precise measurement of such constructs, and conclude that rigorous descriptive research, direct observation and accurate measurement of suicidal thoughts and behaviors could support a better understanding of suicide, and how to prevent it. Given the great diversity in the factors that contribute to suicide, and the wide variation amongst older adults in general, aiming to develop mathematical, predictive models may be an unrealistic goal.

Cabello et al. (2020) raise questions as to the unique characteristics of older adults and whether existing theories apply or could be adapted. Stanley et al. (2016) reviewed a variety of theories from this perspective, offering implications for older adults for each one. They concluded that most theories have not been tested with an older adult population, nor with specific sub-populations of older adults, such as Veterans, sexual minorities, or people living in long-term care, which would be valuable if targets for intervention are to be identified. A variety of age-related considerations such as older adults having had more time to contemplate suicide, an accumulation of contributors over

a longer period (rather than response to one event), and facing life transitions that may be viewed negatively (such as forced retirement) all may factor in (Monette, 2012).

Most theories that dominate the discourse at this time strive to better understand the ideation-to-action trajectory but lack a broader perspective that theories like the *Critical-Ecological Framework* could offer (Norris et al., 2013). As Norris and colleagues discuss, this framework combines Bronfenbrenner's focus on context, including the interdependent levels of the environment (macrosystem, exosystem, mesosystem, and microsystem), with action-oriented critical theory, which incorporates the process of becoming critically conscious, providing a lens through which to both perceive and contest oppression and examine how long-held ideologies such as ageism can be opposed to make way for a different future.

In addition, the *Social-Ecological Suicide Prevention Model* focuses attention on the need for integrated multi-level approaches across the prevention spectrum (prevention, intervention, postvention), using universal, selective and indicated approaches (Cramer & Kapusta, 2017). If we are to bring into focus a greater understanding of suicide and older adults, we must oppose ideologies such as ageism, and the "societal perception that it's entirely normal for an elderly person to experience a certain degree of hopelessness and sadness" (Monette, 2012, p. E886). As such, the use of critical-ecological theory can complement the ideation-to-action framework, and both will be used to guide this study.

Critique of Methods

The study of suicide presents inherent challenges, in that those who die by suicide are no longer accessible as informants. To learn about their experience, approaches that rely on second-hand reports of those who were in their midst are often used. One example is *psychological autopsy*, an approach in which explanatory clues are collected following a suicide, and close contacts such as friends, relatives or health care providers are asked to reflect on possible contributing factors (Kjølseth et al., 2010b). While this method may yield valuable information, it can be challenging to obtain. Family members may be too distraught or unwilling to discuss the situation. They may intentionally withhold information, especially if it is self-incriminating, such as the person dying following a dispute, or if elder abuse is at play, or they may be unaware of the range of contributing factors. Health care providers may feel limited in ethical consent to disclose information and may also hold an incomplete picture of the circumstance. Coroner or post-mortem reports that document information such as means used or diagnosis at time of death may be referenced, but they are not consistently available to researchers and may lack accurate detail, such as mistaking a suicide for an accidental death (Monette, 2012). Further, some causes known as "silent suicide" may be overlooked, including intentional starvation or dehydration, intentional medication misuse or non-compliance, and non-accidental accidents (Upadhyaya & Sher, 2019, p. 365).

The use of secondary data is also seen in various types of quantitative studies and literature reviews (see for example, Beghi et al., 2021; Choi et al., 2019; Conejero et al.,

2018; Ngamini Ngui et al., 2015; Obuobi-Donkor et al., 2021). While these approaches offer synthesized data often derived from large data sets, they reflect very diverse studies (in terms of variables, timeframes, geographical locations, culture, populations and study designs) making comparison difficult. They seldom focus on individuals with an actual attempt of suicide in their past, and often reflect discrepancies in how suicidal behaviour is defined. Further, they may lack disaggregated information regarding age, gender, sexuality, geography, culture, specific illnesses or causes of disability, and how old age itself is stratified, with some countries considering those in their 40's as older adults (Fässberg et al., 2016). Terms similar to *young-olds* (65 – 74), *middle-olds* (75 – 84), and *old-olds* (85+) are sometimes used to offer more clarity (Conejero et al., 2018; Koo et al., 2017). The terms *third age* and *fourth age* are also used, not necessarily relating to chronological age (Johnson et al., 2020).

Suicide notes or other forms of documentation such as journal entries, text messages or emails sometimes exist, but can be challenging for researchers to obtain access. In a study of suicide notes, Cheung et al. (2015) found explanations related to unbearable physical and psychological symptoms, apologies, notes of appreciation, farewells, and expressions of anger. Indicators of reduced quality of life, health problems, concerns about functioning, fear of going to long-term care, and other stressors were also noted. Other authors reported a range of subject matter in suicide notes, with some indicating suicide was the logical next step of a life lived, while others described an escape from intolerable suffering, either in the present or in a perceived future (Cuperfain

et al., 2022). Cuperfain et al. also found the documented causes of suicide to be multifactorial, with most notes indicating an overlap of identified themes. Although suicide notes can yield valuable information, in the absence of their author, the researcher cannot request clarification or expansion on any of the information found, again leaving others to speculate.

Finally, there are first-hand reports of those who attempted, but did not die by suicide, or who harbor suicidal ideation but have not acted on it thus far. While these first-hand reports are likely the most accurate, it is important to note that *suicidal ideation* is not the same as *suicide attempt* and experiences vary widely (Klonsky et al., 2017). Those with suicidal ideation may not have reached the "tipping point" (and may never reach it), whereas those who attempted and survived did, making them a more accurate source of information regarding the experience. Likewise, there is a difference between *active* and *passive* approaches, sometimes referred to as *direct* and *indirect;* they are two different constructs with different intentions, and should be addressed as such (Wand et al., 2018a). As Wand et al. clarify, active approaches to suicide reflect a deliberate attempt to end one's life imminently, while passive actions such as refusing food or misuse of medications have a more prolonged trajectory. These passive or indirect actions align with silent suicide, discussed above.

Drawing on first-hand knowledge is likely to be the most accurate source of information about the experiences related to suicide, but few such studies exist. Australian psychiatrist and researcher, Anne Wand and her colleagues are the most

prominent qualitative researchers currently publishing on the topic of older adults (particularly those over age 80) and suicide. Their research draws on qualitative interviews of both individuals who had experienced self-harm or a suicide attempt (Wand, Draper, et al., 2019; Wand et al., 2018b) as well as caregivers/friends (Wand, Peisah, et al., 2019). Wand et al. also reviewed qualitative studies regarding self-harm and suicide in older adults, and concluded such studies were "scant" with only eight studies meeting their inclusion criteria, only two of which were Canadian (2018a, p. 289). Some other examples of qualitative research regarding suicide with older adults include Figueiredo et al. (2015) who used qualitative interviews focused on the use of coping strategies to overcome suicidal ideation following a suicide attempt, Bonnewyn and colleagues (2014) who used qualitative interviews to examine the antecedents to suicide attempts, and Zhang et al. (2022) who interviewed older adults with suicidal ideation in nursing homes to explore their help-seeking experiences.

Most studies that access older adults directly have used quantitative methods, and often engage a diverse group of older adults, not those who have actually attempted suicide. For example, Heisel and Flett (2016) presented healthy community-residing older adults with a battery of tests to explore suicide-related constructs such as reasons for living, presence or absence of depression, and perceptions of social supports. Likewise, Lee et al. (2019) drew on community-dwelling adults over age 65 who presented at a public health centre for various reasons, and collected survey information

relating to thoughts of suicide and whether or not they were involved in caring for grandchildren.

In the field of suicide in older adults, the use of qualitative methods is almost non-existent, leaving their voices unheard. Thus, this exploratory, qualitative study directly engaged older adults who have an actual suicide attempt in their recent past, providing a valuable first-voice perspective which may be beneficial to inform clinical practice and future theory development in this area.

Review of Literature

The majority of the literature regarding suicide in older adults focuses on risk factors and protective factors. However, as Auger (2019) concluded, "suicide involves a highly complex set of interconnected interactions that involve psychological, societal, cultural, genetic, biochemical and social factors" (p. 249). The constellation of risk factors and protective factors is ever-changing and differs for each person.

Risk Factors

Regarding causality of suicide, several studies focus on risk factors (see for example, Conwell, 2018; Segal et al., 2018; Westefeld et al., 2015; Zhang, 2019). However, there is not a clear cause-and-effect relationship that explains exactly why some people attempt suicide while others do not, making it impossible to predict. The most common risk factors include the presence of physical or mental health symptoms (such as pain or depression), impacts on functional ability (such as driving or mobility issues), limited social support (including emotional and instrumental), and negative

feelings/perceptions about the present and future (grief, hopelessness, sense of burden). These factors are often examined through the lens of *loss.* They are often inter-related (e.g., arthritis pain impacting functional ability; lack of social support contributing to depression) and intersect with personal factors such as resiliency. Coping with the COVID-19 pandemic has also emerged as a risk factor.

While many factors commonly co-exist, the literature offers the strongest correlation between suicide and mental disorders, particularly depression and bipolar disorder (O'Rourke et al., 2017; Obuobi-Donkor et al., 2021; Westefeld et al., 2015; Zhang, 2019). For example, as both Obuobi-Donkor et al. (2021) and Zhang (2019) discussed, over 90% of people who die by suicide have been diagnosed with a mental disorder (although generally speaking, only a small percentage of people with a mental disorder will attempt suicide). However, Barry (2019) noted there is growing evidence to suggest that depression is not an essential precursor. In a recent retrospective analysis of suicide deaths, Schmutte and Wilkinson (2020) found that 69% of males and 50% of females did not have a mental health diagnosis, but acknowledge the possibility of under-reporting of symptoms, and lack of screening, diagnosing, and treating mental health conditions. Further, Fiske and O'Reilly (2016) reported that older adults who die by suicide are more likely to have a depressive disorder than younger adults.

The presence of a chronic physical health condition is common among people who attempt or die by suicide, but again, there is not a clear cause-and-effect relationship; it is not predictive of suicide (Westefeld et al., 2015). Ngamini Ngui and colleagues

(2015) found chronic health conditions such as arthritis, cardiovascular disease, renal failure, and headaches to exist in all members of the 2,493 member cohort under study. Interestingly, their study also noted the presence of at least one mental disorder (including diagnoses such as depression and schizophrenia, as well as personality disorders and drug or alcohol dependency) in each case. In addition, as Obuobi-Donkor et al. (2021) reported, although chronic pain was ranked highly as a correlate to suicide, simply the belief that one had a malignant illness such as cancer was correlated with higher rates of suicide as well, suggesting anxiety and hopelessness about the future. Likewise, concern that one might become a burden, or that they had little left to offer could add to the risk (Wand et al., 2018a).

The suicide risk for older adults with dementia is also explored in the literature (Choi et al., 2021; Cipriani et al., 2013; Diehl-Schmid et al., 2017; Draper & Brodaty, 2015; Jae Woo et al., 2021). As these authors discuss, the risk of suicide is most notable in the early stages (or the first year) when the individual may have insight into their prognosis, and the capacity to carry out the act. In addition, psychiatric co-morbidities such as depression increase the risk. As Schmutte et al. (2022) point out, given the concerns of the first year, suicide risk assessment is an important an accompaniment to confirming a diagnosis of dementia. As time goes by, increased supervision by caregivers coupled with diminishing cognitive abilities make suicide less likely.

Older adults are less likely to communicate their intentions about suicide, and although they are likely to have seen a health care provider in the month leading up to a

suicide, it did not result in them obtaining the necessary help (Segal et al., 2018). Many primary care physicians are unprepared to screen for, diagnose and treat depression in older adults, suggesting a need for improved training in this regard (McKay et al., 2022). In addition, some older adults may lack trust in their healthcare providers or fear their situation cannot be helped, and may not share sensitive information related to functional decline and suicidal ideation for fear of losing their autonomy (Kjølseth et al., 2010a).

Links between illness, disability and suicidality have also been identified, with the greatest risk of suicide arising when there was a significant negative impact on independence, sense of usefulness, value, dignity, and pleasure in life (Fässberg et al., 2016; Kjølseth et al., 2010a; Obuobi-Donkor et al., 2021). In their systematic review examining the link between illness, disability and suicidality, Fassberg and colleagues reported, "we actually know little about what at-risk, physically ill patients want, and need, to help them relieve their distress" (Fässberg et al., 2016, p. 190). Loss of mobility and other aspects of independent functioning such as impaired ability to complete self-care tasks and loss of driving can impact autonomy regarding social and community activities, increase sense of burden and have a significant impact on quality of life (Mournet et al., 2020; Westefeld et al., 2015). As Kjølseth et al. (2010a) confirmed, age and illness-related functional decline impacted quality of life in areas associated with freedom and self-determination; maintaining dignity as older adults face losses in physical ability and self-sufficiency is critical. Obuobi-Donkor et al. (2021) also concluded that functional impairment was correlated to suicide, suggesting that it was

associated with higher levels of depression. Thus, timely diagnosis of physical and mental illness, followed by the most effective treatments which may slow the process of disability hold potential to mitigate suicide risk.

There is considerable research relating to the relationship between social isolation and loneliness and suicide in older adults (see for example, Heuser & Howe, 2019; Niu et al., 2020; Obuobi-Donkor et al., 2021). Losing social supports due to the death of intimate partners and friends, retirement, or health changes has been identified as a risk factor for suicide (Westefeld et al., 2015), but as Heuser and Howe (2019) found, following an extensive literature review, the relationship is not clear. In their qualitative study, Bonnewyn et al. (2014) found that significant losses of various types (e.g., spouse, health) introduced a major disruption to life whereby participants either did not want or were not successful in maintaining social connections. For example, they may decline invitations or not know how to open the conversation about troubling matters (even when emotional support was available), resulting in them feeling alone. Obuoui-Donkor et al. further discussed that living alone and loneliness are not one and the same; one can be lonely in the midst of people, such as in long-term care, but well connected socially when living alone. Furthermore, they note, relationship difficulties and family conflict can be risk factors for suicide. Nicholson (2012) reviewed the impact of social isolation on health and determined that the lack of a sense of belonging, and limited contact with others had detrimental health impacts. Interestingly, Nicholson discussed not only positive impacts of social contact, but the possibility of *negative health exchanges*

whereby someone may feel overburdened by a particular social contact. Social support is also discussed in the literature from the perspective of what an older adult has to offer. For example, as Lee et al. (2019) reported, contributing to care of grandchildren, as long as it does not exceed physical and psychological capacity, can enhance self-worth and family connections and reduce sense of burdensomeness. However, as they discuss, these benefits may be minimized when grandparents become full-time caregivers due to the dysfunction of their own children, such as in the case of substance abuse, neglect, intimate partner violence or incarceration. Negative impacts such as depression, stress, isolation, financial difficulties and disruption of their own activities can result. Thus, quality of social supports and interactions, and not quantity, is the key. Westefeld and colleagues further discussed the risk factors, suggesting that the disproportionate rise in older adults may outpace the number of available caregivers, resulting in what they referred to as the *dependency ratio* which may exacerbate the feeling of being a burden, and subsequently, suicide risk (Westefeld et al., 2015).

The recent literature has begun to explore how the COVID-19 pandemic has influenced risk for suicide (Conejero et al., 2021; Courtet & Olié, 2021; Flett & Heisel, 2021; Ivbijaro et al., 2021; Le et al., 2020). For example, in their recent narrative review, Ivbijaro et al. (2021) concluded there is emerging evidence regarding an increase in suicide and suicidal ideation since the onset of the pandemic. The pandemic has caused "unprecedented medical, social, and economic upheaval across the globe, and inflicted profound psychological pain on many people" (Le et al., 2020, p. 526). As older adults

experience COVID-related increases in stress, uncertainty, fear and despair, limited access to social supports and healthcare, and increased anxiety due to the volatility of investments and the impact on retirement savings, estimates of up to a six-fold increase in suicide attempts among older adults have been predicted (Flett & Heisel, 2021).

Conejero et al. (2021) propose a biological explanation for the increased vulnerability for suicide for people who have been infected with the virus, highlighting the association with receptors in the brain that are associated with mood disorders and suicide. As Conejero et al. discuss, those coping with the implications of COVID restrictions such as isolation or social distancing may also be at risk due to the increase in *social pain* which could lead to suicide. Given the fear of contracting the virus itself, experiencing the virus and its aftermath or being close to someone who contracted it, and/or coping with the many imposed restrictions and their associated outcomes, the correlation is highly likely, not only for those with pre-existing mental disorders, but for many others who are experiencing a broad range of stressors and risk factors. Other authors confirmed that risk factors such as fear of contracting the virus, isolation and reduced social interaction, domestic violence, increased alcohol or drug abuse, and reduced access to mental health care may also be exacerbated as a result of the COVID restrictions and could contribute to suicide (Aquila et al., 2020).

