How Can the Lens of Dislocation Theory Further Understanding of Why People Contemplate Suicide?

By

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Abstract

The reasons for suicide remain a widely researched topic. The majority of research on suicide offers reasons for suicide that are attributed to individuals having an underlying mental disorder. Research is needed on reasons for suicide that do not include underlying mental disorders. This thesis then asks, how can the lens of dislocation theory further understanding of why people contemplate suicide? Using a thematic analysis, this research yielded five reasons for suicide most commonly found in the current literature: depression, shame, burdensomeness, escape from pain, and isolation. In discussion, this thesis examines those five reasons through the lens of dislocation theory, presented by Alexander (2008). Dislocation theory is defined by enduring a lack of psychosocial integration, essentially feeling physically, emotionally, psychologically, and/or spiritually disconnected from others (Alexander, 2008). Findings conclude that the reasons for suicide can be understood differently when viewed through the lens of dislocation theory and offer insight into the individuals’ broader social context that contributed to suicide.

Keywords: suicide, depression, shame, burdensomeness, escape from pain, isolation, dislocation
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Dedication

This thesis is dedicated to all of the people who have suffered, struggled, supported, grieved, and lost to suicide. Each story of resilience, agency, dignity, strength and pain, I carry with me as I continue to search for greater understanding of suicide.
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Chapter One

According to the Canadian Association for Suicide Prevention (2016), ten people die each day by suicide. For every one death, it is estimated there are twenty-five to thirty previous suicide attempts (Canadian Association for Suicide Prevention, 2016). Additionally, the Canadian Association for Suicide Prevention (2016) states that for every one death by suicide, there are seven to ten people profoundly affected by this loss. These statistics are purely estimates, and their validity and reliability are limited in large part to the societal stigma still associated with suicide; because of this stigma, health professionals and family members may avoid reporting deaths as suicides (Canadian Association for Suicide Prevention, 2016; McIntosh, 2009).

As important as it is to understand the current landscape of suicide in Canada, it is equally important to understand its history. The term suicide was first used in the year 1651, and is derived from the Latin suicidium, which is a combination of the pronoun for ‘self’ and the verb ‘to kill’ (McIntosh, 2009). Despite the term suicide being rather recent, there is vast evidence of this act present throughout history. For example, ancient Greek and Roman philosophers made arguments either defending suicide (e.g. Seneca, Cicero), or condemning it (e.g. Pythagoras, Aristotle, Plato) (McIntosh, 2009). The concept of suicide is also present in the teachings of many religious groups, either strongly against or with more ambivalent viewpoints around it (McIntosh, 2009; Durkheim, 1952). For example, inside the Vedas, a collection of ancient Indian texts, references to self-killing and the promotion of it can be found dating back to 4,000 BC (Beattie & Devitt, 2015). Religions that were against the act of suicide, such as the Roman Catholic Church, influenced many laws regarding suicide (McIntosh, 2009). Some of these laws included refusal of burial and possible excommunication of the family (McIntosh, 2009). In
some cases, the bodies of individuals who died by suicide were even dragged through the streets by horses or thrown in the sewer (McIntosh, 2009). Around the mid-1800’s, attitudes toward suicide began to change from being sinful to a sign of insanity, or of an “unsound” mind (McIntosh, 2009). It may be that these historical laws and religious views created and cultivated the societal shame and stigma associated with the taking of one’s own life that continues into the present day.

Currently, the majority of research on suicide and suicidal risk factors states that the biggest risk factor for suicidal ideation is having a current underlying mental disorder (Money & Pridmore, 2017; Hjelmeland & Knizek, 2017; Canadian Association for Suicide Prevention, 2016; Pridmore, 2015). However, in 1867, French sociologist Emile Durkheim introduced the concept that suicide might be a social phenomenon, proposing that individuals who are not integrated into society are at risk of suicide. This was the first introduction to an alternative view of reasons for suicide that did not include an underlying mental disorder (Pridmore, 2015; McIntosh, 2009; Durkheim, 1952).

When researching suicidal ideation, much of the data is limited to rationales claiming underlying mental disorders as the primary reason. Some writers frame suicidal ideation as a problem that exists within the person themselves, via a diagnosis of a mental disorder (Brown, Comtois & Linehan, 2002; Hjelmeland & Knizek, 2017), while others believe that this view ignores the broader social context of what is going on in the lives of these individuals (Pridmore, 2015, Money & Pridmore, 2017). This thesis interprets common themes from research on suicide and suicidal ideation through the lens of Alexander’s (2008) dislocation theory in order to gain greater understanding of individuals’ lived experience with suicidal ideation. In particular, it asks...
how can the lens of dislocation theory further understanding of why people contemplate suicide. This theory will be described in detail later in this chapter as well as in chapter two.

**Significance**

Each day in Canada 10 people will end their lives by suicide and 200 more will attempt to do the same (Canadian Association for Suicide Prevention, 2016). For this reason alone, continued research is needed on this subject. There has been research conducted on suicidal ideation and isolation (DeMartini, 2014), suicidal ideation and shame and guilt (Keats, 2012), suicide and Borderline Personality Disorder (Brown, Comtois, & Linehan, 2002), and suicide and stigma (Frey, Hans, & Cerel, 2016), among others. Although widely researched, this thesis integrates the common themes from previous research into one document that has the potential to be used as a reference. To my knowledge however, no research has been done examining suicide through the lens of the dislocation theory, which has the potential to add an additional layer of contextual information to the themes from the research. The outcome may be relevant to the field of counselling, psychotherapy, and psychiatry for the treatment planning of individuals experiencing suicidal ideation. Also, it has potential relevance to organizations and policy makers in regards to prevention and intervention programs, as well as the development of resources more specifically tailored to individuals experiencing suicidal ideation. This information might also provide insight and resources to caregivers of individuals experiencing suicidal ideation.

**Definitions**

In order to define dislocation, it is important to define psychosocial integration. Alexander (2008) defines psychosocial integration as “the necessity of integrating social belonging and individual autonomy for the achievement of human wholeness” (p. 58). For the
purposes of this thesis, the dislocation theory presented by Alexander (2008) is defined as “an enduring lack of psychosocial integration, no matter how it comes about” (p. 59). The process of dislocation can occur in someone who has been geographically separated from their community through war and poverty, or even in someone who has never left home, but feels isolated and disconnected from their social context (Alexander, 2008).

Suicidal ideation is a term that will be frequently used throughout this document. For the purposes of this thesis, the Sage Encyclopedia definition by Chesin and Singh (2017) will be used. They define suicidal ideation as:

Thinking about ending one’s own life. Suicidal ideation ranges in severity from infrequent, fleeting wishes to be dead or thoughts that life is not worth living to persistent contemplation of killing oneself. The latter type of suicidal ideation is referred to as active suicidal ideation. Severe active suicidal ideation includes specific plans that include how an individual would kill himself or herself and intention to act on these thoughts. (p. 3399)

The term suicide is generally defined using words that associate its meaning with a crime (i.e. “commit”). Underpinning this word choice is the fact that suicide was a crime up until 1971, when suicide was decriminalized in Canada (McIntosh, 2009). Despite the legal connotations no longer fitting, suicide is still defined in the Oxford English Dictionary as:

Suicide, n\(^1\). – One who dies by his own hand; one who commits self-murder. Also one who attempts or has a tendency to attempt suicide

Suicide, n\(^2\). – The act of taking one’s own life, self-murder

Suicide, v. – To commit suicide
The term resistance is also one that is used throughout this thesis; Wade (1997) defines resistance to violence and oppression as:

Any mental or behavioral act through which a person attempts to expose, withstand, repel, stop, prevent, abstain from, strive against, impede, refuse to comply with, or oppose any form of violence or oppression (including any type of disrespect), or the conditions that make such acts possible, may be understood as a form of resistance. (p. 25)

The language used to describe suicide is important as it either conceals or highlights individuals’ resistance; the term “committing suicide” hides victims’ resistance to violence and oppression (White et al., 2016, Wade, 1997). In more current literature and training, individuals are discouraged from using the words “commit” suicide and instead introduce phrases such as “complete suicide,” “die by suicide” and “suicided” (Applied Suicide Intervention Skills Training, personal communication, October 2016; White et al., 2016).

**Personal Connection to the Topic**

Imagine feeling hopeless and alone, feeling profound sadness and indescribable pain, and feeling disconnected from the people around you to the point where you consider taking your life. Imagine feeling this way and then being told by a doctor, psychologist, psychiatrist, therapist, social worker, and family and friends, people to whom you have looked for help, that the reason you feel like this is because you have something fundamentally disordered within you. You have “depression”; you have “borderline personality disorder”; in other words, you are told that the problem lies within you.

Throughout my life suicide and suicidal ideation is something that I have been face-to-face with both personally and professionally. As a young teenage girl who felt completely
misunderstood by the world, alone and abandoned by people who were supposed to care the most, I responded to my situation with passive suicidal ideation. Although I did not ever attempt to take my life, I can understand the feelings associated with those thoughts as I too have experienced them. In those moments, I felt helpless and hopeless and disconnected from the people closest to me. I felt as though no one could hear me when I talked, no one was really listening.

Additionally, through my professional work at a high-risk mental health and substance use clinic and through providing counselling services to adults experiencing suicidal ideation, I have witnessed the courage and vulnerability it takes for each person to reach out for help. Like many others, I have lost several friends, co-workers, and clients to suicide and countless more who have experienced suicidal ideation in their lives, some on a daily basis. I have been a support and ally to individuals who have lost people to suicide and experienced their complex feelings of grief and helplessness. I have felt the utter relief of supporting someone through a crisis of contemplating suicide, and the tremendous heartbreak of receiving the news that they took their life. It is for these reasons that I write this thesis, for all the people that I and countless others have lost. Their stories are the ones that I carry with me and give me hope that greater understanding can be found.

Nature of the Study

Throughout history, modern medicine has maintained that suicide is triggered by an underlying mental disorder (Money & Pridmore, 2017; Hjelmeland & Knizek, 2017; Joiner, Buchman-Schmitt, & Chu, 2017; Pridmore, 2015). Over the past three years, I have worked with individuals experiencing suicidal thoughts, which has allowed me to bear witness to the strength and courage of these individuals. I have observed that the majority of treatment planning is based
on the underlying premise that there is something fundamentally wrong with these individuals, and this generally results in varying Diagnostic Statistical Manual 5th edition (DSM-V) diagnoses of a mental disorder. Within the treatment plans for these people, there is a limited account of the greater social context in which these thoughts are occurring. And yet, according to some researchers, it is possible that there might be more to the story. This begs the question of: How can the lens of dislocation theory further understanding of why people contemplate suicide?

Suicidal individuals face multiple variations of emotional and psychological experiences, of which dislocation is only one example (Alexander, 2008). Humans are social beings and psychosocial integration is essential to human life (Nitulescu, 2016; Alexander, 2008). Lack of psychosocial integration is what Alexander (2008) defines as dislocation. This thesis uses a thematic analysis of text-based, peer-reviewed data to explore common themes associated with how suicidal individuals respond to their social context through the lens of Alexander’s (2008) dislocation theory. This may provide further understanding to current beliefs based on the medical model, and may offer caregivers, support workers, and individuals themselves a broader grasp of suicidal ideation.

**Assumptions**

When treatment planning for individuals with suicidal ideation, reasons for living are considered protective factors that mitigate the risk of completing suicide (Brüdern et al. 2018; McIntosh, 2009). Victor Frankl, a psychiatrist and neurologist who developed logotherapy in the year 1926 to better help individuals whose outlook on life jeopardized their success with therapy, defined having a reason to live as a belief the person has something meaningful in their life (Frankl & Batthyány, 2010). It is the belief of mental health professionals based on their research
that increasing reasons to live (i.e. protective factors) is a successful intervention (Frankl & Batthyány, 2010).

**Limitations**

This thesis is a step toward further research in this area, and is drawing specifically on previously published research. The population used most frequently in past and current research is dominantly individuals within inpatient units. However, there are immeasurable differences amongst specific populations of individuals such as age, ethnicity, religion, gender, and socioeconomic status, as they relate to suicide. These populations each deserve the respect and honour of their own specific research on this topic, as each demographic can have vast differences in how they respond to suicide and suicidal ideation. With this being said, there could also be similarities that can be applicable from this research to different demographics, and for this reason I do cite research done in other countries.

**Ethical Consideration**

The topic of suicide and suicidal ideation is one that is sensitive to many people, and in reading this thesis there may be research, accounts of individual’s experiences, or words that generate an emotional response in someone. For this reason, please ensure you as the reader are mindful of how you are responding to this information; take breaks if you need, be gentle with yourself, seek help, seek connection, reach out, talk to someone, know that you are not alone in this. If you are in need of support please call your local crisis line – Vancouver Island Crisis line 1-888-494-3888, police, or access an online crisis chat.
Chapter Two: Literature Review

In order to view suicidal ideation through the lens of the dislocation theory, it is essential to first understand the context in which suicidal ideation is more commonly considered. Providing a contextual background on this topic builds the foundation upon which the themes included in this thesis have been identified. Prior to conducting my research, I completed a literature review of City University of Seattle’s online databases. Specifically, my searches included the general terms “reasons for suicide” and “causes of suicide.” These searches were purposely limited to peer reviewed articles from the last five years, in order to privilege the most recent and current research. After this preliminary search, I organized the data into two categories. Following the literature review, the second round of data collection was used to complete a thematic analysis, which will be explained in detail in chapter three.

Many of the current theoretical explanations of suicide and suicidal ideation focus on a single area or issue, overlooking the possible multiplicity of factors in individual incidents of suicide (McIntosh, 2009). The need for a more integrated theory of suicide is necessary in order to increase prevention and intervention strategies (McIntosh, 2009). The dislocation theory created by Alexander (2008) will be reviewed below as it is based on theory that takes into account multiple factors that might contribute to an individual’s behavior (e.g. addiction, suicide).