While it may be premature to accurately determine the impact of the pandemic on suicide rates, Wand et al. predict “the pandemic is likely to result in a confluence of the risk factors for suicidal behaviors” (2020, p. 1225). As they, and others point out, policies

such as social distancing and quarantine by definition promote social isolation (Jawaid, 2020). People may feel disconnected from others as their usual social opportunities are modified, regular appointments may be cancelled or held virtually, and they may experience heightened anxiety due to uncertainty and fear about the pandemic itself, all of which can exacerbate mental health symptoms. The authors (Wand et al.) concluded that the pandemic is likely to continue to increase the prevalence of risk factors for suicide which will be layered on top of existing stressors. Older adults may come to feel they do not matter. They need to feel valued and connected to others rather than feeling the impacts of agism where they may feel expendable and disposable (Flett & Heisel, 2021).

Protective factors

As Flett and Heisel point out, "the feeling of mattering provides a sense of connection and comfort and a source of resilience that is a strong buffer of life problems and feelings of stress and distress" (2021, p. 2452). As a counterpoint to the many risk factors for suicide in older adults, several authors have also drawn attention to protective factors to mitigate the risk (Aviad & Cohen-Louck, 2021; Cabello et al., 2020; Obuobi-Donkor et al., 2021; Segal et al., 2018). As they discuss, the presence of strong social supports, social connectedness and the opportunity for social interactions are among the strongest protective factors. Other factors include overall health condition, receiving timely and appropriate care for mental and physical health problems, having a sense of purpose in life, effective coping skills, and being adaptable to change. Opportunities for

helping others such as offering informal support can decrease perceived burdensomeness and help with social connection (Smith et al., 2020). Aviad and Cohen-Luck add that having an internal locus of control is a protective factor against the risk or the potential for suicide in older adults (2021). Klosnky and May (2015) identified connectedness as a key protective factor against escalating suicidal ideation. Aligning with Flett and Heisel's discussion of *mattering* (2021), Klonskey and May (2015) clarify, connectedness often means social connections, but they add that other connections or attachments such as to jobs, roles, and interests, as well as connection to a purpose in life or sense of meaning can all contribute to keeping the person invested in life. Having a meaningful role in caring for grandchildren (Lee et al., 2019), pet ownership (Young et al., 2020), being physically active (Laflamme et al., 2022), and having opportunities to give or contribute to others (Jawaid, 2020; Smith et al., 2020) have also been identified as protective factors against suicide in older adults. Studies relating to the resiliency of older adults as a protective factor are also emerging. For example, Heisel and Flett (2016) developed a conceptual framework that examines predisposing risk factors and how suicidal ideation could be mitigated by resiliency. Being part of a culture or religion that discourages suicide (Segal et al., 2018), or feeling a sense of belonging and connectedness to a religious community (Pulgar et al., 2022) have been discussed as protective factors, but as Pulgar et al. point out, if faith is shaken, which may happen in the face of daunting life stressors, it can contribute to "unbelonging" and thus, increase risk for suicide (p. 737).

While there is clear identification of a wide range of risk factors and protective factors that impact suicide in older adults in the literature, there is a lack of agreement of the configuration of factors that either push someone to the "tipping point" or prevent them from moving in that direction. Furthermore, as Kleiman et al. (2017) found, suicidal ideation is not a fixed state that culminates with a suicide attempt. It fluctuates over time. Given its complexity and the uniqueness of individuals, attempting to predict suicide is futile. Although mitigating risk factors and maximizing protective factors remain as promising approaches to the prevention of suicide, more information is needed directly from those who have experienced a suicide attempt. As Flett and Heisel (2021) point out, research about mattering is about the individual person:

> It is about the significance of the older person's individual story and life narrative. It is about whether the individual feels seen and heard and valued versus invisible and unheard and someone who does not count to the people in their lives and perhaps society as a whole. (p. 2450)

Older adults can succumb to discriminatory healthcare practices that treat them like a burden, and negative stereotypes perpetuated by ageism, with significant impact on well-being (Butcher & Ingram, 2018). Suicidal behaviour in older adults "remains an under-studied and emerging public health priority given increasing trends in suicide in older age cohorts, coupled with an increase in the size of the older age population" (Page et al., 2021, p. 760). In addition the most recent suicide prevention strategy in Canada, *Working Together to Prevent Suicide in Canada: The Federal Framework for Suicide*

Prevention identified seniors among those for whom there is a knowledge gap in Canada (HealthCanada, 2016).

As Van Orden and Conwell (2016) concluded, more qualitative research regarding suicide in older adults is needed "to capitalize on the wisdom attained by listening to the voice of the older person" (p. 13). Further, Beghi and colleagues noted the close relationship between self-harm and suicide in older adults, and suggested "insights and opportunities for suicide prevention may be gleaned by in-depth interviews with those who survive self-harm" (2021, p. 194).

Purpose

Although several theoretical explanations exist, and some risk factors and protective factors have been identified, there is a lack of consensus on how suicidal ideation arises, how older adults move from ideation-to-action, and whether their trajectory differs from other age groups. What is the experience like, before, after and during the attempt? Furthermore, there is limited research from Canada, particularly Atlantic Canada, and little of it is focused on older adults. The purpose of this study was to create an opportunity for people over age 50 who have recently attempted suicide to share their personal experience. A better understanding of what leads older adults to attempt suicide may help us to develop approaches to suicide prevention that better address their needs.

A further purpose of this research was to participate in the Roots of Hope – Early Adopters project initiated by the MHCC. In response to context-specific data, in this case,

the 2020 New Brunswick Coroner's Report which indicated that 27% of the 108 suicides in the province were attributed to those over age 60, or just over 50% in those over age 50 (Ouellette, 2021), a focus on older adults and suicide prevention was selected. The Roots of Hope project urges participating communities to use their five-pillar framework, including means safety (limiting access to common methods), public awareness (increasing community-level awareness of risks), specialized supports (including prevention, intervention, and postvention services across populations), training and networks (ensuring adequate training and resources) and research (addressing research priorities and evaluating outcomes) to structure suicide prevention initiatives. This study served as a pilot project and will inform the development of a protocol for a larger provincial study.

Drawing on participants from Atlantic Canada, the current study addressed the following: 1) What contributing factors led the participants to consider suicide? 2) What was the experience like, before, during and after an attempted suicide? 3) How did the participants transition from thought (ideation) to action? and, 4) What protective factors contribute to coping now?

Chapter 2: Examining Reflexivity

Watch your Hats

Suicide is a very sensitive topic, one not easily talked about in today's society. For me, there was no choice. I answered the phone one Sunday morning in 1999, only to hear my mother say, "Judy is gone." Gone? Where had she gone? My sister Judy's life, coloured by drugs and alcohol, had taken a path quite different from my own. As a family, we had feared her untimely death might result "by accident" from the risky behaviour she often chose, but we were unprepared to learn she had intentionally taken her own life. At the age of 48, she was gone. Not coming back. Many questions and no opportunity to have them answered. That is what suicide is like – the unfathomable.

Defined as "practices through which researchers self-consciously critique, appraise, and evaluate how their subjectivity and context influence the research processes" (Olmos-Vega et al., 2023, p. 242), reflexivity is a key component of trustworthiness in qualitative research. My experience of losing my sister certainly placed the subject of suicide loss in a light that other researchers may not see. What was she thinking? Should we have seen it coming? What might have been done to stop it? Had she tried to get help? Did she think about how others would be affected? Her son? How could we make sense of her decision? These were questions my family and I have contemplated for years. I was unsure how my own unanswered questions would impact my interactions. What emotions would be awakened?

My personal experience was not the only avenue suicide had taken into my life. My professional role placed me right in its path. As I reflected on my 25-year career as an occupational therapist practicing in the field of mental health, I could visualize many of the distressed clients I encountered. I recall chasing one girl out the back door of the hospital, my heart pounding as I realized she might outrun me, and I would never see her again. “Cathy, why won’t you let me die?” she shouted back at me. Somehow, in the middle of the parking lot, she stopped, and through tears and heavy pants, we talked. She wasn’t running from me, she was running from her atrocious past – a past she later wrote a book about. I recall thinking “I don’t know what to do here. I can’t make it go away.” All I could think of was “be yourself, be here for her. Show her you care.”

She was but one of the many people I met working in the acute-care psychiatric unit of a large regional hospital. People there are seen at their worst, typically in times of crisis, as many patients were admitted following a suicide attempt. Young people. Older people. Those in between. Suicide made no distinction. I did observe one key difference. With younger people, for many, the “crisis” that led to a suicide attempt often seemed like something that might look different in the days and weeks ahead. For older people, that hopefulness was not always there. It seemed there was “one more thing” piled on – perhaps a death of a close friend or partner, a diagnosis with a daunting prognosis, or some other stressor that made life feel like it was all too much. It was challenging to work with both groups, to help them refocus on the positives, or the “reasons for living” that are often discussed in suicide prevention, but I enjoyed the challenge of journeying with

them, and the reward when you were able to see someone come out the other side with a glimmer of hope.

This research started with the startling realization that where I live, over 25% of all suicides were attributed to older adults – those over age 60. That was 29 people in 2020 (Ouellette, 2021). As I looked around the neighbourhood, I wondered, who were those 29 people? Someone's mother or father, sister or brother, spouse or partner, grandparent, or friend? I wanted to better understand their stories. In older adults, there are estimates that one in four attempts result in a completed suicide (Van Orden & Conwell, 2016), so if there were 29 suicides, there could be three times that number of people who made an attempt in 2020. Given that my research allowed the experience to be up to ten years in the past, there would be hundreds of people out there who matched the eligibility criteria, but they were not easy to find. I waited patiently, and by expanding my recruitment strategy, I eventually found four participants. I am so grateful they agreed to share their stories.

"Watch your hats," I called this reflexivity statement. I had no idea how hard it would be to keep my "researcher" hat on, and my "occupational therapist" hat off! As I began to hear stories about the challenges of finding something meaningful to do as health challenges met retirement, how hard it was to carry a past characterized by guilt, the need to find a sense of purpose when your life was defined as "therapy," and how something like losing your driver's license could change the trajectory of your life, I struggled not to jump in and try to help. I struggled to explore in more depth and not say

aloud what I was thinking, and I struggled not to call the participants back in the weeks following the research, just to make sure they were okay. But what *could* I do? Show them I care.

As I reflect on my assumptions, expectations, behaviour, emotions, and unconscious responses (Finlay, 1998) I came away thinking that once again "I didn't know what I didn't know." Each participant took me on a journey that was unexpected, and that challenged my assumptions. It was an emotional experience, not only to be there with them as they shared intimate details of their life experiences, but to listen to their spoken words later, and document their stories in ways that honored them for sharing. As they shared the lasting impacts on their families, it touched me to think back on how my family might have felt if my sister had survived. Would we have treated her differently? Would the relationships have changed? For the better? For worse? We will never know.

I come away from the experience acknowledging the insight of Creswell and Poth (2018) who discuss "the turn toward the relationship between the researcher and the researched in which both parties will learn and change in the encounter" (p. 73). I hope I can share the experiences of the participants in ways they will value, as all were interested in helping others. I come away having learned but wanting to learn more and plan to extend the research, realizing that the people affected by suicide are not only the ones who die. There is much grief in those left behind, and much despair in those who attempted and did not die and may attempt again, or in those who didn't attempt, but wish they were dead. If my work can play one small part in raising awareness and helping us

as a society to be mindful of those who are suffering and thinking of suicide, it will be a success.

Chapter 3: Methodology and Methods

Methodology

Narrative Inquiry was chosen as the methodology for this study due to its focus on "the study of experience as story" (Clandinin, 2006, p. 45). It lends well to sharing stories of lived experience and accounts of specific events or actions, specifically ones with a turning point (Creswell & Poth, 2018) or critical event (Mertova & Webster, 2020). As Creswell and Poth discuss, narrative research is a good choice for obtaining detailed stories or experiences of a single individual or a small number of individuals (in this case, four). True to narrative research, the researcher can encourage the telling of related stories that inform the research questions and later "restory" them in a chronology that illuminates a sequence of events (Creswell & Poth, 2018, p. 72). This was a helpful strategy, as the stories were not told in chronological order. As Mertova and Webster (2020) explained, although not necessarily explanatory, connections among the elements within the sequence of events suggested causal links.

Recruitment of Participants

A purposive sampling strategy was designed in collaboration with Addiction and Mental Health Services of Horizon Health Network. In preparation for recruitment, ethics approval was obtained from the research ethics boards of Mount Saint Vincent University and Horizon Health Network. Clinical staff were provided with a "Letter to Service Providers" (see Appendix A) to inform them of the details of the study. If they identified suitable candidates, they provided them with an "Invitation to Participate in Research"

(see Appendix B). Although I had obtained formal approval and informal agreement from a wide range of healthcare providers to assist with recruitment, they did not initially identify candidates who met the recruitment criteria. After two months, this approach had yielded no participants, so expansions to the recruitment strategy were made, including additional advertising methods (Facebook), expansion of eligibility criteria (age and time since the event) and of geographic inclusion (to include an additional province). Throughout the research, two amendments to the original protocol were approved, and ethics clearance was obtained from an additional collaborating agency. Potential participants were asked to contact me directly by telephone or email, at which time we scheduled an in-person interview.

Inclusion Criteria

Eligible participants included those who are:

- currently over age 50, with a history of a suicide attempt from 1 – 10 years in the past (to capture the experience of a suicide attempt as an older adult, but not so recent that the participant has not processed the event)
- had a connection to a mental health professional or another available support network
- were cognitively and physically able to participate in two interviews (one 60-90 minutes, and the other, 30-60 minutes)

Ethical Considerations/Safeguards

Speaking to people about suicide is a highly sensitive matter, and precautions must be taken to ensure their safety. As the primary investigator in this study, I am a licensed and insured occupational therapist with over 20 years of experience, most of which was obtained on an acute care psychiatry unit where the majority of clients were admitted with suicide attempts or strong suicidal ideation. I have explicit and recently updated training in SafeTALK screening and Applied Suicide Intervention Skills Training (ASIST), which proved beneficial throughout the research. Each participant was provided with a detailed consent form (See Appendix C), confirming that the interviews would be recorded, and informing them of their right to discontinue or withdraw from the study. The limits of confidentiality were discussed. Following each interview, I confirmed that the participant had access to a support person if needed and provided further contacts applicable to their geographic location. All COVID-19 pandemic protocols relevant at the time of the interviews as dictated by the New Brunswick Office of the Chief Medical Officer of Health, Department of Public Health and local health authorities were followed.

Data Collection

Qualitative interviews lend well as a method of data collection when using the Narrative methodology. The study started with one interview approximately 90 minutes in length, audio recorded with the participant's consent and later transcribed verbatim. In keeping with the narrative approach, participants were supported to "tell their story"

through the use of open-ended questions and thematic cues. The questions were developed specifically for this study (see Appendix D). Participants were asked to talk about their life more broadly as a means of rapport-building and gradually focused in on how they first began to entertain ideas of suicide (the evolution of suicidal ideation). They were asked to share as much as they were comfortable with regarding the event itself, and how they felt about not completing the suicide. Finally, they were asked to share their thoughts about how they feel now, what keeps them from further attempts, and what advice they would have for others. A second interview (30 – 60 minutes) was held with each participant approximately one month after the first to clarify points raised in the first interview and to provide an opportunity for participants to add additional information. At the second interview, to enhance trustworthiness and as a means of member checking, participants were provided with a verbal summary of key points from their first interview based on an initial analysis. As Carlson (2010) discusses, this process of member checking which allows participants to confirm your interpretation can be achieved by asking questions such as "*Am I on the right track?"* or "*Did I understand this in the same way you meant it?*" (p. 1105). This approach was used, and all participants confirmed the preliminary summary, adding detail and clarification throughout.

Analysis

Analysis began through the use of memos or reflective notes taken throughout the data collection and transcription process (Bryman, 2016). Following each participant's

first interview, the recording was reviewed and a general outline of events was documented. This preliminary analysis formed the basis of interview two. Transcripts were uploaded to the qualitative data analysis software, MAXQDA. The preliminary analysis followed the five-stage narrative thematic analysis process described by Butina (2015) which includes organizing the data, obtaining a general sense of the information, preliminary coding, identifying categories or themes, and interpretation of the data, keeping an eye to events as they unfolded (stories), and turning points that contribute to the overall experience. True to the narrative approach, Creswell and Poth (2018) discuss how narrative data should be analyzed "for the story they have to tell, a chronology of unfolding events, and turning points or epiphanies" (p. 198), but both stories and themes can result. The chronology of each narrative illuminated the contributing impact of past events on present experiences. Attention to the usual elements of a story, including the characters, setting, problem, actions, and resolution supplemented with the "the three-dimensional space approach" (Creswell & Poth, 2018, p. 198) which examines social interactions, continuity (past, present, future) and situation (context) further guided the analysis. Upon completion of the analysis, the data were interpreted to derive meaning from the stories told, with an eye to emerging trends across participants, resulting in themes presented as a cross-case analysis.