The current literature on suicide and suicidal ideation can be split into two clear themes: research that suggests the reason for suicide is the presence of an underlying mental disorder (Hjelmeland & Knizek, 2017; Kene & Hovey, 2014; Price, 2012; Brown, Comtois & Linehan, 2002), and research that suggest reasons for suicide that do not include mental disorders (Akotia, Knizek, Hjelmeland, & Kinyanda, 2019; Brüdern et al., 2018; Money & Pridmore, 2017). In the
following section I will outline the research that claims mental disorders are the reason for suicide. I will then review the literature that attributes suicidality to causes other than mental illness.

**Underlying Mental Disorder as Motivation for Suicide**

For decades, modern medicine has claimed the reason for an act of suicide is the presence of an underlying mental disorder (Money & Pridmore, 2017; Hjelmeland & Knizek, 2017; Joiner, Buchman-Schmitt, & Chu, 2017; Brown, Comtois & Linehan, 2002). Service providers come to these diagnoses through clinical assessment tools such as the DSM-V. Among the most common diagnoses for individuals with suicidal ideation are: post traumatic stress disorder (PTSD), depression, and borderline personality disorder (BPD) (Hjelmeland & Knizek, 2017; Kene & Hovey, 2014; Price, 2012; Brown, Comtois & Linehan, 2002).

**Post traumatic stress disorder.** Current literature indicates that having the diagnosis of post traumatic stress disorder is a major risk factor for suicide (Martin, Vujanovic & Day, 2017; Bentley et al., 2015; Price, 2012). PTSD is defined in the DSM-V as:

- Exposure to actual or threatened death, serious injury, or sexual violence by either directly experiencing the event, witnessing the event, learning about the event as it occurred to a close family or friend, or experiencing repeated or extreme exposure to aversive details of traumatic events. (American Psychological Association, 2013, p.265)

Based on this definition, individuals must also have the presence of one or more of the following symptoms:

- Recurrent, involuntary and intrusive distressing memories of the event, recurrent distressing dreams of the event, dissociative reactions such as flashbacks of the event, intense or prolonged psychological distress at the exposure to internal or external cues
that may resemble the event, and/or marked physiological reactions to internal or external cues that resemble the event. (American Psychological Association, 2013, p. 265)

Trauma is said to “destabilize a person’s basic beliefs in the self and the world,” essentially creating a lived experience that the world is not safe (Keats, 2012, p. 623). Although not all traumatic events produce a diagnosis of PTSD, individuals with this diagnosis are said to be 5 times more likely to complete suicide (Price, 2012). Price (2012), a prominent researcher for the National Institute of Mental Health states: “Women with sexual abuse treated in a psychiatric setting reported that 50% to 70% have made a suicide attempt; studies of veterans report that as many as 35% of combat veterans exhibit suicidality” (p. 658). Professors in the department of Psychology from the University of Houston, Texas, Martin, Vujanovic & Day (2017), conducted research with 128 adults in acute-care psychiatric inpatient settings. They claimed that individuals with high levels of PTSD symptom severity combined with problems in emotion regulation displayed the highest levels of suicidal ideation (Martin, Vujanovic & Day, 2017). Additionally, childhood experiences of trauma have been found to decrease one’s reasons for living (Rieger, Peter & Roberts, 2015). Similarly, researchers from Boston University, that used literature from 180 cases where anxiety was used to predict suicidality, claimed that having a diagnosis of PTSD had the largest overall effect of all anxiety disorders, on risk of suicide attempts (Bentley et al., 2015). They concluded from their meta-analysis that acute heightened arousal was more often associated with suicide deaths, urging further research into the difference between the role of anxiety disorders such as PTSD and general affective states of anxiety. Chronic PTSD may, over time, develop into depression (Price, 2012).

The research above is clearly based on the assumption that suicidality is caused by individual pathology, as something disordered and in need of being fixed. However, not all
researchers agree. Dr. Allan Wade, a professor, and researcher associated with the development of Response Based Practice, (Wade, 2000), stated that: “85 to 90 percent of people with a mental illness diagnosis have experienced some form of trauma or violence in their lives” (Allan Wade, personal communication, Feb.18th, 2017). From a Response Based Theory perspective then, those who are suicidal have been victims of violence and rather than being flawed or weak are instead, shown to be resisting or showing strength in attempting to preserve their own sense of dignity (Wade, 2000).

**Depression.** It has been argued that depression, compared with other psychiatric disorders, is one of the strongest risk factors associated with suicidal behaviour, including ideation and attempts (Luo, Wang, Wang, & Cai, 2016; Rieger, Peter & Roberts, 2015; Pridmore, 2015; Schaller & Wolfersdorf, 2010). Although there are different diagnoses and severities of depression, when referring to depression the majority of research uses the definition of major depressive disorder, defined by the DSM-V as five or more of the following symptoms present in the same two-week period:

- Depressed mood most of the day, close to every day, diminished interest in all or most activities, significant weight loss, insomnia or hypersomnia close to every day,
- Psychomotor agitation or retardation, fatigue or loss of energy, feelings of worthlessness or excessive guilt, decrease in ability to concentrate, recurrent thoughts of death including suicidal ideation. (American Psychological Association, 2013, p.161)

By studying psychological autopsies of psychiatric inpatients, Schaller and Wolfersdorf (2010) claim that 40 to 60 percent of all people who died by suicide had a diagnosis of major depressive disorder. Individuals with depression are characterized as having negative or pessimistic thoughts, feeling like life has no meaning, and lacking confidence in the future (Luo et al., 2016).
These characteristics are said to increase levels of suicidal ideation. In one study, a middle-aged man talks about his experience with depression:

The problem with depression is that it’s, it’s a series of, of negative introspective thoughts that consume you, that, uh, you don’t know how to deal with and the only way to deal with getting rid of them is to get rid of yourself. (Oliffe et al., 2019, p. 323)

Some researchers report that when working with individuals with depression, care providers must help individuals to discover meaning in their life and to increase their reasons for living in order to decrease the risk of suicide (Luo, Wang, Wang, & Cai, 2016). Others insist that it is a combination of antidepressant medication and psychotherapy that is the most successful in treating depression and decreasing risk of suicide (McIntosh, 2009; Pridmore, 2015). Much like the research on PTSD and suicide, the literature on depression and suicide shows the pathologizing of the individual by the medical system. While a link has been shown between having a diagnosis of depression and suicidality, it is not a necessary cause of suicide as not all diagnoses of depression result in suicidality (Pridmore, 2015). Researchers do not appear to have explored the broader context in which the individual’s responses occur.

**Borderline personality disorder.** Suicidal behavior is a common trait of individuals diagnosed with Borderline Personality Disorder (Hayashi et al., 2017). BPD is defined by the DSM-V as “a pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity, beginning by early adulthood and present in a variety of contexts” (American Psychological Association, 2013, p. 663). Suicidal behavior including gestures, threats, and self-mutilation is said to alleviate the persistent distress and interpersonal dysfunction caused by BPD (Hayashi et al., 2017). The existing research on BPD shows conflicting viewpoints around self-mutilation. For example, in a study of 104 adolescent
inpatients and 290 adult inpatients with BPD, adolescents engaged in higher levels of self-mutilating behavior than adults with BPD; however, adults are more likely to have a history of numerous suicide attempts (Goodman et al., 2017). Other research contends that a diagnosis of BPD is associated with non-suicidal self-injury and threats of suicide rather than actual attempts or completed suicides (Homan, Sim, Fargo, & Twohig, 2017; Tillman et al., 2017). Another study states that BPD alone does not predict suicide, but when it is co-occurring with bipolar disorder the frequency of attempts is increased (Zimmerman et al., 2014).

In all of these studies, the focus appears to be on linking diagnosis to suicidality without studying the social context of the person’s life. The diagnoses, again place the problem within the individual rather than as an adaptive, resourceful and protective response to what is happening in their life. It is important to note that many of the research studies claiming mental disorders as reasons for suicide are conducted on individuals who are currently inpatients at psychiatric facilities and therefore already have a current diagnosis of a mental disorder (Hayashi et al., 2017; Goodman et al., 2017; Tillman et al., 2017).

**Reasons that Do Not Include Underlying Mental Disorders**

Contrary to the traditional medical model, there have been numerous studies done on reasons for suicide that do not focus on underlying mental disorders: these alternative reasons include exhaustion, escape from pain, shame and guilt, and isolation (Brüdern et al., 2018; Money & Pridmore, 2017; Hjelmeland & Knizek, 2017; Pridmore, 2015). There is no denying the link between mental disorders and suicide; however, there are many people with diagnosed mental disorders who do not experience suicidal ideation (Brüdern et al., 2018). Understanding mental disorders as the sole risk factor or the reason for suicide has a limited power in understanding this phenomenon (Akotia et al., 2019; Brüdern et al., 2018). Instead of being
supported by the medical model of suicide, which focuses on biological causes for suicide such as DSM-V diagnoses, much of this research is based on the socio-cultural theoretical standpoint of suicide which examines factors within an individual’s social and cultural context (Akotia et al., 2019; Money & Pridmore, 2017; Hjelmeland & Knizek, 2017; Pridmore, 2015). Reasons for suicide are linked to beliefs individuals have about themselves and about the world around them (Kene & Hovey, 2014). These beliefs cause individuals to perceive stressors differently and either serves to confirm or deny their beliefs and can contribute to a reason for suicide (Kene & Hovey, 2014).

Akotia et al., (2019), professors in the department of Psychology at the University of Ghana, Africa, outline that much of the research on suicide is based on the perspective of high-income Western countries and does not account for the socioeconomic factors influencing suicide rates in low- and middle-income countries. They propose an alternative to the Western view that states mental illness is the reason for suicide, wherein “social, economic, political, and cultural factors are significant precipitants of suicide” (2019, p. 234). From their research using thirty interviews of individuals who were hospitalized following a suicide attempt, they found that reasons for attempted suicide include: abandonment, shame, lack of support, existential struggles and supernatural reasons (2019). No DSM-V diagnoses are mentioned in the research.

**Exhaustion.** In a study where researchers examined 36 suicide notes left by individuals who completed suicide, the focus was on the influence of mental illness and mental health care in the completion of suicide: a common experience within the studied suicide notes was that the individual experienced exhaustion due to their illness and experiences with mental health treatments (Furqan, Sinyor, Schaffer, Kurdyak & Zaheer, 2018). One suicide note stated: “After trying multiple treatments, without curing my mental illness, I have realized that a solution other
than death just does not exist” (2018, p. 103). It is important to consider these words, “without curing my mental illness,” how the individual internalizes the pathologized language as if it is a part of them that cannot be cured. Society, mental health professionals, doctors and the community have been taught that diagnoses are necessary for suicide and are therefore working to prevent suicide from that model.

**Escape from pain.** Another stated reason for suicide listed in research is the escape from pain. “All behavior is motivated and directed toward attaining pleasure or avoiding pain. In painful circumstances which cannot be otherwise avoided, the cessation of life may be the only means of avoidance” (Money & Pridmore, 2017, p. 13). This pain can be physical, psychological, or emotional (Tillman et al., 2017; Money & Pridmore, 2017; Pridmore, 2015). The loss of a partner, loss of a child and loss of freedom are all experiences that can exhibit physical, psychological and emotional pain that can lead to someone taking their own life (Money & Pridmore, 2017). Researchers at the University of Tasmania, Money and Pridmore (2017), while providing examples from both ancient and current times concerning how losses can trigger suicide, support the argument that not all individuals who complete suicide have been diagnosed with a mental illness. This research asserts that suicidality could be a normal response to situations that are so overwhelming and hopeless that a person sees no other way of ending their suffering (Money & Pridmore, 2017). In another study of a high-risk group of psychiatric patients the term “psychache” was coined to define “an internal experience of intolerable psychological pain leading to suicide as a way to end or escape the pain” (Tillman et al, 2017, p. 21) and was found to be a major risk factor for suicide.

Specific to research on physical pain as a reason for suicide, Fegg, Kraus, Graw, & Bausewein (2016) studied suicide notes as well as medical and police reports of 1069 suicide
cases. From these, 202 cases clearly identified a physical disease as a reason for suicide, the most common physical diseases being cancer, chronic pain, and heart disease. While many of the medical records and autopsy results identified physical diseases, these conditions were not listed as the reason for suicide; therefore, Fegg et al., (2016) claim that the rate of physical diseases as a reason for suicide may be significantly higher. Additionally, there are many similarities in the research on escaping pain as a reason for suicide and depression, PTSD and BPD. All three of these diagnoses include symptoms of suffering, emotional, psychological and sometimes physical pain (Money & Pridmore, 2017; Hjelmeland & Knizek, 2017; Pridmore, 2015).

**Shame.** Shame is a powerful emotion that can direct people’s behaviors, create and foster identities, evaluate social acceptance, and alter attachments to others (Keats, 2012). Shame is an emotion felt both externally, from the reactions of others, or internally, in the ways that people judge and criticize themselves (Keats, 2012). In a recent study of reasons for attempting suicide in Ghana, Akotia et al., (2019) found shame to be a common reason among men to attempt suicide. Situations that the participants perceived as particularly disparaging to their social image were financial issues and marital infidelity (Akotia et al., 2019). It is important to note that in Ghana, and many other societies, the success of a man is measured based on his ability to provide economically for his family, and thus the failure of that might result in immense shame with suicide as one way to resolve it (Akotia et al., 2019). Shame was also associated with marital infidelity for men learning that their wife had been unfaithful to them: this produced feelings of shame in a society where infidelity by one’s wife can be interpreted as the failure to satisfy or provide for the wife (Akotia et al., 2019).

The experience of shame has been linked to symptoms associated with Depression and PTSD (Keats, 2012). Shaming experiences decrease one’s self-esteem and increase one’s self-
criticism, two characteristics closely linked with depression (Keats, 2012). Additionally, individuals with PTSD tend to be prone to higher experiences of shame (Keats, 2012). As stated above, shame is created and reinforced socially. For individuals with PTSD, shame is a reaction to the negative social responses they received before, during and after the traumatic event occurred, thus reinforcing the individual to feel like they are at fault, flawed and disordered.