Chapter 4: Findings

A total of four participants were recruited to participate in this study. Three were obtained through the original protocol whereby they were provided with the invitation and study information by their healthcare provider, and one was obtained through the Facebook advertisement. Three were male, and one was female. One was in their eighties, two in their seventies, one in their fifties. All four participants indicated the same motivation for taking part: a desire to help others. Pseudonyms, and a few slight modifications of details are used to protect confidentiality. What follows is a narrative summary recounting each of the four participants' stories, followed by a cross-case analysis that examines similarities and differences amongst them.

Bob: Twenty-Eight Pills

As he stared at the twenty-eight pills he had lined up on the bathroom sink, Bob's past indiscretions weighed heavy on his mind. How had he allowed certain things to happen, he wondered. "*I am not that type of person, that is not my type. I dislike the type in itself…*" he mused incredulously as he came to terms with the reality of his past, a past that had remained hidden for so many years. Decades. Why did they have to bring it up now?

Bob had enjoyed a full life. He recalled working from the age of ten, picking potatoes and working at a vegetable stand. His teenage years were "*a little wild*." In his adult life, he married and had children. His work involved specialized diving where he travelled widely to do underwater construction and demolition, and occasionally, rescues.

Although he described his working years as "*very good*," the horror of removing bodies from the water stuck with him:

> *I went through recovering bodies. I recovered a man from a truck who went through the ice…I recovered a young fellow up north from a stream. I recovered another boy. He talked to me on Friday and I took him out of the water on Sunday. Those things bother me, and you think of them every now and then.*

Knowing our discussion was to relate to his attempt of suicide, Bob added, shaking his head back and forth, "*I can still remember those things. Now whether that had anything to do with it or not, I don't know. It's something that questions me now eh, was it involved… those deaths, taking people out of the water*."

There were other stressful events in Bob's life. As he continued reflecting on what might have led him to attempt suicide, he recounted his deteriorating health and the possible relationship:

> *I've got something to add to the pills, taking the pills was that I couldn't stand up and I couldn't walk right, and both my hands were numb and I had no feeling down this cheek and down this arm. I fell in the garage one time, and the doctor said 'it might go away for you' but I don't think it will, and it is still there to this day. I think really, that was part of it.*

A stroke? A head injury? The discomfort, the pain, the uncertainty about recovery. Perhaps that was part of it, but as Bob admitted, there was another part. A major part that was difficult to discuss.

As he began to disclose the situation, his demeanor changed to one more downcast. Accused of something he didn't do?

> *I had an incident where my two daughters said that I had incest with them, which I never did. I don't know what the reason was behind it or whatever, but I know I never did. So that was years after it happened, that is when they brought it up.*

Years after it happened? So, it did happen? Over the years, they had maintained a cordial relationship, but one coloured by a sense of foreboding:

> *I knew over all of them years I been waiting… something is going to happen…When you see them it comes back to you, what you did…it seemed that I knew that they knew more or less, so the feelings were between here and there you know…You could tell there was something different about it eh. It was fair…It was not a full friendship. You could tell there's something there*.

He talked with his daughters from time to time and felt appreciated for helping them out periodically with carpentry and plumbing projects in their homes, but added (with regard to the accusation), "*that was never mentioned in all that time*."

Having said that, Bob recounted an earlier visit with one of his daughters, one where his young grandchildren were present:

> *The little girls, one of the granddaughters, I was bouncing her on my knee… I didn't think I was* [doing anything wrong]*, but they did. So whether they were really seeing it and kept it to themselves. They started saying 'don't do that anymore.'*

He later added, "*I must have done some of it, I admit that, but I don't say I was doing that purposely for that. They think I was*." Ambiguity. Coming to terms with the reality of what had happened seemed a challenge. As he described, his daughter didn't say anything in the moment. "*It was just the look on her face when she looked down. She was thinking different than I was*." Was she? His daughter was silent, but her unspoken words were conveyed in a look that was crystal clear: "Don't you even think about it" was the implication, and although this incident might have triggered some memories, it would be years before the words would be said aloud.

The fateful day arrived, the day that set in motion what would ultimately be an attempted suicide. His daughters came to town from afar with the express purpose of confronting their father:

> *They both came home to our house and walked in the house together and they went from there…they said 'do you know what we're here for?' Well I had as much as assumed…the look on their face (*pause*)… It said, 'You're in trouble.'*

He continued:

> *They said 'we've got something we want to talk to you about' and they started and went through it from there. It seemed worse to me, what they were telling me. Some of the stuff seemed worse to me than what I'd of even thought of.*

Some of the stuff? It was hard for him to hear, really hear and acknowledge what they were saying. More ambiguity?

> *They brought that up as if I had done something. I said, 'I didn't do anything.'*

That is one of the stresses there because if you didn't do something, your mind is thinking 'I didn't do it' and someone is saying 'yes you did,' who is right and who is wrong? If you don't do something and you don't believe you did and you can't find any reason for having done something, it makes it difficult to believe that somebody is telling you the truth…After, I said you know, I said 'I didn't really do any of this.' There is something strange here somewhere. (A pause. A tear. A moment of shame? Regret? Remorse? Guilt?) *A bit of it I know now that I did do.*

Gradual acknowledgement, camouflaged by denial, began to emerge, and he started to open up, saying: "*The daughters, one night my wife was away bowling and I went into their bedroom and I caused a commotion… but I didn't go all the way."* He added "*they didn't say anything to her and I didn't either. So that went by for years."* Seems we were dealing with semantics – "I didn't do it" had morphed into "I didn't go all the way" and back and forth we went. Likewise with the apology:

I told them all, I am sorry for what I had done, if I had done it. They say 'it's not about that. You did it' but I still say I didn't do it, not directly to them. If they think I did it, let it be.

I'm sorry for what I had done, IF I had done it. He continued, blaming some of the ambiguity on "not remembering":

I don't understand why they're saying, what I did sounds more, more to them maybe than to me because I don't understand what they're saying because I don't

remember. I don't know whether I don't remember, I did it and don't remember, or didn't do it but in my own mind I didn't do it, you know, what they're saying

The only thing I know is the little, the daughter, she was quite excited. I went to the bed clothes and she was quite excited about that (later clarified "excited" to mean "upset"). *The brother was home but he was asleep eh. She went in and went to bed with him, the younger girl… she got up from bed, got up from her bed and went in and stayed in his room. She was upset, 'get out, get out', whatever.*

As he went on with the story, he moved to how often incidents had occurred:

I went into the room, eh…that was part of it…only once that I remember that with her. She remembers, she seems to remember more and so does the older daughter… the older daughter is the same. She remembers more incidents.

Only once? Maybe not. He later acknowledged, "*The older daughter that first time wasn't there*," implying there were other incidents.

Another day, two days that I remember. That was when the oldest daughter (young teenager) *and I, we were sitting on her bed talking… but I don't ever remember touching her. I told her when we were talking about it, talking about it when she brought it up. I said 'do you remember when I said we've got to stop this now?' eh, and she said 'was it you or was it me?' and I thought it was me who said we were going to stop this now… and it stopped then…I don't know how long it was going on for. Not a long time, couldn't have been.*

Couldn't have been. What happened next? As the visit concluded, Bob clarified that his daughters seemed accepting of his apology: "*The girls – when I said I was sorry, they said 'well that's alright then.' I was not sure it was alright still."* Did they want to call the police? Would charges be laid? No, Bob said,

> *…no, but I told them I would go and get some help, and I did go get some help, yes I did, yes, social workers…and one social worker came out to the house…I went to them and I went for different weeks and they came to the house and we talked about it and nothing ever came of it.*

The daughters left, leaving Bob home alone. From there, the daughters shared the situation with rest of the family. "*They were not happy naturally and I wasn't either, and they told the rest of the family."* Bob was quite sure the rest of the family – his wife and son – had not known any of it, but now they knew. It was all out in the open, albeit cloaked in ambiguity. Bob agreed to get help, and started working with social workers, individually and with his wife.

As time went by and Bob explained the whole situation to social workers, he said "*it was all getting to me…it tries to control your mind and if you let it, that is what happens. That is what was happening to me."* He started in earnest to think about ways of ending his life. The guns. He had five of them in the basement, and although he resisted using them each time the thought arose, he had come close. "*I looked at the rifles different times and I thought well this is not the way to do it, and then I left that aside.*"

Although Bob's wife was very angry and upset, she chose to stay and work through the situation. Bob's son was not so forgiving. As Bob speculated, "*his wife had it done to her by her father and he knew that. He knew that I had done it and that made him twice as mad I guess, eh, so I can't really blame him for that*." A little while later, his son came to Bob's house, and a heated argument ensued. He brought it all up again, Bob said. Bob's wife was also quite upset at the time and left. "*She was really upset and you couldn't blame her…She was upset over that for quite some time. She probably still is."* The arguing continued, and as Bob recalls, *"He said 'I don't want to see you again' and I said 'okay, I don't want to see you either.'"* Bob got up and went into the bathroom:

> M*y mind was rattled again… I opened the medicine chest and the pills were looking me right in the face and there's the way to shorten things up...I reached in the cabinet I took the jar out and I counted 28. There was more in there than 28 but I took the 28… 'this should do it.' I didn't know how many you had to take. I took 28 and I thought that was enough to do it, but it wasn't… at the time I took the pills, I just wish I was gone. Out of sight out of mind, bother nobody else.*

It wasn't enough, but when he returned to the living room, he sat down and started to feel woozy. He admitted to taking the pills, prompting his son to call an ambulance. "*I suppose I wanted him to…I wasn't feeling right. I knew something was going to happen."* Bob was soon whisked off to the hospital, but recalls little about the stay:

> *They tried to take the pills out of me and I stayed overnight there. I don't know what happened after that…They said when you take too many pills like that you could do*

> *your liver in and you could be gone. I said 'that was the plan' but that shouldn't be the plan. There must be another plan, see somebody, so I went to see somebody.*

As he was already connected with mental health services, they were able to adapt the treatment plan and continue working with him regarding his suicidal ideation, but he recalls little detail about the therapy: *"They gave me information on what I should do, what I shouldn't do… not to do it, and be careful what you're doing.*" He recalls being disappointed at the time that he did not die: "*I still wonder why I didn't die. That was my goal at the time, to end it all eh, but it didn't."* As time went on, he continued to look at his gun collection, and felt he couldn't trust himself. He shared some close calls with social workers:

> *I told them about them, the social workers, and they said the best thing to do was to get rid of the guns so I did…the five of them were gone, and the ammunition with them…I figured that was the smartest thing to do too. Better for the weapons to be gone so I got rid of the weapons and the ammunition.*

Bob continued therapy for several weeks afterwards, but putting the whole family back together was not to be. Although his wife was prepared to stay and his daughters had come to some resolution, his son was already interested in severing ties before the attempt, and even more resolved afterwards. With his son refusing to visit the family home or participate in family events where his father would be present, alongside Bob's mounting health concerns, the decision was made for him to enter long-term care.

So, they put me in here (long-term care) *and once they put me in here, so now she will be alone there and I'll be alone out here, so anything that hasn't gone forth will not be in the middle of us all the time.*

Bob has now spent about five years in long-term care. He says it is a nice place and they are good to him. His wife visits regularly. "*She says she still loves me, and this is five years later*" he clarified. They have made an agreement not to further discuss the past. Although he remains disappointed that he cannot live at home or even visit, he is happy that the situation feels somewhat resolved:

When some of them let go some, you start to come back to yourself a bit…I would like it to be back like it was before. It's really just the one now, the two girls are a little bit…not as much as they were when it first came out.

Reflecting on how the attempt did not result in his death, Bob added,

Then it would have been all over and settled, but as it is now see, I am not at the home, my house…and they have suppers there and they have meals, all of them, but I am not there, I'm in here… I miss being home."

Mark: Tomorrow is Another Day

"*There's still times to this day that I just look up in the cupboard and see a bunch of pills, and I say 'Is this the day*?'" Mark admitted as he discussed the ups and downs that have characterized his life. He recalls mental health challenges (not labelled as such at the time) dating back to young childhood, filtering through his working years and

accompanying him into older adulthood. Now that he layers on a variety of health concerns, thoughts of ending his life are never far away.

In Mark's earliest memories, he recalls "*I had times when it wasn't just the way it should have been. I didn't know at the time that you would call it depression."* He struggled in school, coped poorly with stress, and found it difficult to be around people. The way his brother recalled it, "*my brother tells me, how did he say it, you would get blinky or something because my nerves would get bad and I would twitch and my eyes would twitch*." Although he experienced many symptoms, little help was available. Suffering through on your own was the order of the day.

As a young adult, he continued to struggle with being around people, sometimes feeling the need to escape from it all. "*I did go through periods where I didn't want to be around people… and one time I took a knapsack and stuck my thumb out and went clear to BC."* Upon his return, Mark drew on his many talents and interests to craft a career that encompassed construction, mining, and work as a high-voltage electrician across the country. He married and raised a family, but from time to time, his mental health issues would rear their ugly head. His work was at times dangerous, for himself and for those he supervised. As he described, "*I sometimes took a little bit too much to heart on some jobs. I know that bothered me."* He described the work environment in the mines, and speculated on why he might have liked it so much:

> *I liked that, working underground and the reason I think I liked it, it was hard work but I was by myself. There was other guys underground but I'd be working by myself*

doing my own thing. Dark, nobody around me. I could sit on the rock floor and turn the light out and nothing there, and I enjoyed that.

Although Mark worked successfully for many years, learning new skills and achieving various promotions, he says it all came crashing down on what would be his last day of work:

I fell apart on the job site…things just fell apart on me…that last day at work I went to my buddy… I said 'you have got to take me out of here', and he said 'why?' and I said 'because I'm not going to make it if I don't' and he said 'you were working up on the high platforms, weren't you?' and I said 'yes, and if I had stayed there I wouldn't be around now.' I was up a long ways in the air then. It was all high voltage… it would have been a matter of just putting my arm up like that and it would have been all over. Instant electrocution, you are an instant French Fry at that voltage. But I did know enough to come down out of there and tell my buddy.

Mark was hospitalized, and re-connected to mental health services, but was not able to return to work.

His early departure from work left Mark with much time on his hands. Mark describes motorcycling, especially longer trips, as the most joyful activity in his life, one he can do alongside his wife. When inclement weather prevents it, Mark spends his time reading or on social outings with friends. He struggles to cope with stress, and even though he is not directly involved, he is often troubled when he hears of workplace accidents that might have been prevented, especially those involving his previous crew:

There was an accident on site and it would have been the crew that I was looking after and a guy got hurt real bad and I found out the circumstances of it and I know right to this day that if I had been there it wouldn't of happened. I know just as sure as I am sitting in this chair it would never happen and that bothered me terrible.

As guilt, worry and depression invaded Mark's life, so too did thoughts of ending his life. As Mark recounted, sudden urges would lead to risky behaviour and near misses, including a close call with a cement mixer. As he describes,

It was bad enough that day, I was going down the (road) and I almost went head on into a cement truck, that is how bad I felt… I almost hit head on, almost. It was that close for me. I was actually out over the line.

The only thing causing him to veer off at the last minute was concern for the other driver, he says. "*I didn't want to screw up that poor truck driver's day, and it would of. I don't want to bother anybody else."*

Another day, he was riding his motorcycle, an activity that was normally "*a really good release*" for him. On this day however, impulsivity kicked in:

I was really down and I went down the (road)…you know that bad intersection. I was way back at the turn and I could see the lights up there, and that light was green. I said it's going to be red in a second and I cranked that motorcycle up and I went through the intersection and it was still red and the cars were going the opposite way and I went through the intersection at probably 170 (kilometers per hour)… I figured that was another way out…I pulled over at the top of the hill and

I broke right out in a sweat. I just sat there and shook my head and said 'what is wrong with you?.' I did it right on the spur the moment.

Mark had this and other close calls (some of which led him to seek help) but says he normally would just "*shrug it off the best I could"* and keep going. That was the intent. Keep going. But Mark would soon find himself unable to shrug it off.

As Mark explained, it was not one big event that happened, but a series of events:

Been building up, building up, building up. I was depressed, everything was going downhill. I couldn't shake it. It just seemed to me everything was just in a turmoil. I was going down and I just couldn't seem to bring myself out of it. It didn't matter what I did, and then my wife and I had a big row so she stormed out of the house and I told her when she left, I said 'If you leave, if you leave I won't be here when you come back' and that is when it started and then the rest is history.

Mark elaborated:

I just got to where this isn't really worth it. I was just tired of life I guess…It was just finances and it didn't seem to have to be very much to drive me down the hole further. Maybe the car would quit and then the washing machine blew up and one thing and another. It was just, I can't even remember everything that happened at the time, but I just kept going down and down and down and then this was the final straw I think… when I got in the big row with my wife and she went out the door. I said 'good, I really don't want do this anymore. I'm not going to do this any more.'

Mark gathered up pills and poured them out on the kitchen table. As he described, the pills were on the table and "*I was sitting there eating them."* Whether his wife alerted his son, or whether his son arrived at the door by chance, Mark does not know, but his son arrived just as he was continuing to consume the pills.

> *I was sitting right there with a bottle of them right there and I'd dumped half of them out on the table, and I was sitting right there with a glass of water and just throwing them in my mouth and chewing them up and eating them.*

As his son took notice of what was going on, he said,

> *'what are you doing?' and I said 'go on, go home.' I told him 'I am just going to lay down. Go on home, leave me alone.' Well he would not do that…Of course he wouldn't. He called 911 and that is when the ambulance and the RCMP was there.*

Mark's other son arrived shortly after, having been called by his brother. Mark felt bad that his sons were so distressed, in a panic, but soon found himself in an ambulance.

After a brief hospitalization, Mark returned home and continued to work with a nurse from mental health services but has mixed feelings about the attempt. When discussing his son's timely arrival at the house, he says "*I'm not sure if I was glad to see my son or not. I still don't know. When he came in, I didn't want to see him. That really pissed me off."* Sometimes, he thinks he was happy to have his process stopped, and other times he is not sure. As he puts it, "*sometimes I have regrets that it didn't accomplish what I wanted to do. I didn't do it right, but I have regrets about what it did to the ones around me."*

Mark continued with therapy for quite a while after the attempt but offers no assurances that a future attempt will not occur. He has built back a good relationship with his sons and enjoys spending time with them. They offer to take him on snowmobiling trips, but his deteriorating health makes it impossible to go. They take him on work calls, and although he says he enjoys going out with them as they make quotes on potential jobs, he feels very out of touch now that technology has advanced so much since his working days. Mark has grandsons, and a great granddaughter, he says with a smile. He and his wife spend time together, and particularly like travelling (which was slowed down somewhat by the pandemic) and outings with friends. And, when his concentration permits, he enjoys reading, "*sit with a book for three hours and not speak to anybody, have a cup of tea."*

However, in spite of the positives in Marks' life, he says many of his friends are now deceased or unavailable ("*heart attacks and strokes and crippled up and they don't get out and don't call very often*"), previous counsellors have moved on, he struggles to talk to his wife (although loves her dearly, he says), and does not want to burden his sons. He is experiencing some physical health changes, and concerns with his mental health are never far away:

> *I know that some of my thoughts aren't right and my thoughts the following day, if I can fight through it might be different. Right to this day three nights out of seven I go to bed and I would just as soon not wake up in the morning… I wake up in the*

morning and I say 'shit, I have to go through another one.' We will see how today works out. Sometimes I get in these holes and I just can't get out of them, I just can't.

One thing he finds helpful even now (roughly five years after the attempt) is some "question cards" his nurse provided. The cards ask you to consider questions such as "*Are you sure what are you thinking now is it the same thoughts you had yesterday or will you have tomorrow?*" When Mark contemplates the questions, he is most often able to press on.

Another thing Mark takes comfort in is discussing the option of MAiD. He has collected information and has discussed with his doctor that as his health deteriorates, it is definitely something he will consider. For example, he experiences shortness of breath, and becomes winded easily when performing physical tasks like snowblowing, and tells his doctor he would not consider going on oxygen:

My health is going downhill some. I'm not going to ever get to the point, I can't breathe worth beans now. My legs and everything's all going from just 50 years of construction and I'm no different than any other guy that did it. I am not going to get to that point where… I have seen friends who have had strokes and if I can help it I am not ever going to go that route and now the laws are passed, I've looked into that. I am on the e-mail list for Dying with Dignity. I've done a fair bit of research. It is getting better I believe. Will I use it? I don't know.

Mark continues to do what he can but describes himself as very independent. Acknowledging it is something he shouldn't do ("*I know it's the wrong thing to do*"),

Mark says he takes some whiskey and heads to his camp for a week or so just to get away from everything and to be alone. At other times, he and his wife go for scenic drives, which he finds relaxing. He has a good family doctor and finds his current medication regime to be working but does feel at times that he is "*left hanging*" without someone to talk to.

As we concluded our discussion, Mark reiterated his uncertainty about the future, and having had some disappointing encounters with a variety of helplines and outreach services, he was also unsure where he would turn for help. As soon as the word "suicide" is mentioned, the RCMP is called he says, and you can land in the hospital. Reflecting on a past hospitalization where he had involuntary status imposed on him, Mark said, "*that scared me so bad that I would never in the world call 911 again. I won't call. As far as going to the hospital, that is not a thing that I'm going to do ever again."* He expressed similar dissatisfaction with other helplines. Mark's preference would be to discuss the matter with the person on the phone but does not find that when he makes a call.

Mark's final admission:

> *I still have those feelings sometimes. I haven't acted on anything and I have no, sitting here talking to you, I have no intention to act on them, but am I ever going do it again? I don't know. I can't say that either. If something pushes me over the edge, possibly, I don't know… tomorrow is another day.*

Ruby: Running on Empty

Becoming sexually active as a child is not something most of us can relate to, but for Ruby, that was her reality. At the hands of her father, Ruby experienced inappropriate interactions at age four, exposure to alcohol at age seven, losing her virginity at age nine, pregnancy (and miscarriage) at age twelve, and being passed around to her father's colleagues in her early teenage years. There is little wonder why her first suicide attempt happened at the age of fifteen.

Ruby grew up in a household that exposed her to polar opposite experiences. On the one hand, she had a loving mother and three brothers, two of whom she was especially close and "mothered" in her mother's absence. For many years, her mother worked nights, and was oblivious to the goings on of the household. When her mother was not home, the situation was totally different. "*I looked after the two younger boys, supper, homework, baths. Once I got them all to bed then it was my father's time. If he was drinking or had a porn movie on, then I knew what was coming next"* Ruby recalled.

Normal activities, like having a friend sleep over, required pre-emptive actions. "*If I had a friend stay overnight, I had her sleep on the inside because…I was never sure if he would overstep those boundaries with someone else."* To the best of her knowledge, he never did, but when it came to her, there were no boundaries. The sexual abuse was continuous for years, and Ruby harbored guilt that it was all her fault. She allowed it to happen and didn't speak up. It was all behind her mother's back. "*Mom did not find out*

until I overdosed at 15 and ended up in the ICU, so the doctors told her. That's when she found out…so she put him out the same day."

Although Ruby was pleased to be believed, to her mother's horror (and her own, as she reflects back), she chose not to lay charges, and moved in with her father upon discharge from the hospital. The love-hate relationship continued. Why did she make that choice? Her best guess:

> *I was already an alcoholic by then. He started giving me alcohol when I was seven, so by fifteen, I was already an alcoholic and if I didn't want to go to school, I didn't have to go to school. If I wanted money, I had money. Mom had rules. You didn't drink, and you got up and you went to school.*

It was not a good choice. The sexual relationship continued. Her mother worried about her constantly. "*She would find me in the ditch. She would go looking for me. I would be so drunk in a ditch somewhere, and I was cutting my wrists and she was begging me to come home and I just didn't*." With little supervision, she was heavily into partying and drinking. One night, as she left a party, she was "gang-raped" and left to die by three boys she thought were her friends. The attack was so brutal she required reconstructive surgery that rendered her unable to have natural childbirth. Although she knew their names, she chose not to reveal them or press charges, for fear of retaliation. "*That family would have made sure, if I had laid charges that family would have made sure I was dead*."

School was also a challenge for Ruby. As a young teen, she recalls being propositioned by two different teachers and engaged in inappropriate sexual activities repeatedly with both. She was "mouthy" and always in trouble, frequently fell asleep in class and struggled to focus on schoolwork. In grade nine, she was approached by the guidance counsellor, who seemed to have figured out that she was being sexually abused, and speculated it was at home. Ruby's response: "*As soon as he said it, I quit school. I was scared that they were going to call the police and have him* (her father) *charged and that is not what I wanted at that time."* Committed to the love-hate relationship, she still did not want him charged, but the time would come.

A few years later, once Ruby had moved away from her father and started a family of her own, she learned that he was in a relationship with a woman who had a nine-year-old daughter. "*When I found that out*" she reports, "*I went and laid charges so that he couldn't hurt her. She was taken out of the house immediately, so she never had to experience that*." Just as she had at times been the "protector" of her brothers, once standing between one of them and the gun her father held, she stepped forward, but had not been able to be her own protector. She reflected on her decision: "*Even then, I didn't want to lay the charges, but I couldn't allow, I wouldn't have been able to live with myself knowing that he hurt this nine-year-old."* Part of you wanted to protect him and part of you wanted to protect her, I observed. "*Yes*," she confirmed. Following a lengthy investigation and trial, her father was found guilty and sentenced to twelve years in prison. Although she went forward with charges, she held a lot back in her testimony, this

time to protect her mother who was with her in court. "*I held a lot back because Mom did not know the whole story, so I didn't talk about him taking me to work. I didn't talk about the sex after I moved in with him."* Ruby's father did not end up serving much of his sentence and was soon released, sparking a life-long fear that he would seek out her or other family members and harm them. He had threatened retaliation before: "*I knew what my father was capable of and when he told me that I would not have a mother and brothers, I knew I probably would not have had a mother and brothers."*

As she navigated her twenties with multiple abusive partners, Ruby again made an attempt to end her life. Her life since has been one of many ups and downs, mostly downs. She gave birth to three children, and now enjoys grandchildren, but by going forward with the charges, she not only lost the support of her father's family, but also that of her mother's. Regarding her father, she said, "*I destroyed his career. I destroyed his name. His family stopped, I mean, I have nothing to do with them anyway…his sister saw me in the mall and said, 'thanks for ruining the family's name.'"* More concerning to Ruby is the loss of support from her mother's family. Her mother is now deceased after a lengthy battle with cancer, and she would dearly love the support of her family, but it seems they are not there for her as she is sure her mother would have been. "*They have all walked away. My mother had ten brothers and sisters. My mother would have walked through this journey with me. She would have been by my side every day and if I called her, she would be here*." Not so with her family: "*I grew up in a Christian family, and they are all about forgiving. Forgive and you will heal. No, no. So, my mother's family*

stopped talking to me… because I won't forgive him…" Clarifying that sexual assaults were not the only bad things that had happened to her, Ruby added, "*I am angry at God, because I look at God, I look up and I say 'why? Why, just over and over and over and over is stuff happening?"*" She pressed on raising three children on her own in virtual isolation, feeling abandoned by friends and family she had once relied upon.

Her daughters grew up, started careers and had children, but there were many struggles with her son who was considerably younger. He was diagnosed with ADHD and autism and was angry and violent, adding drug and alcohol abuse to the mix during his teen years. Ruby had completely stopped using alcohol, and just as she was able to seek therapy for all she had been through, the day-to-day struggles with her son and his abusive father took centre stage. "*He* (son) *started smoking pot at 14, then he started putting holes in the wall. He was 15 and 16 he was throwing me down the stairs*." Ruby's fears escalated, and her needs again were pushed into the background. There is ongoing stress with her son's father, a man she described as sexually, mentally and physically abusive. Against Ruby's wishes, he maintains a role in her son's life:

> *I have actually had three restraining orders against him, so he is not allowed in my yard still to this day even though my son is in his 20's. He has to go there to visit, and if he does show up here, my son has to meet him out in the street. He is not allowed in the yard, because he would do this to me* (shooting motion) *and point his finger at me.*

Ruby lives in fear that the situation will worsen, and he will act on his threats.

As Ruby reflected on her progress in therapy, she noted, "*I'm taking five steps ahead and I'm taking ten back. Just when I start thinking I am doing better, bang. I'm sitting there in tears again and I'm calling and I'm crying and I'm saying 'please'.*" She adds, "*I dissociate a lot,"* clarifying the need to distract her thoughts when they become overwhelming. While the therapy has explored a wide range of Ruby's concerns, she realized that guilt for all that had happened pervaded her life:

> *As a survivor of it, you definitely feel like it is your fault. Why didn't I speak up...I am so heartbroken. I am so sad all the time because I try so hard not to blame myself. I should have spoken up. When those guys raped me, I should have spoken up. When those teachers were doing what they were doing, I should have spoken up. Looking back, I think, could I have done something different? Could I have done things differently?*

Layered on the guilt, she lives in constant fear that one of her abusers will show up at her home with intentions to hurt her. To cope, she angles her sofa in front of the living room window and spends much of her day being hypervigilant to passing cars. She clarifies her concern. "*He* (her father) *is still living and I don't know where. I don't know where he's living and two of the guys that raped me, I don't know where they're living* (the third died by suicide, she heard)." Could this one be my father? Could this one be my rapist? is the implication. She maintains a dog, in hopes he could alert her of danger if she needs to slip away from the window.

Fear. Guilt. Depression. Anxiety. PTSD. Pain. It all got to be too much. "*I felt like there was no hope, there was just no hope and I still go through those emotions*." The therapy itself was at times re-traumatizing, especially as she was asked by her therapist to write victim impact statements. The experience triggered her and led to more self-harm. With little help for her mental health, coupled by emerging physical health issues, and a mounting list of fears and triggers, thoughts of suicide once again invaded Ruby's life. "*I just was in survival mode*," she reflected. It culminated late one night. She had purchased antifreeze, based on advice it would be an effective way to kill some rodents she had recently spotted in her yard. A large rat in particular. Maybe if it could kill the rat, it could kill me?

> *I crashed, I just crashed. Everything came crashing down… All of the feelings. Living the way I live, just living the way I live, I can't do this anymore. I can't live with the nightmares. I can't live with the triggers. And it is not fair to my kids. They have to watch me go through all this. That is what I was thinking at the time. I drank antifreeze… I mentally crashed. I felt like there was no hope, there was just no hope.*

She drank enough antifreeze, she thought, to end her life, and went to bed in hopes it would have the desired effect. Although she described it as "impulsive" it was long in the making. Almost fifty years since that four-year-old girl was violated.

In the morning, her daughter stopped by, and noticed right away that something was wrong:

She said 'Mom what did you get into'? So, I didn't tell her, and she said, 'I am calling 911' and I said 'no you're not' and I started to tell her where my life insurance was, where everything was, and she said 'I am calling 911 or I am taking you to the hospital.' I said 'well, before you take me anywhere you are going to shower me' because I really thought at the time, if we took that time, there would be nothing she could do to save me.

She was wrong. As the doctors in ICU struggled to save a combative Ruby, they had to tie her hands down so they could insert tubes and administer dialysis.

To say that Ruby has struggled since her most recent suicide attempt almost a year and a half ago would be an understatement. She clarified that to her, being suicidal and attempting suicide are not the same. Ruby lives with chronic suicidal ideations and describes how she feels:

I am holding on to a thread…It is hard to accept that I don't have control of my thoughts. My thoughts control me and that is what I have a hard time with and that is why I am so suicidal. My thoughts have full control, and I am very impulsive. The cutting, cutting my legs, cutting my arms, that's just all impulse from triggers or I had a bad night and the next thing you know I'm in the shower and that is what I am doing.

The cutting distracts her thoughts for the moment, she says, as she described a process of cleaning up blood and attending to the wounds, sometimes trying to glue her skin back in place. She lives with constant pain, constant bombardment with unwanted thoughts, and

constant visualizations of her death that make it impossible for her to participate in previously enjoyed activities such as gardening or going to the gym. "*I am running on empty,"* she observes, and is tired of putting on a front for everyone around her while she tries to find a purpose to go on:

> *Am I going to get better, or is this always going to be me? I can't find a purpose. I don't know what my purpose is. It is not that I am asking 'why me?' It's just, 'why am I still here? What is my purpose?' And I do ask that a lot, even to God. What do you want me to do? What is my purpose here?*

She has created a list of who will get what upon her death, speaking fondly of treasured items and how much they will mean to this or that grandchild. Her day-to-day life is filled with self-harm (cutting) and one therapy after another as her team of health professionals strive in every way possible to help keep her alive. "*They are always trying to get me to wait for something,"* special events, she notes, such as Christmas or the next birthday of one of her grandchildren. She struggles to stay motivated, wondering when she will improve and when the therapy will end:

> *Am I going to be able to function without all these triggers and things that set me off, nightmares, and different things, alcohol, voices when I go to the grocery store. Am I always going to be hypervigilant? Am I always going to be shaking? Am I always going to have to take anxiety medication? Am I always going to have to take the medications I am on? Those are things that I look at.*

She has tried to reach out to old friends and relatives to whom she once felt close but feels socially excluded. As much as she would like to have social contacts who are not professionals and who are not her children, she retains only one friend, and fears she is a burden to him. She sees her old friends and relatives on Facebook where they post pictures of all of the events in their lives, but in spite of letting them know she would be interested in joining in, they don't invite her. She describes the exclusion as "*painful.*" She would love the opportunity to be there for them, and give of herself, because as she clarifies, "*I am still me*" – a thoughtful, loving person who cares about others.