**Isolation.** Isolation in relation to suicide can be generally defined as feeling different from others and/or feeling different from one’s typical self, resulting in feeling internally or externally isolated (American Psychological Association, 2013). Although mental disorders can cause feelings of aloneness and separateness from others, they are not the only reason for these feelings (DeMartini, 2014; Oliffe et al., 2019). Arguments have been made by researchers that a lack of support contributes to risk of suicide: this may include geographic separation from one’s family, or feeling unable to talk to family members about feelings (Akotia et al., 2019; Oliffe et al., 2019). This lack of support can lead to feeling both internally and externally isolated from families and communities: “My parents are not here…I cannot call on them…I call my mum on the phone…and she says she is tired of me and my calls” (Akotia et al., 2019, p. 237). Many individuals feel they have to hide their suicidal thoughts and feelings from the people around them in order to protect them, or feel previous attempts to share their thoughts have been minimized, which further isolates the individual:

For the past maybe year I’ve felt that way [suicidal]—but it’s—I don’t know—it’s weird, I haven’t really talked to my family about it at all, because the last thing you want is to worry them, but it’s . . . but I think for now it’s good. (Oliffe et al., 2019, p. 318)

A man aged 60-69 years old spoke about the societal stigma that isolates individuals:
I’m more of a loner … being diagnosed with a – mental health disorder, it’s not seen by the general public as the same as being diagnosed with any other kind of physical ailment… I always find myself feeling separate and feeling the subject of, uh, other people’s judgments. (Oliffe et al., 2019, p. 324)

It is clear that these researchers highlight the lived experience of these individuals through their own words (Oliffe et al., 2019). The voices of individuals who have experienced these feelings are powerful and are a testament to how isolation plays a large role in suicidal ideation.

**Dislocation Theory**

Dr. Bruce Alexander is a psychologist, researcher, and professor at Simon Fraser University in Vancouver, Canada. Frustrated by current addiction literature, he delved into historical literature and found powerful insights into addiction (Alexander, 2008). Alexander used a historical approach in creating dislocation theory to explain addiction as a societal problem, finding that societal determinants were much more powerful predictors of addiction than individual ones (Alexander, 2008). This is in stark contrast to the more accepted views in current literature that regards addiction as fundamentally an individual problem (Alexander, 2008). As mentioned in the introduction of this thesis, psychosocial integration is a necessity of human life:

[It] is a profound interdependence between individual and society that normally grows and develops throughout each person’s lifespan. Psychosocial integration reconciles people’s vital needs for social belonging with their equally vital needs for individual autonomy and achievement. (Alexander, 2008, p. 58)
Alexander (2008) argues that addiction is a way of adapting to sustained dislocation: “addiction is neither a disease nor a moral failure, but a narrow focused lifestyle that functions as a meager substitute for people who desperately lack psychosocial integration” (p. 62). Similarly, it may be possible that suicidal thoughts are too, a response to a lack of psychosocial integration. Although Alexander (2008) does not write specifically about suicide and dislocation, he does state that “[dislocation] …regularly precipitates suicide and less direct forms of self-destruction” (p. 59) due to the fact that prolonged dislocation leads to intolerable emotional anguish and shame.

While the research primarily associates suicidality with mental illness, many acknowledge that the current approach is not producing any change (Akotia et al., 2019; Money & Pridmore, 2017; Hjelmeland & Knizek, 2017; Pridmore, 2015). When considering dislocation theory, there are similarities between the experience of dislocation and the experiences outlined in the research on suicide. It is with this in mind that I chose to complete a thematic analysis of current literature, followed by an examination of the themes from that analysis through the lens of the dislocation theory.
Chapter Three: Methods

In this chapter, I outline the methodological framework for my approach and the thematic analysis used to investigate the thesis question. Additionally, I give explanations of the philosophical assumption of constructivism underpinning the research, and the thematic analysis method. This chapter includes the procedures for completing a thematic analysis, particularly regarding searching and collecting the data, the selection criteria, and the process of data examination.

This thesis asks: how can the lens of dislocation theory further understanding of why people contemplate suicide? This thesis focuses on methodologies that capture the voices of both academics and non-academics. For this reason, I chose a qualitative methodology due to its ability to provide rich detail and to place the research in existing theory (Braun & Clarke, 2006). Thematic analysis allows for the flexibility to explore, locate, organize, understand, and analyze data into different themes and sub themes while leaving space for both academic and non-academic literature (Braun & Clarke, 2006).

Philosophical Assumption

Philosophical assumptions are a set of beliefs that guide the nature of research presented by a researcher (Creswell, 2014). Each philosophical assumption views the world in distinctly, which influences the way the research is done (Creswell, 2014). In addition, all theoretical frameworks carry with them their own set of assumptions about the nature of data and what it represents (Creswell, 2014; Braun & Clarke, 2006). Thematic analysis’s flexibility lends itself to many different theoretical frameworks and has a specific philosophical assumption, which is discussed below.
Constructivist Approach

The constructivist approach to research is grounded in the belief that individuals seek understanding of the world through developing subjective meaning in their experiences (Creswell, 2014; Braun & Clarke, 2006). In addition, a constructivist method “examines ways in which events, realities, meanings, [and] experiences are the effects of a range of discourses operating within society” (Braun & Clarke, 2006, p. 81). Subjective meaning is formed through an individual’s interaction with society, as well as through social and cultural norms that influence what is socially acceptable and what is not (Creswell, 2014). This approach focuses on research that is based on the contexts in which people live their lives (Creswell, 2014). As this thesis is oriented toward the social context of people’s lives, the purpose is to place the reasons for suicide within this social context. Without the consideration of social context and how this context is influenced by societal norms, the person contemplating or completing the act of suicide may be viewed as selfish, insane or deeply disturbed (Pridmore, 2015; Turnbull, 2014).

Thematic Analysis

Within the field of social sciences, especially psychology, thematic analysis is a popular choice of methodology for research, yet it is rarely acknowledged due to its flexibility and multiple interpretations within many different types of research (Braun & Clarke, 2006). Thematic analysis is an evidence-based method that provides the researcher with the ability to capture data from a review of current literature that includes both academic and non-academic perspectives (Creswell, 2014). Thematic analysis also allows the researcher to thoroughly analyze and describe patterns (Creswell, 2014), or meanings (Braun & Clarke, 2006) within and across the data set.
Furthermore, this thesis is considered a theoretical thematic analysis as the coding was aimed at a particular research question (Braun & Clarke, 2006). Themes can be defined as “patterns across the data set that captures something important on the data and ideas on the thesis question” (Braun & Clarke, 2006, p. 82). A theoretical thematic analysis looks for “latent” themes that go beyond the semantic meaning of what has been written in an attempt to summarize and interpret deeper meanings (Braun & Clarke, 2006). For this study, a thematic analysis methodology supports the goal of gaining greater understanding of the themes from existing research on reasons for suicide. To conduct this research, this thesis uses the six phases of thematic analysis proposed by Braun and Clarke (2006): these phases are not strictly linear as there is often movement back and forth between phases.