Moving forward, Ruby notes how much she would appreciate having people stop by just to visit, or who would not be judgmental if she did share how she was feeling. There are so many times when she feels, "*I can't take any more me. I can't take any more of the day… I can't take anymore.*" She finds it frustrating that if you call helplines and mention suicide, you end up with police and an ambulance in your yard:

> *I would like to be able to call the CHIMO line* (a local crisis help line, available 24 hours a day) *or the mobile crisis* (a mental health crisis line affiliated with mental health services) *and just talk to them on my days when I think today is the day, without having policemen and ambulance and everybody show up. I would like to be able to call them and just talk to them and have them talk to me and say it is going to be OK. Today is not the day.*

She would like to see more education available for the public to reduce stigma and make it more acceptable for people to talk about mental health and suicide. And so, for Ruby, her struggles continue, but today is not the day.

Ray: I Wish I Could Undo it All

The most satisfying years of Ray's life were the thirty-two years he spent teaching. He recounted with a beaming smile, "*the principal said, 'you're the strictest teacher in the school and yet you have 40 to 50 students to come visit you every year. That's amazing, that says something.*'" Ray was pleased to attribute his popularity as a trusted confidant to treating everyone the same, whether you liked them or not. That was the secret.

Ray married and raised four children, and now enjoys several grandchildren. As a homeowner, Ray found a lot to do in his retirement years. He had always taken an active role in maintaining the family home, willingly participating in tasks such as vacuuming, cleaning bathrooms, and managing the outdoor work. In addition, he was very active, with long walks being his preferred activity. At the end of each day, he was tired. He described his bedtime routine:

> *When I'd go to bed at night, I'd be quite tired, and my usual routine was I would think about all I had done that day. I would say, 'I got that done, I got that done, that's good, that's good.' I would feel good about all that, and then you think 'what*

are you going to do tomorrow?' and then you go about doing that the next day, and then you'd drift off to sleep. That has been my routine for years.

The list of achievements was sufficient for Ray to feel good about himself, and the deferred "to do" list not daunting. This routine continued for years, until health issues started to creep into Ray's life.

Ray, meet cancer. Prostate cancer, bladder cancer, kidney cancer, stomach cancer. Of course, with each one came a series of scans, scopes, surgeries and procedures, but Ray did not let cancer get the better of him. As he recalls:

I can remember being out walking and I could hardly stand up I was so faint and so weak, but I kept walking to try to build up the strength. I made a come-back every time. (Doctor) is my urologist and she thinks I've got 11 lives.

More than the average cat, we joked, but just as a determined Ray successfully navigated through multiple bouts of cancer, he experiences a heart attack.

The heart attack turned out to be not as bad as originally thought, and was treatable with a routine surgical procedure, but for Ray, it was life-changing:

I overreacted. I thought this was the end of owning a house, I am not going to be able to take care of this, so we immediately sought to sell it. We got a bid that was over what we asked and went into an apartment.

Ray and his wife had owned three different houses in their life together, so they were quite familiar with the demands of home ownership, but what they were not familiar with were the demands (or lack of demands) that came with apartment living.

It caught me by surprise, actually. I was busy, and all of a sudden everything was where it was supposed to be in the apartment…I was helping, moving stuff around and relocating stuff in the apartment, and then all of a sudden, I realized, I have got nothing to do. I haven't got a darn thing to do. Just sit and watch television.

No longer could he lie in bed and reminisce about his achievements of the day and could come up with few items to add to the to-do list for the day ahead. "*It is just one monotonous day after another and when you've been active all your life, monotony is something you can't live with"* he added.

About this time, Ray reports he was diagnosed with COPD and was having trouble breathing. He gained some relief from blowing a fan on his face, but while the fan may have helped with the breathing problem, it resulted in the development of dry eye disease. "*That is a curse,"* Ray says. "*You have itchy eyes, you got red eyes. You can't watch TV so here I am, nothing to do and I can't watch TV very much. I'm watching TV with sunglasses on."*

The accumulation of health problems was getting to be all too much for Ray. With so much going on, and Ray's outlook that things were only going to get worse, Ray shared, "*what person in their right mind wouldn't look for a way out*." He began to think in earnest about suicide. He even discussed MAiD with his family doctor, suggesting that when someone's quality of life is so compromised, they should be able to make the decision for themselves – but not prematurely, not too quickly. Ray thought of other options as well:

> *So to me, it was well thought out. I thought about it when I was walking, thought of other ways to kill myself. I didn't want a whole lot of people to know. I didn't want my wife to live in shame… I thought of climbing up the new apartment in our area there and jumping off the top.*

As it turned out, Ray made two attempts to end his life, but lives to share the story.

Ray and his wife had planned a long-awaited trip. Travel had been limited by the pandemic, so they were looking forward resuming this previously enjoyed activity together, but when the time came, Ray's eye issues, alongside other health concerns led to the decision for him to stay back. His wife went on her own with another family member. In her absence, Ray was presented with the perfect scenario, he thought. "*I had a perfect opportunity…when she was away and nobody would discover me. She might call the next night, maybe alert somebody,"* but then, as Ray reflected on what held him back,

> *I didn't want to ruin her trip. I didn't want her to look back and say 'he did that while I was on my trip. If I'd been home' she might have said, 'if I'd been home maybe he wouldn't of done that.' I did not want her to have any guilt feelings about anything.*

Instead, Ray waited until she was home, but not long. "*The first day she was home I took an overdose, (pills), 70 or 80 of them. I took it late that night after she had gone to bed, and she never discovered me until the next day at noon."* When she was unable to rouse him, she called the ambulance and Ray was promptly taken to the hospital where he

remained for a week. In the hospital, he rallied quite quickly and was soon up walking the halls.

When it was time for discharge, the doctor in charge (not his regular doctor) was concerned and wanted him to see a psychiatrist. Having reiterated that he did not consider himself to be crazy, he declined. Adamantly. "*I said 'no, I'm not going to see anybody' and she said 'I strongly recommend you see somebody' and I said 'I am not going to see anybody. That's it. End of conversation*.'" In an encounter that Ray viewed as retaliation, the doctor informed him she would see to it that he lost his driver's license. Upon his discharge from the hospital, Ray was still experiencing itchy eyes, but felt the impacts of his overdose were resolved, and did not warrant such a drastic move. He was blindsided by her threat to have his driver's license revoked. He was even more shocked and devastated when he received the disappointing official news:

> *When I got a letter from the motor vehicle branch I went back in the corner and wept silently, because before I could take the car and I could go…now my wife had to drive me, pick me up, wait around, sometimes go back home then come back. This is a big nuisance. This is terrible.*

As he seethed with anger in the weeks ahead, thoughts of suicide again invaded his thoughts. Four bouts of cancer. That was one thing. Loss of his license was a step toward someone, his wife, having to take care of him, and that was not something he wanted to live with.

Just weeks after his first attempt, Ray could go on no more. He waited until his wife was out, and took drastic action:

> *So the second time, I stabbed myself…I was thinking of the license and I was thinking of the dry eyes and all the other health problems and also a big factor to me is I never want anybody to take care of me, especially my wife.*

Thinking back on the actual day, he added:

> *It was an awful hard thing to do. I contemplated that and even did it in the shower so I wouldn't make a big mess and the day I did, I had all these old towels, and I was trying not to make a big mess around the bathroom. I put all these towels into a bag. I lost a lot of blood… I was still conscious the whole time, but I was getting weaker. I got to the point where I could not get up. I was just laying there and she came in, she came home…and so after 15 minutes went by she got suspicious and decided to come in and I was laying on the floor. She didn't know. She couldn't tell what was happening to me because I had all these towels in the bag and I was like this* (curled up) *on the floor. I did not want blood all over the place for her to clean up.*

He didn't want her to have to clean up, just as he previously didn't want her to feel guilt over not being home but did not seem to foresee the trauma she experienced by finding him in this condition.

Once again arriving at the hospital by ambulance, he was met by the same emergency room doctor he was treated by for his previous attempt only weeks earlier (not

the one who had his license taken away). The doctor said, "'*I was here when you did the overdose.' He said 'you're lucky' and I said 'I don't know. I don't feel that way right now'"* But, his views have changed considerably since then.

The second attempt did result in him being connected with a psychiatrist, one with whom he has developed a strong working relationship. She, along with Ray's family doctor collaborated to help Ray to get his driver's license back, confirming to Ray that it was taken away on illegitimate grounds. He is still angry about it and blames the action as a primary cause of his attempt. As he clarified, "*If it wasn't for that, I might not of attempted the second time. It was that terrible. It was that terrible for me to lose my license."*

As he strives to move forward, he admits "*to do what I did, I was hurting a lot*" but adds, "*I feel lucky right now*." He was disappointed in the moment that the attempt did not result in his death, but with each passing month, he has seen improvements in his quality of life. His psychiatrist provides periodic check-ins and monitors his medication. He continued to seek help for his dry eye condition and has finally found an effective treatment. Getting his license back was very significant, not only for his own autonomy, but he has been able to offer his services to others needing drives. There are still times when he says he is "*bored out of my mind*" but he attends a range of sporting events and hopes to go fishing and motorcycling soon. He and his wife are making a point of doing activities together at home and in the community. The pandemic had many services and activities shut down, but over the past year, things have gradually opened up providing

more opportunities for Ray to engage in both previously enjoyed and new leisure activities. He is even taking on a leadership role in some cases, offering to organize, teach or lead his preferred games in collaboration with local seniors' centres. Although these activities have helped to mitigate the monotony he felt after selling his home, Ray acknowledges "*these games and things, they only take you so far. You feel you have to do something else, accomplish in life*." Although well into his seventies, he aspires to get a part-time job. "*If I could get a job for four or five hours a day, even four hours a day would be a big help. I don't really want to turn to volunteering yet. I might eventually,"* he says.

As Ray looks back on all that has happened, in spite of all of his health concerns, he says "*still it is the license that bothers me the most*." He feels great regret about the ways in which his suicide attempts have impacted his family and their relationships. Three of his children did not learn of the first attempt, but the second attempt was much more brutal and his wife required help to cope with the situation. As he recalls his wife's reaction,

> *She was so traumatized she had to call the kids in to help her. She needed support from the kids but that has caused complications. I would just as soon they didn't know anything. That is one reason for somebody not to do it. What the kids will think … they kind of look at me sometimes like I'm a freak show or something.*

The relationships are changed, and "*it is almost hard for me to look them in the eyes*" he says. Only one of his children has actually spoken to him about it, trying to convince Ray

to draw closer to God if he battles this in the future, and tried to normalize the situation of dependency:

> *He said to me 'when you get married that's your wife's responsibility. She has to take care of you and the other way around too.' I have to take care of her. That was the response from one, and the other three never said a word.*

The others have made no mention of what happened, and they go about their lives as if it didn't, but it feels different to Ray. Perhaps they just don't know what to say, Ray speculates. As he cautions, others should consider "*If you survive, how are you going to face your kids. What are you going to say to them? Be very careful what you do. You can't turn it around*." In addition, Ray says his wife struggles with guilt for not noticing symptoms or warning signs, and he feels bad about that. Ray is moving forward, trying to find meaningful activities to keep him busy, but his final wish: "*I wish I could undo it all*."

Cross-case Analysis

Bob. Mark. Ruby. Ray. Why them? Why now? Their stories are so unique yet bear some similarities. As Creswell and Poth (2018) point out, in narrative analysis, both stories and themes can result. This cross-case analysis draws on coding and development of themes, as well as memos and reflective notes taken during the data collection, analysis and writing of the individual stories.

Being a Burden, Bearing a Burden

Feeling that one bears a sense of burden was a common theme amongst the participants of this study, but it was exemplified in different ways for each. For Ruby, it was in part the burden she felt on herself, and in part what her circumstances imposed on others. Trauma therapy, mindfulness, victim impact statements, dissociating. None of it would erase the past. She still experiences insomnia and nightmares, triggers that prompt intrusive thoughts, hypervigilance and anxiety, and a range of physical concerns that are not resolving. Her personal experience of burden is coupled by concerns that her situation burdens her friends and family, and even her therapists, as she does not appear to be getting better. She is unable to offer babysitting for her grandchildren and draws on others for support and assistance for drives to appointments or for groceries. Adding to her burden, she tries to keep her distress from them. "*I am so tired of putting a face on for everybody but that's what I do,*" clarifying how she tries to minimize the impact on those around her. Her thoughts at the time of her suicide attempt: "*I just thought I can't take this anymore and my kids can't take this anymore."*

The other participants experienced burden differently. For Bob, his past indiscretions with his daughters were with him throughout his life. Although he knew they remembered what happened just by the way they were around him, the situation was not talked about for many years. The burden associated with the sense of secrecy multiplied when, as adults, the daughters chose to bring it up. Being confronted or

"outed" raised the level of burden to one unacceptable to Bob. He started to look for an escape.

Both Mark and Ray raised concerns that their mounting health concerns would result in them being unable to bear the burden themselves if the situation deteriorated much more and would be too great for their wives to bear. As Ray clarified, with reference to his wife,

> *I don't want that for my wife...I can't do that to her…I don't want anybody taking care of me. If I'm ever in a situation where my wife has to take care of me all the time, I am going to be looking for another way out.*

Likewise, Mark shared that he does not like to ask others for help, preferring to be in the position of helping others. *"If I can avoid going to a home where somebody's got to wipe my nose or wipe drool off my chin or feed me…"* he said with disgust, as he shared examples of others he has seen who have required extensive help. Both Mark and Ray raised the idea of accessing MAiD as one option, should the situation worsen.

All four participants feared being a burden, speaking primarily of the notion of others having to do something for them, either presently or in a perceived future. All had one or more attempts of suicide in their past but did not raise the issue of the emotional trauma those left behind might bear had the suicides been completed.

Leaving Loved Ones Behind

All participants had given thought to those who would be left behind. For example, as much as Ruby spoke of the concern for her son and wanting to protect him

from harm, she recounted a time when her therapist sought to emphasize reasons for living (a common theme in suicide prevention work): "*she says, 'what is (your son) going to do without you?' I said, 'he can go and live with his father*.'" This was a surprising response, given that she had previously described her son's father as "*sexually, mentally and physically abusive,"* both to her and her son. She also spoke of the timing of a potential suicide: "*I begged* (my therapist) *to get me through Christmas. I can't allow this to be my kids' Christmas memory or my grandkids,"* implying that a non-descript day in January would be better received.

Ray similarly spoke of timing. He specifically chose not to make his suicide attempt while his wife was away on a trip, for fear of ruining the trip:

> *I didn't want to ruin her trip. I didn't want her to look back and say 'he did that while I was on my trip. If I'd been home' she might have said, 'if I'd been home, maybe he wouldn't of done that.' I did not want her to have any guilt feelings about anything, so I waited until one day after she was home.*

One day after her trip was chosen in consideration of her potential feelings. He spoke as if his wife would easily get on with her life: "S*he's pretty healthy for her age. She has a lot of friends and a lot of things she's involved in with the friends and stuff. She likes to go on trips. I can't do that to her."* His concern, "I can't do that to her," was in reference to the potential of putting her into the caregiver role if his healthcare needs increased. In consideration of her, he also described how he tried to clean up the blood-stained bathroom after stabbing himself: "*I did not want blood all over the place for her to clean*

up," so he sopped it up with towels as he lay dying (implying it would be the mess and not the death that would be most concerning). However, in the aftermath of this attempt, she was traumatized and harbors guilt feelings for not recognizing the depth of Ray's feelings, responses that Ray did not foresee.

In his discussion of those left behind, Mark minimized the impact. He described a conversation with his sons:

> *I said 'guys, don't worry about things…if I die tomorrow, as far as I'm concerned it is just going to inconvenience a bunch of people for four or five weeks and then it's all going to be over.' People forget about it, leave things alone and get on with their life.*

His sons rebuffed his comments saying they would sadly miss him, but he responded, "t*hat just happens to be the way I was thinking at the time, and I still do by times."* With regard to his wife, although confirming that he dearly loves her, he added in a very "matter of fact" tone, "s*he has got to live with what I do. She will just have to live with what I do. I know that is probably a poor attitude but that is just the way I am right now."*

In Bob's discussion of those left behind, he spoke of it more from the perspective of him being gone, and thus the problems being gone. As he looked at pills in his medicine chest, he recalled saying to himself, "*I said 'now this could end all of this,'*" but what would be ended? Bob's life would be ended, but not the impact the past on his daughters nor on other family members. He had previously examined his guns with

thoughts of suicide, and recalls thinking, "*I would make it shorter for everybody,"* again implying something would be over. Like the others, he drew no attention to the fact that his suicide could have significant repercussions for all.

Apologies: Are You Sorry?

Both Bob and Ruby spoke about apologies, not regarding the suicide attempts, but more related to the past. Bob had harbored his wrong-doings for much of his life, not wanting to discuss them, nor offering an apology for what he had done. He remained ambiguous about what exactly had happened. When the time came and the situation was brought up, Bob did voice an apology of sorts, saying, "*I told them all I am sorry for what I had done, if I had done it"* and repeated it later in the interview, saying "*I am still sorry for what I've done, whatever I've done."* If I had done it? Whatever I had done? These do not sound like apologies that express accountability or deep remorse. Throughout the interview, Bob offered several descriptions of his past, often minimizing the number of times something had happened, or the extent of what had happened. Although his daughters later accepted his apology, his lack of full accountability may have played a role in how the apology was received, as they countered, *"... 'it's not about that. You did it,' but I still say I didn't do it, not directly to them*." What was he sorry for then? It is never made clear, but it was clear he didn't want to discuss it any further.