**Thematic Analysis Process**

**The search and collection of data.** The first phase asks the researcher to familiarize themselves with the data: this involves an exhaustive search for potential articles using search terms from the thesis question (Braun & Clarke, 2006). After general search terms yielded unmanageable results (see Table 1), I selected search terms with a specific focus from the previous searches. To narrow the search results, filters were applied to include only peer-reviewed data, data published within the last 5 years, and data that was directly related to the field of psychology. In addition to searching the City University of Seattle library, I also used Google Open, Google Scholar, and the Canadian Association for Suicide Prevention website to provide further content.

Throughout the research process, it was important to position myself as a witness to what the data was saying, and to be forthcoming about how my own perspectives and biases may
colour the emerging themes (Nowell, Norris, White, & Moules, 2017). In order to achieve this, I used multiple readers to ensure that the data was accurately being captured.
Table 1

Data Search Results

<table>
<thead>
<tr>
<th>Database</th>
<th>Search Terms</th>
<th>Number of Documents</th>
</tr>
</thead>
<tbody>
<tr>
<td>City University of Seattle</td>
<td>Suicide</td>
<td>5,007,306</td>
</tr>
<tr>
<td>City University of Seattle</td>
<td>Reasons for suicide</td>
<td>891,031</td>
</tr>
<tr>
<td>City University of Seattle</td>
<td>Reasons for suicide (limited to the last 5 years)</td>
<td>208,349</td>
</tr>
<tr>
<td>City University of Seattle</td>
<td>Reasons for suicide (limited to the last 5 years in the field of psychology)</td>
<td>5,675</td>
</tr>
<tr>
<td>City University of Seattle</td>
<td>Suicide and social context</td>
<td>3,214</td>
</tr>
<tr>
<td>City University of Seattle</td>
<td>Reasons for suicide and social context</td>
<td>2,155</td>
</tr>
<tr>
<td>City University of Seattle</td>
<td>Cause of suicide (limited to the last 5 years)</td>
<td>4,057</td>
</tr>
<tr>
<td>Google Scholar</td>
<td>Reasons for suicide and social context</td>
<td>997,000</td>
</tr>
<tr>
<td>Google Scholar</td>
<td>Reasons for suicide and social context (limited to the last 5 years)</td>
<td>16,600</td>
</tr>
<tr>
<td>Google Scholar</td>
<td>Cause of Suicide (Limited to the last 5 years)</td>
<td>60,400</td>
</tr>
<tr>
<td>Google Scholar</td>
<td>Why people die by suicide</td>
<td>22,300</td>
</tr>
</tbody>
</table>

Table 1. Data Results from Databases
**The selection criteria.** Due to the sheer volume of research done connecting reasons for suicide and social context, specific criteria were used to select the articles for the thematic analysis. The main purpose of the inclusion and exclusion process was to establish the significance of what the literature had to say (Creswell, 2014). To determine eligibility for inclusion in this study, countless articles were read from abstract to conclusion in order to ensure the article answered the thesis question (Braun & Clarke, 2006). Exclusion criteria included research that was not directly related to the thesis question, research that did not use terms and concepts within the thesis question, research that was not done in the English language, and research that did not yield a specific definable reason for suicide. Additionally, research that yielded more than one reason for suicide was excluded as there was no way to define a clear theme within the parameters of this study. Inclusion criteria consisted of research that was directly related to the thesis question, used terms and concepts within the thesis question, and found a clear and definable reason for suicide. Additionally, I strove to find research that included the voices of individuals with suicidal thoughts or data gathered from suicide notes of individuals who had completed suicide. To be included in this study, non-academic articles needed to contain specific reference to the thesis question. Also, the articles that included the voices of individuals who had experienced suicidal thoughts or completed suicide were given precedence. For example, this would show up through the utilization of suicide notes left from people who have attempted or completed suicide.

**Data Examination**

Next, I examined the body of data produced by the searches. The search engines produced documents in the millions: a large number of the documents produced by these searches contained information that was not relevant to the thesis question. For example, City
University of Seattle’s library search for “reasons for suicide and social context” that yielded 2,155 results, of the first 400 documents – 59 documents met the inclusion criteria. From the entire body of data, 67 documents met the inclusion criteria for this thesis, within which 59 were academic articles and 8 were non-academic articles. I then saved all articles on an external hard drive, creating folders organized by themes based on each article and then classifying the articles into corresponding folders. Overall, 67 documents were chosen for further analysis.

Next, I engaged in an intensive analysis of the data by becoming familiar with all 67 articles (Braun & Clarke, 2006). For example, I read and highlighted the documents and made notes on themes that arose from the readings. During this collating phase of analysis, I ensured that each document included a clear theme that pertained to a reason for suicide. Articles that did not produce a clear theme were put in a miscellaneous folder. This intensive analysis used inductive logic, otherwise known as a bottom up approach (see Flow Chart 1) (Braun & Clarke, 2006). From the 67 documents, 25 articles were chosen for analysis based on the inclusion criteria of this study, within which 23 articles were peer reviewed academic research and 2 articles were non-peer reviewed research. With these 25 articles that met the inclusion criteria, I created an extensive reference list and table to organize the articles in a coherent way (see table 2).
Flow Chart 1: Logic Used for Article Selection

- Data set = 67 articles
- 59 academic articles
- 8 non-academic
- 23 academic articles chosen
- 2 non-academic articles chosen
- n = 25
Review of Themes

In the fourth phase of analysis, I reviewed the identified themes (see Table 2) and made decisions about which themes were too broad, did not have enough data to support them, or perhaps needed to be readjusted (i.e. combined or separated) (Nowell, Norris, White, & Moules, 2017). For example, the theme of “physical reasons” for suicide was merged with the theme “escape of pain.” Also, the theme of “loneliness” was combined with the theme “isolation.”

Reviewing these themes involved two levels of review. First, themes are reviewed to ensure coherency—they had to make sense in the context of the thesis question. If they were coherent, I moved on to level two which involved re-reading the entire data set to ensure themes accurately represented the data (Braun & Clarke, 2006). This level also gave the opportunity to consider any additional themes that may have been missed (Braun & Clarke, 2006).
<table>
<thead>
<tr>
<th>#</th>
<th>Author</th>
<th>Theme</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Crowder &amp; Kemmelmeier (2018)</td>
<td>Shame</td>
</tr>
<tr>
<td>3</td>
<td>Li et al., (2017)</td>
<td>Depression</td>
</tr>
<tr>
<td>4</td>
<td>Fegg, Kraus, Graw, &amp; Bausewein, (2016)</td>
<td>Physical Reasons</td>
</tr>
<tr>
<td>5</td>
<td>DeMartini, (2014)</td>
<td>Isolation</td>
</tr>
<tr>
<td>6</td>
<td>Heelis, Graham, &amp; Jackson, (2016)</td>
<td>Burden</td>
</tr>
<tr>
<td>7</td>
<td>Ibrahim, Amit, &amp; Suen, (2014)</td>
<td>Depression</td>
</tr>
<tr>
<td>9</td>
<td>Lamis et al., (2014)</td>
<td>Depression</td>
</tr>
<tr>
<td>11</td>
<td>Hill &amp; Pettit, (2014)</td>
<td>Burden</td>
</tr>
<tr>
<td>12</td>
<td>Cerel, Frey, Maple, &amp; Kinner, (2016)</td>
<td>Family Stressors</td>
</tr>
<tr>
<td>13</td>
<td>Morrison &amp; Hopkins, (2019)</td>
<td>Depression</td>
</tr>
<tr>
<td>15</td>
<td>Chen, Kang, &amp; Lin (2017)</td>
<td>Depression</td>
</tr>
<tr>
<td>16</td>
<td>Goldblatt et al., (2016)</td>
<td>Escape from Pain</td>
</tr>
<tr>
<td>17</td>
<td>Li, Li, Wang, &amp; Bao, (2016)</td>
<td>Hopelessness</td>
</tr>
<tr>
<td>18</td>
<td>Cockshaw, Shochet, &amp; Obst, (2014)</td>
<td>Isolation</td>
</tr>
<tr>
<td>19</td>
<td>Chung, Ryan, &amp; Large, (2016)</td>
<td>Adverse Experience in Hospital</td>
</tr>
<tr>
<td>20</td>
<td>Soole, Kõlves, &amp; De Leo, (2014)</td>
<td>Rural Area</td>
</tr>
<tr>
<td>22</td>
<td>Oliffe et al., (2019)</td>
<td>Isolation</td>
</tr>
<tr>
<td>23</td>
<td>Pompili et al., (2015)</td>
<td>Depression</td>
</tr>
<tr>
<td>24</td>
<td>Turnbull, (2014) – Google scholar</td>
<td>Isolation</td>
</tr>
</tbody>
</table>
Defining Themes