Ruby waited years to hear an apology. Her father had always denied (or said he would deny) doing anything to Ruby, but he sent her a letter of apology from jail. Ruby

did not accept his apology, realizing he had most likely been coached to write it. “Sorry about taking your childhood,” he wrote, to which Ruby’s reaction was, “*no, you didn’t take my childhood, you took my whole life*.” From her perspective, he had never shown remorse, even in court, and “*enjoyed everything he did too much*,” seeming unmoved by her cries. An apology typically begs forgiveness of some type, and Ruby was not inclined to offer it, even at the expense of family support. She wanted more than a perhaps-coached letter from jail, but it was not forthcoming. “*I can’t forgive what he did, because he is not sorry and it's not going to make me feel any better because I can't forget*.” At this point she wants nothing more than to be notified of his death. “*Maybe then I will be at peace,”* she concluded.

For Ruby, it became more about forgiving herself. She harbored guilt and blame most of her life. Her therapists have tried to help her to forgive her younger self. “*They tried to get me to go back to the inner child… Go back to that little girl and forgive her, but I can't go back there because I don't know how.”* It does beg the question, how do you forgive yourself? How do you craft an apology to a young child who fell victim to her beloved father, or a rebellious teenager who struggled to survive? Unlike Ruby, Bob did not raise the issue of forgiving himself, even though his actions were exceedingly contradictory to his values.

Regarding the suicide attempt, Ruby did not discuss an apology to her children, but did discuss how badly she feels that they live in fear it will happen again, and she cannot reassure them that it won’t. Similarly for Ray, there was no apology but there was

remorse. He is especially moved by the fact that his wife feels guilt for not noticing the signs. In his mind, he had minimized the circumstances that might lead her to feel blame, but to no avail. In addition, it has impacted his relationships with his children and their partners. Of course, his wish "to undo it all" cannot be granted. Only one of his children has spoken to him about it, and when he is with the others, it is the "elephant in the room." It has changed the relationships, and for that, he is sorry.

Likewise for Mark, there were no apologies following his suicide attempt, but he too felt remorse for what his family had been subjected to. It was his son who found him at the kitchen table swallowing pills and had to insist on him getting into the ambulance and going to the hospital. "*It was hard, it was hard on him, and it was hard on my other son,"* he said. He added, "*Do I have regrets about doing it? Yes, in some ways, but not others. Sometimes I have regrets that it didn't accomplish what I wanted to do… but I have regrets about what it did to the ones around me,"* illustrating that in his case, similar to both Bob and Ray, the relationships are changed.

From Me to You: What Might Help

While all four participants had suggestions for what might be helpful to others in a similar position, their views varied considerably. They spoke in part about what they were doing or had done, and what they did and did not find helpful.

Although all participants spoke of taking medications to help with depression and anxiety, only Ruby expanded on it with regard to suicide, saying, "*I don't want them anymore. They have put so much weight on me, which is huge for me, but I know they're*

keeping me alive if I take them." For Ruby, although we sat at the kitchen table beside piles of books, homework sheets, binders, workbooks, and a computer on which she participates via Zoom in therapeutic sessions, individually and in groups, her advice to others was:

> *When it comes to suicide, my biggest thing is to have people around you, outside of the professionals, who understand without judgment and support you because I would do anything to have that…Don't be scared to talk about it, and don't put me in a position that I have to hide it. If today I am feeling suicidal, I want to be able to tell somebody that. 'This is how I am feeling today and I just need you to sit with me. Come have a coffee with me, come have a glass of water with me, come and just sit with me. Don't talk about any of that. Let's just have a conversation, a visit.'*

Just have a conversation or a visit. Someone to talk to. These simple things are not available to Ruby right now. Her whole life appears to be oriented around her therapies, but she expresses great concern that she is not getting any better. She named numerous therapists in the course of our interviews – a wellness coach, a nurse, a physiotherapist, a psychiatrist – but expressed a weariness with it all. "*When does it end? What is going to be the outcome?*" she wonders.

Both Ruby and Mark raised concerns about calling the various helplines that are listed as mental health resources in their communities. Their issues were the same: They just wanted to talk, but both pointed out that as soon as the word *suicide* was said, you could expect RCMP, an ambulance, or police to arrive in your driveway. On one

occasion, Ruby was taken to the hospital by ambulance but sent home after a few questions, leaving her to feel invalidated and not likely to call again.

Mark has disdain for many people with whom he has come in contact through mental health services, and lacks trust in "the system," but he does value his family doctor with whom he has openly discussed MAiD. He has also connected with one community-based nurse in particular. His praise for her included feeling listened to. She "*stepped up to the plate*" and got him the help he needed in the moment by accompanying him to the hospital, and in the follow up care where she provided him with tools such as the "question cards" to get him over the rough spots.

What does Ray recommend for others who may be considering ending their lives? Counselling? No, he says, "*the last thing that was on my mind would be counselling*." Instead, he recommends finding something meaningful to do, and wishes he had done so sooner to avoid feeling useless. "*Check the senior centres, take up bowling again, look for a part time job. The approach I am taking is the approach I would recommend…try to find things to do."* This approach seems to be working for Ray. For Bob, his advice to others considering suicide is "*I wouldn't do it*."

Chapter 5: Discussion and Conclusion

This study addressed the following questions: 1) What contributing factors led the participants to consider suicide? 2) What was the experience like, before, during and after an attempted suicide? 3) How did the participants transition from thought (ideation) to action? and, 4) What protective factors contribute to coping now? The study concludes with an emphasis on not only preventing suicide but supporting older adults to find meaning and purpose in living.

Contributing Factors

The findings of this study confirmed and expanded the findings of previous authors regarding suicide and older adults. In the Interpersonal Theory of Suicide, based on the ideation-to-action framework, perceived burdensomeness and thwarted belonging coupled by hopelessness are key contributing factors to suicide risk, but must be accompanied by an acquired capability to move beyond thoughts of suicide and take action (Van Orden et al., 2010).

This study revealed that perceived burdensomeness could relate not only to being or becoming a burden to others, but also the challenges related to bearing a burden yourself. Both Bob and Ruby conveyed that others would be better off without them, but in addition, Bob was bearing a sense of foreboding regarding family secrets he hoped he would never have to talk about. For Ruby, the trauma and abuse to which she was subjected in her youth translated into constant fear and hypervigilance she struggled to bear. These scenarios were different from the concerns of becoming a burden to their

wives that both Ray and Mark described. Their fears were more about deteriorating health and their future inability to remain independent and what that would mean for others. These examples align with other research that discusses the notion that given the perceived burden, those left behind would be better off. For example, Chu et al. (2017) discuss the thinking that might lead to self-sacrifice for the good of others, and how "perceived burdensomeness may represent a fatal miscalculation by suicidal individuals regarding the need to sacrifice themselves." (p. 1315). This is particularly relevant, as none of the participants shared examples of family members overtly indicating they felt burdened.

Thwarted belonging was also experienced by the participants in various ways. Ruby had made known some of her father's wrong-doings when she pursued legal action. In doing so, her relationships with friends and family were negatively impacted. She believes they think she will talk publicly about her past and her painful present, leading them to avoid contact with her. This reaction may be related *social ambiguity* which can be experienced by friends and family who struggle to know what to do or say or what is considered appropriate behavior in this circumstance (Jordan, 2017). Because of the exclusion, Ruby feels like she no longer belongs in the family, nor, at times, in the world. Although she maintains reciprocally-caring relationships with her children, a key component of belonging (Van Orden et al., 2010), she is limited in what she can offer to her family. This lack of reciprocity contributes to burdensomeness and thwarted belonging. She feels very much alone and without a purpose in life. Bob also

experiences a sense of not belonging in the family. His transition to long-term care was a demarcation of his banishment. He is no longer welcome, even for short visits, to his life-long home, and he also got to the point of feeling like he did not belong in the world. Long-term care may be misinterpreted as a social environment without acknowledging that one is among strangers and can feel very alone. Bob must adapt, knowing the situation is unlikely to change. Mark described becoming disconnected from friends in his post-retirement years, feeling as if they no longer had anything in common. He says he now has no one in whom to confide, choosing not to confide in his wife or sons for fear of burdening them. Ray drew attention to thwarted belonging, pointing to the lack of a meaningful role in the world that led to his first suicide attempt (having lost his "homeowner" role, albeit by choice), and the disappointing changes in the way his family treat him in the aftermath of his second attempt.

All of the participants indicated the ways in which feelings of hopelessness led to their suicide attempt. Bob is not hopeful for reconciliation within his family, as it has been formally agreed that they will not further discuss the issues and the new modus operandi of the family has been established. Bob will have to make the best of things in his long-term care location, away from former friends and neighbours, but appreciates that his wife (and occasionally, his daughters) will continue to visit. Ruby's life is defined by therapy, and she can see no light at the end of the tunnel. She repeatedly asks herself "*how will this end? What will be the outcome*?" as she sees little change resulting from the various therapies. Ruby, Mark and Ray indicate that given the chronic nature of their

health concerns, coupled by interpersonal and psychosocial issues that appear to be worsening, future suicide attempts are not out of the question, confirming what previous studies have found. Hopelessness regarding potential change in their perceptions of burden and thwarted belonging correlate with suicide risk (Van Orden et al., 2010).

While perceived burdensomeness, thwarted belonging and hopelessness account for many of the contributing factors that fueled suicidal ideation, each participant described other antecedents that "pushed them over the edge" on the day in question. For Mark, a "row" with his wife. For Bob, family secrets being brought out into the open. For Ray, feeling useless prior to his first attempt and feeling even worse the second time in the aftermath of losing his driver's license. For Ruby, an overall crash.

While these events may represent the tipping point, it is clear that for each person, there was a cumulation of factors that may have had an impact. Is it the tipping point, or the tip of the iceberg? It can be difficult to attribute the cause to one thing, and yet similarly difficult to attribute it to the range of events long in the past. As Daray et al. (2016) discuss, childhood sexual abuse increases risk of suicidal ideation and suicide attempts in adults. Ruby's early victimization may have placed her at risk. Others authors have confirmed the association between adverse childhood experiences, revictimization and the onset of mental disorders including depression and anxiety, drawing links to resulting suicidal behaviour (van der Feltz-Cornelis et al., 2019). Victimization has been known to result in resilience and post-traumatic growth, but for Ruby, it seems less likely due to her *negative accommodation* whereby she embraces thoughts such as "I have no

control over my life. Danger is everywhere" discussed by Blackie et al. (2016, p. 410). For Ruby a simple trip to the grocery store, a workout at the gym, or even staying home conveys danger, fueling her fear and hypervigilance and preventing recovery.

Both Ruby and Bob may bear the burden of *moral injury*, the emotional, spiritual, and social suffering that can result following a trauma that violates firmly held values. As Fani et al. (2021) discuss, although moral injury has been explored primarily in military populations, there is now research to suggest that civilians are also subject. Moral injury can result from being the perpetrator of morally injurious behaviour, or the victim. Further, as Fani et al. found, moral injury is associated with risk for suicidal behaviour. In Ruby's case, she experienced extreme betrayal at multiple points in her life in both her microsystem (with violation by her father and by partners) and exosystems (with violation by her father's colleagues and within the school system). Bob may have experienced moral injury due to his history of *moral transgressions*. Moral transgressions refer to actions a person commits that are in opposition to their own moral beliefs (Houtsma et al., 2017). As Bob clarified in his discussion of the actions he had taken with his young daughters, "*I don't really like that myself. Anytime I hear anything about that, I don't like to hear it*," clarifying they were in opposition to his values. Bob exemplifies cognitive dissonance, where efforts are made to reconcile behaviour with the discomfort resulting from actions that run contrary to values (Aguilar et al., 2022), by forgetting, denying or minimizing what occurred ("*I don't remember*"; "*I didn't do anything*"; "*only once*"; "*I didn't go all the way"*). Bob may have been further exposed to moral injury

when he was exposed to recovering dead bodies. As Richardson and Lamson discuss, exposure to human remains is among the experiences that may cause "deeper rooted injuries to the soul" and profound shame, guilt, or anger which have been linked to suicidality (2022, p. 145).

The Experience, Before, During and After: Ideation-to-Action

For all of the participants, there was much contemplation that preceded their attempted suicide. Bob had closely examined his guns, guns he had used many times throughout his life, but was unprepared to point one at himself. Perhaps his reticence was related to his process of acquiring capacity – a requirement according to the Interpersonal Theory of Suicide (Van Orden et al., 2010). Both Ruby and Mark acknowledged risk-taking behaviours specifically related to the possibility of self-harm or death, but they were in a passing moment in time. Ruby described periodically walking out in front of cars and busses without looking. Likewise, Mark sped through an intersection on a red light, not pausing to look. Another day, he veered toward an oncoming cement truck but swerved at the last second so as not to ruin the day of its driver. Interestingly, neither turned back and tried again when the risky behaviour did not result in harm. The impulse seemed to have passed.

These actions align with an emerging body of research that explores how suicidal ideation fluctuates. As Klonskey and May (2010) discovered, although there is a literature to support a link between impulsivity and suicidal behaviour, their study found that trait impulsivity levels were similar in individuals with suicidal ideation and suicide

attempts, thus indicating that it is not impulsivity itself that leads to an attempt. This may be reflective of suicidal ambivalence that can be reflected in the fluctuation between the wish to live and the wish to die (Oakey-Frost et al., 2023). It is a dynamic state that can exhibit variability across hours, days or weeks, and may depend on fluctuations in intensity of suicidal desire and ability to resist the urge to make a lethal attempt (Kleiman et al., 2017). Thus, the person may live in a persistent state of suicidal ideation without ever moving forward with an attempt, or could make an attempt, but not repeat it in the near future.

Many of the known risk factors for suicide, several of which emerged in this research, such as depression and hopelessness, are better predictors of suicidal ideation than suicide attempts (Klonsky et al., 2017), which may explain why participants don't repeatedly reach the point of attempting. Many people live with depression and hopelessness without ever considering suicide, but as Klonsky et al. point out, it is diminished fear of pain, injury, and death that are more likely to increase the person's capability to attempt suicide. Van Orden et al (2010) confirmed that the *desire* to engage in suicidal behaviour is different from the *capability* to engage in suicidal behaviour, and according the Interpersonal Theory of Suicide, it is the development of capability that is a stronger predictor of suicide, when in the presence of perceived burdensomeness, thwarted belonging and hopelessness.

Three of the participants in this study described their suicide attempt as impulsive, in the sense that it was unplanned on the day it occurred. Brokke et al. (2022) are among

those who have confirmed the link between impulsivity and suicide, and suggest that impulsivity may include those who respond before considering the consequences, seek sensation, or are risk-takers. Ruby admitted she engages heavily in self-harm (cutting) as a means of seeking sensation and feeling something other than the feelings that arise when she thinks about her past. Some authors have described how although self-harm can be a precursor to suicide attempts, it can be unrelated to an intent to die and used as a means of emotion regulation (Van Orden et al., 2010). In Ruby's case, her cutting seems unrelated to an intent to die, as she has engaged in it for many years, and describes immediately tending to her wounds once she has inflicted them on herself. When it came to attempting suicide, she turned to antifreeze, a more lethal choice, she thought. For Bob, the feelings were intermittent. He had thought of it before (eyeing his guns) and then thought of it again. Ruby and Mark had entertained thoughts of suicide off and on for a period of time before the actual day, not unlike someone carrying an engagement ring in their pocket and being unsure when they might initiate a proposal. For Mark, a "row" with his wife prompted the action. For Ruby, it was a more cumulative effect, but for both, there were many factors at play.

Bob, Ray (on his first attempt) and Mark all chose drug overdoses, relying on pills that were readily available in their homes, while Ruby chose antifreeze. This aligned with Rogers et al. (2022), whose findings reflected that a person's own medications, and other drugs (including over-the-counter), followed by poisons were the main methods considered by their suicidal participants. All four participants in the current study were

discovered by family members and taken to the hospital either by ambulance or by the person who found them, and all remember little about their stay. Bob and Ray spoke at length about the consequences of their suicide attempt and the negative impact on family relationships. While Ray's attempts were planned in advance, he admits to not thinking it through. His first attempt remained hidden from family members other than his wife, but the second, a more violent attempt, could not be kept from them, and it was this one that has most negatively impacted family relationships.

The "Three-Step Theory" also offers clarification on the ideation-to-action progression (Klonsky et al., 2021). This theory suggests that suicide ideation can arise from pain (often psychological pain) and hopelessness which all participants identified. Next, as Klonsky et al discuss, pain and hopelessness can impact a person's ability to connect in relationships, to activities, and to meaning in life. This can progress to building capacity to attempt suicide. Aligning with this second step, all participants spoke of boredom, lacking purpose or meaning, or disconnection from previous friends and family. In step three, ongoing psychological pain and hopelessness (little hope for improvement) may overwhelm ability to engage in previously valued activities or to engage with existing social contacts and strengthen suicidal desire. While withdrawal from valued activities and social contacts strengthens desire for suicide, Klonsky et al. suggest that connectedness may help to make life worth living, making it a worthwhile target for intervention. Likewise, Espeland et al. (2023) discuss the importance of establishing new daily routines in the aftermath of a suicide attempt as a means toward

recovery. Although their study was completed with younger participants, their finding that "establishing a new everyday life…provides the opportunity to be active in one's life, experience mastering and apply oneself to something that is perceived as meaningful" (p. 555) seems especially relevant to older adults who often lack the built-in structure that working or going to school provides.

Protective Factors: Coping Now

All of the participants take medications to help with symptoms related to depression and anxiety, but all agree that is not enough. Even though Ruby has engaged in numerous therapies, like Mark, she most values having someone to talk to – someone with whom you can be yourself and be honest. She engages in a great deal of dysfunctional activity, such as maintaining a constant vigil in her living room window, and self-harming when the stress becomes too great. Ray also emphasized the importance of having someone who will listen. As Espeland et al. (2023) describe, a therapeutic alliance with someone who is empathic and tries to find out what was behind the suicide attempt can be helpful. Although having someone who will listen is important, Ray downplayed counselling, instead suggesting that people get involved in something meaningful in the community. As Deuter et al. (2020) found, engaging in meaningful activities was a protective factor for those who had attempted suicide. After two suicide attempts, Ray is adapting to no longer being a homeowner by engaging in community-based activities, but he now wishes he had sought them out sooner. Mark is also trying to be more involved with friends and family, but has had some friends die, reinforcing the

reality that when one is in their 70's, you may need to prepare for this to happen. Knowing that MAiD is now legal in Canada is another way that both Mark and Ray cope with their current circumstance. They take comfort from knowing that if their health deteriorates, an option exists. Bob is resigned to his circumstance. He knows it will not change for the better and seems to accept that. In the absence of his former social network and access to previously-enjoyed activities, he tries to be active in the activities of the long-term care facility that is now his home, but wishes things could be different. And so, he waits.

Moving Beyond Suicide Prevention: Disrupting the Dominant Discourse

An examination of the challenges faced by the participants of this study illustrated that suicide prevention must occur across the lifespan and across ecological levels. In a world where we hear so much about needing "more mental health services, better mental health services, more accessible mental health services," (not mentioned by a single participant), we don't stop to think about whether addressing the needs exclusively on an individual basis (the main focus of existing mental health services) is the answer. How can prevention happen further upstream, long before people find themselves in despair? How does environment (proximal and distal) play a role?

As White (2017) contends, from a critical suicidology perspective, suicide prevention practices most often reflect a biomedical or individualistic perspective, resulting in solutions that "target individuals for change, but leave the specific social, political and cultural context of people's lives – including the corrosive effects of

structural inequalities – unaccounted for" (p. 472). As Bantjes and Swartz (2017) add, pathologizing the symptoms makes the individual into a psychiatric patient and tasks mental health workers with preventing suicide in a context that minimizes attention to cultural and socio-political influences. Recovery-oriented practice, the prevailing paradigm in mental health care, which focuses on supporting people with mental health problems to "enjoy a meaningful life in their community while striving to achieve their full potential" even when symptoms persist (Kirby et al., 2009, p. 122)) was identified as one of the strategic priorities in Canada's most recent mental health strategy, *Changing Directions, Changing Lives* (MHCC, 2012). As the strategy clarifies, recovery involves building on individual, family, cultural and community strengths. In the follow-up *Guidelines for Recovery-Oriented Practice*, hope, dignity and inclusion are the guiding values (MHCC, 2015), indicative of a relational perspective that depends on an accepting environment. Canada has been well intended in identifying that health and well-being go beyond individual treatment, acknowledging that the social determinants of health must be considered if the desired outcomes are to be achieved, but in a subsequent document, *Advancing the Mental Health Strategy for Canada: A Framework for Action*, an evaluation of progress indicated "we are failing to provide services capable of addressing these determinants" (MHCC, 2016, p. 8). Further, they add, if the mental health system does not give increased consideration to the social determinants, "time and resources will be wasted and results will be diminished" (p. 8).

Similarly in New Brunswick (the home of all participants in the current study), attention to the social determinants of health has gained attention. Recent community health needs assessments have revealed the need to enhance attention to upstream initiatives (Holland, 2017). For example, they suggest that approaches for seniors might focus on social support and environments by providing "programs that get seniors engaged, connected and mobile" (p. 24), thus decreasing demand on acute healthcare. In addition, the federally-supported recovery philosophy has been embraced through a variety of provincial government initiatives in New Brunswick. However, even though recovery-oriented practice and a "stepped-care" model is endorsed (drawing attention to both environmental and individual influences), the emphasis remains on more mental health services, better mental health services, and more accessible mental health services (faster first contact, reduced wait times, easier navigation) (GNB, 2021), which are much needed, but not the whole story. There is little focused attention to the needs of older adults, with whom the recovery model is difficult to apply, and virtually no attention to the ways in which broader contextual issues such as inclusivity and ideologies such as ageism might be addressed as older adult look to belong and matter in their communities. As Holland (2017) concluded, there is a need in healthcare to "bring real issues that have a significant impact on health status to the forefront of our discussions, our decision-making, our actions and our investments, and in that context, our organization and population thrive" (p. 1).

It is time to disrupt the dominant discourse (one which devalues older adults and over-simplifies the response to mental health issues) and shift our focus toward one that confronts harmful and oppressive ideologies and encourages a society where the opportunities for older adulthood are integrated, widespread, supported and celebrated. The *Critical-Ecological Framework* provides a lens through which to examine how such ideologies can be opposed to make way for a different future (Norris et al., 2013), and can be helpful in this regard. Challenging ideology has been described as "the very heart of the critical theory" (Brookfield, 2005, p. 40). To apply critical theory, rather than accepting the status quo, we "must grumble" as the starting point of ideology critique (p. 69), as we reflect on what we observe and experience in the world around us and consider how it might be changed for the better. Thus, critical theory can serve as a catalyst for such transformation, toward "beautiful consequences" (p. 8).

Our grumbling in this case might start with noticing how the biomedical approach to mental health care can be inconsistent regarding the recovery needs of those who have been suicidal (Espeland et al., 2023), potentially failing to identify the broader risks that older adults face. For example, as Espeland et al. contend, the considerable focus on medication may contribute to passivity rather than supporting people to become active agents in change. It is not surprising that pharmaceutical interventions garner the most support, if support is measured by randomized control trials. The multi-billion-dollar industry can well afford to sponsor a wide range of research initiatives in a "doctor knows best" culture. Of course, they "win" as we look to the published literature for

evidence, but does that really mean the interventions arising from the non-medical world are less effective? We are starting to see more approaches that acknowledge the need to address symptom management *and* highlight the need to live a meaningful life in a supportive environment. As the participants of this study confirmed, life-affirming approaches that help people to not only manage symptoms, but to find meaning and purpose are called for (Van Orden et al., 2012). Finding meaning is not as easy as it sounds and can vary for each person. Not all older adults have the same interests, skills, preferences, goals or resources, so stereotypical pat suggestions will not suffice. Fitzpatrick and River (2018) suggest we must "move away from paternalistic approaches and begin to work with persons who are, or have been, suicidal to acknowledge them as experts in the development of comprehensive, acceptable, and useful services" (p. 199), thus supporting a shift in culture whereby their opinions and lived experiences are valued.

The *Social-Ecological Suicide Prevention Model* focuses attention on the need for universal, selective and indicated approaches reflecting opportunities within the interdependent levels of the environment (macrosystem, exosystem, mesosystem, and microsystem) (Cramer & Kapusta, 2017). A public health approach embraces the notion that we need not wait until a person endorses strong suicidal ideation to intervene (Van Orden & Conwell, 2016). While indicated approaches for such individuals are important, selective and universal strategies can cast a wider net, "catching" people before they become acutely suicidal. As Van Orden and Conwell discuss, older adults do not readily seek specialized mental health services. Thus, selective initiatives that address issues

such as social isolation at a community level, or universal approaches that offer widespread awareness or broader policy changes to address social determinants of health could be considered (de Mendonça Lima et al., 2021; Sakashita & Oyama, 2019).

As we further apply this to suicide prevention, we might see universal approaches (population-level) within the macrosystem where culture, inextricably linked with pervading ideologies play a role, and in the exosystem which deals with supports, services and regulation. At the macrosystem level, we can confront ideologies including capitalism, familialism and ageism. As Rochon et al. contend, ageism is "is a largely neglected social determinant of health" (2021, p. 648). Likewise, capitalism and familialism are somewhat invisible influences. Amongst the participants of this study, take Ray as an example. Although he was well into his seventies and financially secure, he wanted to get a job, perhaps reflective of capitalist perspectives, seeing paid work as more highly valued than other activities ("*If I could get a job… I don't really want to turn to volunteering yet…You feel you have to do something else, accomplish in life*.") Interestingly, he mentioned volunteering, as that is often the first thing suggested to older adults, likely manifesting ageist views. While volunteering might appeal to some, Ray wanted to combat his feelings of worthlessness with paid employment. Although there is evidence to support the notion that volunteering can provide a sense of purpose and meaning, as well as a positive impact on physical and mental health, Whalley Hammell discusses how there is a an "overwhelming preponderance of studies reporting the benefits of volunteering [that] uncritically reproduce the hegemonic neoliberal discourse"

failing to identify the "devolution of community care to the fluctuating availability and whims of unpaid volunteers" (Whalley Hammell, 2020, p. 161). Further, she adds, the notion of expecting certain groups of people (those with disabilities or a mental illness, which often encompass older adults who experience suicidal ideation) to work without remuneration suggests their time and effort is of little value, and they are incapable of "real" work. Macrosystem approaches could be effective in creating a culture where older adults are welcomed and valued in the workplace, not in a patronizing manner, but one that conveys value and respect. This could be considered a universal approach to suicide prevention – one that does not focus on people who *are* suicidal, nor on those who are high risk, but rather for everyone. This approach also addresses the segregation that often happens with older adults (such as hosting activities *for seniors at seniors' centres*) by welcoming employees of all ages in the workplace. The same integrated approach (across age groups) lends well to leisure activities as well.

As we look at Ruby, her staunch protection of her father, coupled by her decision to keep everything from her mother, are likely indicators of familialism. Power imbalances and patriarchy may also play a role, extended when her father shared her for a sexual purpose with male colleagues, or when she was approached by male teachers. Universal prevention initiatives that focus on making such activity not only socially unacceptable, but also exosystem responses such as stronger penalties from prosecution may be considered. Other universal strategies include widespread means reduction, more education and public awareness on risk and protective factors for older adults, as well as

knowledge about healthy aging and the fact that it is not normal to be depressed in older adulthood (Erlangsen et al., 2011).

Considerations in the exosystem may include the range and availability of services. As mentioned, existing healthcare services are almost exclusively focused on the pathology of the individual who is exhibiting symptoms of one variety or another, with little attention to macro or exosystem factors. In relationship to suicide risk, this often includes people who are experiencing signs of depression. Selective approaches could be extended within the exosystem to offer a broader range of activities that support prevention and promote wellness. As the participants of this study confirmed, it was not another pill or therapy they needed. Other selective approaches could include enhanced screening and outreach for those at risk (Erlangsen et al., 2011), which could be formal or informal. In an effort to shift the conversation, White (2017, p. 478) suggests adding "life activating" questions to "provoke engagement with life" when screening for suicide risk.

The mesosystem and microsystem can have a positive impact, but might contribute to suicide risk as people face social isolation, loneliness, and decreasing independence. In this study, family conflict, fear of dependence, shrinking social circles and diminishing health all played a role. Given their recent suicide attempts, indicated approaches could lend well (but not to the exclusion of selective and universal approaches). These might include accessing timely healthcare, collaboration with family and/or friends, referring to a broad range of community resources, follow-up such as home visits or phone calls, ensuring healthcare providers are well prepared in suicide risk

assessment, and exploring future perspectives (Erlangsen et al., 2011). As Erlangsen et al. suggest, a comprehensive prevention program is advised, incorporating universal, selective, and indicated interventions.

Arising from this research, no one suggested the need for more mental health services, better mental health services, or more accessible mental health services, but all spoke in various ways about having meaningful things to do and to having a purpose. Similarly, Beach et al. (2021) found that having meaning and purpose helped to mitigate suicidal ideation. As Roberts and Bannigan (2018) suggest, there are four dimensions of personal meaning that people can attain from participation in chosen meaningful activities, including a sense of fulfilment, a sense of restoration, social, cultural, and intergenerational connection, and identity shaping. Other authors have drawn on Viktor Frankl's exploration of meaning, suggesting that it is highly individualized and can derive from contributing to the world, gaining enjoyment from relationships and experiences, attitudes about positive and negative aspects of life, and connection to something greater than the self (Heisel et al., 2020). Programs to address transitions that occur in older adulthood, such as retirement, may be helpful to support people in adjusting to social and psychological changes and to find meaning in their shifting environments (Heisel et al., 2020; Page et al., 2021). As Ng et al. (2021) reported, in older adulthood, having friends, particularly those with whom you can connect on a regular basis, had a positive impact on happiness, life satisfaction and emotional well-

being. Thus, a range of services that could ensure easy access to one another, such as transportation or affordable valued activities to attend together could be beneficial.

Interventions such as social prescribing (common in the United Kingdom), an approach that helps to address psychosocial issues and enhance community well-being by connecting people with community-based resources and social supports, are showing promise as a response to mental health issues (Chatterjee et al., 2018). This can include prescribing such things as exercise, art, craft activities, book clubs or cultural or educational activities within the community as an adjunct (not a replacement) to traditional healthcare, with the intention that the activity in itself will have a positive impact on mental health (Morton et al., 2015; Sumner et al., 2021). While the mechanism of action has not been clearly discerned (e.g., distraction, social connection, enjoying the activity itself), promising results based on such activity in museums, libraries, art galleries, community gardens, music or choir groups and sports clubs have been found (Buechner et al., 2023). As Morton et al. (2015) expands, participants in their study experienced an increased sense of purpose and achievement, feeling more confidant, reduced depression and anxiety, and increased self-efficacy and well-being, all desirable outcomes from mental health interventions.

As much as social prescribing sounds promising, the notion of "prescribing" suggests a distancing from self-determination. Rebeiro and Cook found that providing opportunity rather than prescription in social environments that support belonging may be helpful to increase meaningful participation (Rebeiro, 2001; Rebeiro & Cook, 1999). By

connecting people with existing community activities (and not only those intended for seniors, or for people with mental health issues), people can "distance themselves from either the physical or mental ill-health they were experiencing…they will not be seen through a lens of their disease" (Redmond et al., 2019, p. 241). Men's Sheds are an example of a community-based setting where men, in this case, can feel welcome, socialize with others and undertake meaningful projects (Crabtree et al., 2018). Settings such as a Men's Shed could potentially address the challenges faced by both Ray and Mark as they struggled to find meaningful activity in their post-retirement years. While such opportunities may be challenging to arrange, as Baker and Irving (2016) clarify, *boundary spanners* who may originate in healthcare settings can develop pathways for access through collaborative networks in the community. This approach, they contend, can have positive health-generating effects, and may result in cost savings to the healthcare system.

Engaging in leisure in general is a particularly important aspect of older adulthood, especially as work-related pursuits scale down. When leisure is absent, negative impacts on mental health can result (Yilmaz & Karaca, 2020). Leisure can be readily enacted in a wide range of personal or community-based settings, but has remained "largely neglected (and perhaps undervalued)" as a cost-effective contributor to mental health and social inclusion (Iwasaki et al., 2014, p. 159). Physical activity itself shows correlation with reduced suicidal ideation (Laflamme et al., 2022). Greater attention to the leisure needs of older adults presents another opportunity for a

community-level response to support physical and mental health and well-being. Such responses must include older adults, adopting a "doing with" rather than a "doing for" or "doing to" approach. As Owen et al. (2022) found, activities that involve learning a new skill or enabled a sense of achievement contributed to enhancing sense of purpose of older adults in long-term care. Participants appreciated a challenge and found activities typically offered did not always hold appeal.

Occupational therapists address leisure interests from the broader perspective of engaging in occupations that are meaningful (Wright-St Clair, 2012), and have much to offer regarding the assessment of an individual's interests and abilities, and helping them to find activities that are a match. They can help with advocacy around access issues (e.g., physical access), and support people who struggle with physical or emotional challenges that limit participation (Hauser et al., 2022). As Whalley-Hammell pointed out, "the need for both the ability and opportunity to experience and express pleasure, purpose, accomplishment, and meaning in life through engagement in roles and occupations…is of central importance to human wellbeing" (Whalley Hammell, 2020, p. 106). Occupational therapy interventions have proven beneficial to support leisure participation which may help to mitigate the impacts of social isolation and improve overall well-being (Smallfield & Molitor, 2018).