In the fifth phase of analysis, themes were defined and named. To do this, I made decisions about what part of the data each theme represented and wrote a detailed analysis about why that theme is relevant as well and how it contributes to the interpretation of the data (Braun & Clarke, 2006; Nowell, Norris, White, & Moules, 2017). At this phase, it was essential to define what a particular theme was and what it was not; if that was not possible, then further refinement of the themes was required (Braun & Clarke (2006). To further identify themes, I used a latent approach, which refers to seeking to understand the core ideas and assumptions that are informing the theme through it’s underlying meaning and messages that may be embedded (Braun & Clarke, 2006). A latent approach helps in understanding how each theme may intersect, overlap, or include aspects of the dislocation theory. A latent approach allows the researcher to look beyond the semantic meaning of a theme and interpret the underlying meaning and assumptions that make it up (Braun & Clarke, 2006). For instance, when talking about someone stating that they are sad, a latent approach would allow researchers to further identify and explore what was beneath that feeling such as this person was grieving the loss of their mother instead of just using the semantic, face value, meaning of sad. This is particularly useful when looking at the themes of this thesis through the lens of the dislocation theory. In no particular order, the five final themes that were identified after the fifth phase of thematic analysis were: depression, isolation, shame, burden, and escape from pain.

Report

The last phase of a thematic analysis involves producing a report that interweaves the literature with the research findings (Nowell, Norris, White, & Moules, 2017). In chapter four of this thesis, each of the five final themes are interpreted and examined using a latent approach.
This approach will also assist in viewing themes through the lens of the dislocation theory, which will be done in chapter five.
Chapter Four: Results

After analyzing the 25 documents, these five themes kept emerging from the search results as the main reasons for contemplating or completing the act of suicide: depression, shame, burdensomeness, escape from pain, and isolation. In this chapter, I examine the data set and provide an analytic narrative by discussing each theme (Braun & Clarke, 2006). In chapter five, each theme is discussed in relation to dislocation theory.

Summary of Themes

**Depression.** The majority of research that has been done on reasons for suicide claim that depression is the strongest risk factor for completion of suicide (Morrison & Hopkins, 2019; Li et al., 2017; Chen, Kang, & Lin, 2017; Lamis et al., 2014; Ibrahim, Amit, & Suen, 2014). The theme of depression as a reason for suicide was present in eight documents out of the dataset of 25 documents, which was the largest number of documents specific to one theme. Although depression is named as the strongest risk factor for suicide, the majority of the research also concluded that hopelessness in combination with the symptoms of depression predicted the strongest risk of completed suicide (Morrison & Hopkins, 2019; Li et al., 2017; Pompili et al., 2015; Lamis et al., 2014).

Chen, Kang, & Lin (2017), professors and researchers from Quanzhou Normal University in China, studied suicidal ideation and behavior in Chinese university students. They found that individuals with a higher level of knowledge about suicidal behavior, even if they were highly depressed, were able to better manage their own suicide risk. Therefore, they suggest that increasing the availability of information on suicide and prevention strategies may help suicidal individuals protect themselves during suicidal episodes (Chen, Kang, & Lin, 2017).
Additionally, some of the research aimed to demonstrate reasons other than depression for suicide, such as anxiety or family stressors. Nonetheless, the results corroborated the claims in previous literature that depression was the largest reason for suicide rather than what might be identified as social context leading to depression (Cerel, Frey, Maple, & Kinner, 2016; Ibrahim, Amit, & Suen, 2014). For example, the document that stated “family stressors” as the reason for suicide indicated that 67.4% of all participants had major depressive disorder (Cerel et al., 2016). Furthermore, individuals following a stroke are said to be at increased risk of suicide due to depression categorized by feelings of hopelessness, helplessness, and social isolation (Pompili et al., 2015).

The research conducted by Cerel et al., (2016), professors in the Department of Social Work at the University of Kentucky, privileged the voices of participants who focused on family stressors (yet had diagnoses of depression) as the reason for suicidal thoughts:

I tried to call my daughter ... and whoever answered the phone was some girl had said [my daughter] did not want to talk to me and I heard my daughter’s voice in the background saying ... ‘I don’t want anything to do with her.’ And I felt so bad, like I don’t deserve to live. (p. 2333)

It is important to note that not all individuals who have depression are suicidal. Yet the research shows how powerful the symptoms of depression can be when paired with other occurrences, such as family stressors and hopelessness (Chen, Kang, & Lin, 2017; Cerel, Frey, Maple, & Kinner, 2016). Another example is the research done by Li et al. (2017), professors at Medical Universities in China that studied Chinese outpatients from four different hospitals. They concluded that anxiety and depression commonly occur together in patients presenting at
hospital, and the presence of anxiety indicates a higher likelihood of suicidal ideation (Li et al., 2017).