Thus, there is a wide variety of interventions, initiatives and approaches within and outside of traditional healthcare that could lend well to changing the discourse on mental health and address the needs of older adults long before suicide enters the picture.

Marsh encourages “community-owned” approaches bringing service users and service providers together to “build collaborative, relationally-focused solutions founded on strengths-based (rather than deficit) models” (2016, pp. 27-28). Navigating options to situate these approaches across the ecological spectrum will be the next challenge.

Limitations and Directions for Future Research

This study relied upon a small number of participants and used a cross-sectional approach. While the opportunity to hear the participants’ stories offered important insights into the experience of a suicide attempt, it must be acknowledged that each person is an expert on their own experiences only. In addition, given the fluctuating nature of suicidal ideation, and the discrepant ways in which people tend to story their past, contacting those same people in another time frame may result in a different story. The use of tools such as the Ecological Momentary Assessment (which allows for multiple time points for data collection) may be helpful in future research to explore the fluctuations inherent with suicidal ideation, and illuminate possibilities for intervention (Kleiman et al., 2017). As Bantjes and Swartz (2019) suggest, narratives from close family and friends might augment the information gleaned from the first-person accounts, and could be a beneficial addition to future research. Future research might also draw upon a more culturally and geographically diverse population.

Conclusions

In conclusion, the Narrative Inquiry method has proven to be a valuable research tool to illuminate the depth and breadth of the experience of a suicide attempt from a vantage point that has not been readily available in the literature. In New Brunswick, Canada, the existing documents related to suicide (i.e., The Coroner's Report) detail collective information about the age and gender of the individuals, the geographical area of the province, environment (where it occurred) and the means used. There is no further information available regarding contributing factors, the ideation-to-action to trajectory, or advice survivors would have for others. This study contributes to the body of knowledge on suicide prevention by presenting co-created in-depth stories which allowed participants to reflect on the trajectory of their lives and highlight what they saw as contributing factors to their suicide attempt. As we explored the factors, it was soon evident how different the four experiences were, and how each would call for different next steps.

The contributing factors shared by the participants were wide-ranging. For some, a series of adverse events punctuated their lives from a young age. For Ruby, childhood sexual abuse, and related incidents of abuse as a young adult, compounded by mounting physical and mental health challenges, and for Mark, early childhood experiences with anxiety and depression, and previous risky behaviour provided the backdrop. On the day of the attempt, each person described the ideation-to-action trajectory they experienced. Ruby described a build-up of stresses followed by a "crash" while for Mark, a number of

ups and downs culminated with a dispute with his wife. Bob carried a lifelong burden resulting from his indiscretions when his children were young, along with other periodic stressors, but his tipping point was reached when family members chose to confront him. Thus, it was not the indiscretions themselves, but rather the response to confrontation that pushed his hand. For Ray, although he had a daunting list of prior health concerns, losing his driver's license was the last straw. Aligning with the Interpersonal Theory of Suicide, all participants indicated the extent to which they feared being a burden or discussed the burden they had to bear. They all came to the point of not belonging and felt the world would be better off without them. All had become hopeless, which contributed to their capacity to take action. Of note, their desire to take action fluctuated, at times even within a given day. As they reflected on what helped them to cope in the present, the prevailing answer was related to engaging in something meaningful.

If you listen to the radio or read the local newspapers, you will soon hear the refrain of what is needed to address mental health issues: more mental health services, better mental health services, more accessible mental health services. This refrain was not echoed by the participants of this study. Rather, they described wanting someone to talk to, and not having police and ambulances arrive in their driveways if they phoned a help line and mentioned the "s" word. They simply wanted to talk and be listened to and understood. Similarly, they wanted their own families and friends to have a better understanding but didn't want to always be the one who had to explain. They also wanted

meaningful things to do, to feel like they had a purpose in life and to belong and feel included.

The idea that suicidal ideation was a fluid construct that could vary over the course of minutes, hours or days, and the predominant thoughts on one day could vary considerably from those on another day make it a challenge for those focused on prevention. When you think of prevention, it would be much easier to have a check-list of things to look for, but it is not that easy. The varying presentations call for universal, selective and indicated approaches to prevention to address the fluctuations, and to support people to work through them.

By using the Critical-Ecological Framework to deepen the analysis it was soon evident that there are multi-level influences that contribute, and multi-level responses that address both distal and proximal factors. The negative impact of macrosystem influences such as ageism that made Ray struggle to re-join the work world, the exosystem factors such as the school system that failed to protect Ruby, the mesosystem that retains a focus on mental health services when environments issues deserve equal attention, and the microsystem stressors that each participants experienced all play a part. A range of opportunities stand to be developed or accessed, as increased value is placed on participating in naturally-occurring community-based settings, as an adjunct to “more mental health services, better mental health services, more accessible mental health services”.

To apply the Critical-Ecological Framework, there is a need to both critique and transform, but doing so requires collective action. If we collectively hope for the "beautiful consequences" where ageism is contested and older adults are valued and included (Brookfield, 2005, p. 8), we must continue to not only critique but transform the future – a future that waits for all of us. As we work our way through the Decade of Healthy Ageing (2021–2030), we must seek partners to share in this important work.

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Appendix A: Letter to Service Providers

LETTER TO SERVICE PROVIDERS (for assistance with recruitment)

TITLE OF STUDY: Suicide of Older Adults: A Sad Ending to an Untold Story

PRINCIPAL INVESTIGATOR: Catherine White, PhD, OT Reg NB (Prevention Coordinator, Addiction and Mental Health Services, Horizon Health Network, Zone 3); MSVU MA student, Department of Family Studies and Gerontology

PURPOSE

The purpose this study is:

1. To create an opportunity for older adults (50+) who have attempted suicide (one to ten years ago) to share their experience
2. To use the findings to contribute to clinical care initiatives targeted to the unique needs of older adults with regard to suicide prevention

INTRODUCTION

This study is being completed as part of the Roots of Hope (Early Adopters) collaboration with the Mental Health Commission of Canada. The first phase of the study will serve as a pilot study (up to five participants within Zone 3) and is being completed as part of my Master of Arts (Family Studies and Gerontology) program at Mount Saint Vincent University. Upon completion of the pilot, a second phase is being planned which will focus on the province more broadly, and incorporate both French and English participants, and both rural and urban communities.

To move forward with the pilot study, I am asking for your help in identifying up to five candidates who could serve as key informants.

WHO CAN TAKE PART IN THIS RESEARCH?

Individuals can take part in this research if they are:

- currently over age 50, with a history of a suicide attempt from 1 – 10 years in the past
- affiliated with Addiction and Mental Health Services, Horizon Health Network or have another support network
- cognitively and physically able to participate in two in-person interviews. (The first one will be approximately 60 – 90 minutes, and the second one will be approximately 30 minutes.)

WHAT PARTICIPANTS WILL BE ASKED TO DO

Participants will be asked to complete two in-person interviews with me (to be held in a private area convenient to the participant). The first one will take approximately 60 – 90 minutes. Using Narrative Inquiry methods, they will be asked about their life more broadly and what led them to consider suicide as an older adult. They will be invited to share as much or as little as they are comfortable with regarding the event itself, and how they felt about not completing the suicide. Finally, they will be asked to share their thoughts about what supports their mental health going forward. The interview will be audio-recorded with their consent. A second interview, approximately one month later (to be held in a similar location), will take approximately 30 minutes and will also be audio-recorded. Before the second interview, they will be provided with a summary of key points from their interview (by email, or regular mail), and will have the opportunity to clarify or add anything recalled since the first interview.

Participants will receive a $50 gift card to thank them for their participation in the study, as well as $20 per interview to assist with transportation.

PRIVACY AND CONFIDENTIALITY

All aspects of privacy, confidentiality and safety of participants will be considered, and strategies will be approved by Horizon Health Network Research Ethics Board, and Mount Saint Vincent University Research Ethics Board.

WHAT YOU ARE BEING ASKED TO DO

- Assist with identifying up to five individuals who meet the inclusion criteria stated above.
- Briefly explain the study to the potential participant and present them with an "Invitation to participate in research" letter that I will provide.
- Assist interested participants in contacting me and in arranging the interview time and place
- Advise potential participants that taking part in the research is completely voluntary, and deciding to take part, or not to take part, will not in any way affect their ongoing involvement with Addiction and Mental Health Services or other healthcare services.

Thank you for considering collaboration in research regarding this very important topic.

Research Study Contact Name:

If you have any questions or concerns, please contact:

Catherine White, Catherine.white7@msvu.ca

Appendix B: Invitation to Participate in Research

An invitation to participate in research

Thank you for considering participation in this research study, "Suicide of Older Adults: A Sad Ending to an Untold Story".

The purpose this study is to create an opportunity for people over age 50 who have attempted suicide (1 – 10 years ago) to share their experience. The experiences of older adults are different from experiences of younger people, and a better understanding of what led you to attempt suicide may help us to develop approaches to suicide prevention that better address the needs of older adults.

What you will be asked to do:

You will be asked to participate in two in-person interviews (the first lasting from 60 – 90 minutes, and the second lasting 30 – 60 minutes). They will both be schedule at a time and place that is most convenient for you.

You will receive one $50 gift card as a thank you for your participation, and, if applicable, an additional $20 to assist with transportation costs for each trip.

In the first interview, you will be asked general questions about:

1) The contributing factors that lead older adults to consider suicide
2) What the experience was like for you, before, after and during the experience
3) How you transitioned from thought (ideation) to action, and
4) What protective factors contribute to coping now

The second interview will be focused on clarifying the discussion from the first interview. Before the second interview, you will be provided with a summary of key points from the interview and will have the opportunity to clarify or add anything recalled since the first interview.

There is no pressure to participate. If you choose not to, your decision will in no way impact your ongoing healthcare services.

Thank you for considering this request. **If you would like to participate, I invite you to contact me directly by email or telephone, and we can set up the first interview:**

Catherine White

Email: catherine.white7@msvu.ca

Appendix C: Informed Consent Form

INFORMED CONSENT FORM

TITLE OF STUDY: Suicide of Older Adults: A Sad Ending to an Untold Story

PRINCIPAL INVESTIGATOR: Catherine White, MSVU MA student, Department of Family Studies and Gerontology

THESIS SUPERVISOR: Dr. Deborah Norris, MSVU, Department of Family Studies and Gerontology

PURPOSE

The purpose this study is:

3. To create an opportunity for older adults (50+) who have attempted suicide (one to ten years ago) to share their experience
4. To contribute to the development of clinical care initiatives targeted to the unique needs of older adults with regard to suicide prevention

INTRODUCTION

This study is being completed as part of my Master of Arts (Family Studies and Gerontology) program at Mount Saint Vincent University, in collaboration with Addiction and Mental Health Services, Horizon Health Network in Fredericton, NB (where I am employed).

As a person with a past suicide attempt, your participation in this study could provide valuable information regarding the prevention of suicide. The experiences of older adults are likely different from experiences of younger people, and a better understanding of what leads older adults to attempt suicide may help us to develop approaches to suicide prevention that better address their needs.

WHO CAN TAKE PART IN THIS RESEARCH?

You can take part in this research if you are:

- currently over age 50, with a history of a suicide attempt from 1 – 10 years in the past
- affiliated with Addiction and Mental Health Services, Horizon Health Network, or have another other support network available, e.g. a private counsellor or health professional
- cognitively and physically able to participate in two in-person interviews. (The first one will be approximately 60 – 90 minutes, and the second one will be approximately 30 minutes.)

WHAT YOU WILL BE ASKED TO DO

You will be asked to take part in two in-person interviews. The first one will take approximately 60 – 90 minutes, but you can take more or less time if you like. You will be asked about your life more broadly and what led you to consider suicide. You will be invited to share as much or as little as you are comfortable with regarding the event itself, and how you felt about not completing the suicide. Finally, you will be asked to share your thoughts about how you feel now, and what supports your mental health going forward. You can choose to answer only the questions you are comfortable answering. The interview will be audio-recorded. A second interview, approximately one month later, will take approximately 30 minutes and will also be audio-recorded. Before the second interview, you will be provided with a summary of key points from your interview (by email, or regular mail), and will have the opportunity to clarify or add anything recalled since the first interview.

VOLUNTARY PARTICIPATION

Taking part in this research project is completely up to you. You can stop at any time, for any reason. Deciding to take part, or not to take part, will not in any way affect your ongoing involvement with Addiction and Mental Health Services or other any other healthcare service. There is no pressure to take part, nor to continue once you have started.

PRIVACY AND CONFIDENTIALITY

I will transcribe the interviews myself, and only I will have access to identifying information. The transcripts may be shared with my research supervisor at Mount Saint Vincent University, Dr. Deborah Norris, and my research committee members, Dr. Jeanette Auger from Acadia University, and Dr. Linda Caissie from St. Thomas University, but no others will see them.

The information you provide will be used to create reports or presentations that will be made public, such as presenting at meetings or conferences or writing articles for publication. Your information will be included along with information from one or more others, and I will do my best to ensure you are not identifiable. I will not use your name, or any other personal or identifying information such as family member names or positions, workplaces, home town, etc. That information will be omitted or changed to preserve confidentiality.

All of your information will be kept private and safe. Once the study is complete and results are publicly shared, the audio-recordings will be destroyed. The transcripts and consent forms will be safely stored for 7 years in a locked filing cabinet. Any electronic information will be stored on a password-protected computer, or deleted. Your name or any identifying information will not appear in any reports or presentations resulting from the research.

Your safety is of the utmost concern. If I have concerns that you may be at risk of harming yourself, or if I become concerned that someone else is harming you, I will seek immediate assistance for you.

RISKS AND POTENTIAL BENEFITS

Your participation in the study may be helpful in informing the ongoing development and refinement of approaches to suicide prevention that are especially relevant to older adults. In addition, some people find it helpful to share their story in a supportive environment. Even so, it is possible that talking about your past experience with a suicide attempt could be upsetting. During the interviews, I will pause two or three times to ask if you are OK to continue. If you want to stop, please say so at any time and we will stop. I will ask how you are feeling and assess your potential safety before you leave. I will provide you with numbers to call for help if needed, and if I am imminently concerned that you may hurt yourself, I will ensure you get immediate help.

CONTACT INFORMATION

If you have any questions about your rights as someone taking part in a research study, you may contact the Horizon Health Network Regional Director of Ethics Services at (506)648-6094 or the Research Ethics Board at Mount Saint Vincent University (902) 457-6350.

Research Study Contact Name:

If you have any questions or concerns, please contact:

Catherine White, Catherine.white7@msvu.ca

Consent to Participate in Research Study: Signature page

Title: Suicide of Older Adults: A Sad Ending to an Untold Story

I have read the information provided about this research study, and I understand the purpose of the study.
I have been given the opportunity to have any questions or concerns addressed.
I am aware that the interviews will be audio-recorded.
I understand that my participation in this study is completely voluntary, and I may stop or withdraw at any time up until 24 hours after my second interview. After that, my information may be incorporated into presentations or publications, but my identity will not be revealed.
I understand that the researcher will keep my information private and confidential, and will store it securely.
I consent to take part in this research study.
Participant name: (please print): _____

- Participant signature: _____

I consent to the interviews being audio-recorded, and I agree that quotations from my interview may be used in presentations and reports (acknowledging that my identity will be kept private).

- Participant signature: _____

Date:
Address:
Phone number:
Email address:

I confirm that I have fully explained this study to the participant and answered all questions to their satisfaction.

Name of researcher: (please print): _____

Signature of researcher:_____

Appendix D: Interview Guide

Questions/topics	Prompts/cues
Tell me a bit about your life growing up	-positive aspects -negative events/turning points
How would you describe your older adulthood in general?	-transitions -losses -redefined goals/plans
When did you first start to entertain thoughts of ending your life?	-previous history of mental health issues (onset) -previous suicidal ideation or attempts -contributing factors (micro/macro) -any specific trigger -early transition from thought to action
Tell me about the day you actually attempted suicide.	-impulsive versus well thought out -means (pre-planned, or convenience) -emotions – what were you thinking? -anyone specific you were thinking about?
How were you discovered following your attempt?	-who discovered you (if anyone) -were you surprised, or expecting it -how did you feel in the moment? -how did you feel later that day? The next day? The next week? The next month? -who found out about your attempt? (friends, family, acquaintances, healthcare providers) -how did they respond?

	-how did you feel about others knowing, and about their reactions? -what care/help did you get? Were you taken to the hospital?
When you look back on the experience now, how do you feel?	-relieved or disappointed -ongoing risk?
What has helped you most to get to where you are now?	-health-related services -social supports -inner strength/faith
What advice would you have for health care providers who work with older adults to help to prevent suicide from happening?	-what has been helpful/meaningful -what has not helped
Is there anything you hoped we might talk about today that has not come up?	-any lingering thoughts of suicide -any realignment of hopes/dreams -ensure safety plan