**Shame.** Shame is an emotion created in public but suffered in private: the feeling of shame occurs in response to undesirable judgment by real or imagined others, and most often is associated with violating some form of social code (Crowder & Kemmelmeier, 2018; Keats, 2012). Shame is an incredibly influential emotion for the power it has to direct people’s behavior to comply with societal norms (Keats, 2012). Not only does the feeling of shame involve negative evaluations from others, it involves a negative evaluation of one’s self, which can have damaging consequences as it may seem impossible to change the self (Crowder & Kemmelmeier, 2018). To illustrate, the following passage demonstrates a man’s self-stigma wherein he feels as though he has failed to fulfill his role:

Expectations I’ve had on myself in terms of what I consider to be successes in life—a good father, a good husband, a good provider, um, those are probably at the top of the list, and it’s my belief I failed at—at all of those three responsibilities. (Oliffe et al., 2019, p. 324)

With this in mind, shame then has the ability to suppress individuals’ ability to disclose information that society may consider taboo, such as suicide (Crowder & Kemmelmeier, 2018; Keats, 2012). In particular, shame is connected with the feeling that one can never be remedied in the eyes of others, that one is unworthy, a common theme observed in individuals’ suicide notes (Crowder & Kemmelmeier, 2018). Researching the theme of shame has demonstrated that it is a feeling consistently linked to suicide in many different research documents, yet only two documents state shame as the specific reason for suicide (Crowder & Kemmelmeier, 2018; Chung, Ryan, & Large, 2016).
Admittance to a psychiatric hospital is an experience that conjures many feelings. Chung, Ryan, & Large (2016), professors of the Department of Medicine at the University of New South Wales, claim that the feelings of shame felt during re-integration into normal life after being discharged from a psychiatric hospital is a large contributing factor to suicide. They state that having an adverse experience in hospital includes how patients are exposed to humiliation, stigma, trauma, loss of autonomy, and violence (Chung, Ryan, & Large, 2016). These experiences combined with being discharged too soon, or being followed up too vigorously, are connected with higher rates of suicide (Chung, Ryan, & Large, 2016).

**Burdensomeness.** Being a burden can be understood as the belief that one’s existence is a drain on society and on others; that one is essentially expendable or unwanted (Frey, Hans, & Cerel, 2017; Hill & Pettit, 2014). The theme of perceived burdensomeness, meaning that someone believes they are a burden regardless of that belief’s veracity, is present in many conversations with individuals who have recently attempted suicide:

I felt my mind slip back into the same pattern of thinking I’d had when I was fourteen [age of first suicide attempt]. I hate myself. I’m terrible. I’m not good at anything. There’s no point in me hanging around here ruining other people’s lives. I’ve got to get out of here. I’ve got to figure out a way to get out of my life. (Joiner & Silva, 2012, p.6)

In addition to these conversations, individuals also speak about how they received negative social responses from loved ones following a suicide attempt or disclosure of suicidal ideation:

I felt even more misunderstood … They put the blame on me, and that even gives me more validation to end my life. It just doesn’t help. It validates those negative points on how I feel about myself. You don’t get blamed for having cancer, but you get blamed if
you end up dying by suicide because you just couldn’t deal with it anymore, and to me, that is very unfair. (Frey, Hans & Cerel, 2017, p. 164)

Some researchers state that the presence of perceived burdensomeness alone predicts suicide (Heelis, Graham, & Jackson, 2016; Hill & Pettit, 2014). Others assert that it is a combination of perceived burdensomeness and a lack of belongingness that contributes to the high risk of suicide (Frey, Hans & Cerel, 2017; Joiner & Silva, 2012). It has also been hypothesized that perceived burdensomeness leads to social isolation or social disconnection which then may lead to suicide: “the reason [for suicide] is the conviction that you deserve your loneliness, that no one needs to be cast out more than you do” (Joiner & Silva, 2012, p. 8). In nature, animals have been observed leaving their group to die alone when infected with disease in an effort to avoid passing it on to the rest of the group: researchers say this is reflective of how social alienation and burdensomeness play an essential role in suicide (Joiner & Silva, 2012). Consequently, some researchers say that perceived burdensomeness could be an early warning sign for suicide (Joiner & Silva, 2012). This specific research also states that enhancing connectedness to others will reduce feelings of burdensomeness and facilitate recovery from crises of suicide (Joiner & Silva, 2012).

**Escape from pain.** From an evolutionary standpoint, human beings are naturally inclined to seek pleasure and avoid pain (Burgess, 2005). The theme of escaping from pain as a reason for suicide has been well documented in research (Bantjes, 2017; Goldblatt, Ronningstam, Schechter, Herbstman, & Maltsberger, 2016; Fegg, Kraus, Graw, & Bausewein, 2016; De Leon, Baca-García, & Blasco-Fontecilla, 2015). Mental pain uses the same brain mechanisms as physical pain (De Leon, Baca-García, & Blasco-Fontecilla, 2015); for this reason, the present study uses the term pain to describe physical, emotional, or mental pain. Some authors claim that
suicidal behaviors (attempts, ideation and completions) are caused by mental pain far more frequently than any biological causes (De Leon, Baca-García, & Blasco-Fontecilla, 2015). To illustrate, one individual who recently attempted suicide explains:

I just don’t want to feel this way. I will get any help I can to take it off my mind ... I don’t know why I can’t get healed of this inner pain. It draws me to suicide every time.

(Bantjes, 2017, p. 3)

Other researchers also speak about inner pain: “Overwhelmed with intolerable affect and perceiving no possible escape, patients despair and kill themselves as their only means of fleeing from what they cannot endure” (Goldblatt et al., 2016, p.141). In these quotes, suicide is regarded as a means of reprieve from the constant pain. Bantjes (2017), a professor at Stellenbosch University in South Africa, conducted 80 interviews with individuals recently admitted to hospital following a suicide attempt. In these interviews, individuals expressed a need for greater supports such as:

Alleviation of psychiatric and somatic symptoms, access to integrated psychological care at a primary health care level, help to establish connectedness and belonging, assistance with interpersonal and family conflict and practical help to solve situational problems.

(p.3)

Bantjes (2017) asserts that the lack of support, mentioned above, contributes to reinforce mental pain in suicidal individuals. To decrease the risk of suicide, greater supports are required.

In addition, Fegg, Kraus, Graw, & Bausewein (2016), professors from the Department of Palliative Medicine in Munich, researched suicide notes, police notes, and autopsy records of individuals who had completed suicide in an effort to prove physical pain is a reason for suicide. Their study concluded that out of 1069 cases, every fifth case stated a physical reason for
suicide, but every third case stated a mental reason for suicide; therefore, mental reasons for suicide were more frequent (Fegg et al., 2016). Additionally, Fegg et al., (2016) state that 80% of their participants suffered from a life limiting disease for at least several months, sometimes years, before taking their life. They assert that this suffering creates an unprecedented impact on the quality of a person’s life in terms of dependence on others, medication and side effects, and constant physical pain (Fegg et al., 2016).

**Isolation.** Human beings are social by nature: seeking connection with others in order to feel fulfilled in life (Nitulescu, 2016; DeMartini, 2014; Alexander, 2008). Isolation can be defined as a feeling of alienation or “otherness” from one’s self, family, friends, society, and/or any particular group that is important to a person (Oliffe et al., 2019; DeMartini, 2014). Mental illness can also produce changes in how someone views himself or herself, thus creating internal isolation (Oliffe et al., 2019):

> The process of disintegration is felt as an estranged and uncomfortable Inner force, as a flood of insanity that overtakes the self, and as a sudden process of losing one’s mind. The suicidal act is thus used as an escape from total disintegration of the self. (DeMartini, 2014, p.14)

External isolation is the feeling of otherness in relation to society for innumerable reasons (DeMartini, 2014). The following passage illustrates one research participant’s feelings of external isolation:

> I don’t have much of a life myself, I’m not adding to anybody else’s life. I can go for months and years without talking to family members, so you know, if I’m here or if I’m not here, what difference does it make, really what difference does it make? (Oliffe et al., 2019, p. 318)
Isolation can also occur following different types of loss, which can create feelings of shame, guilt, and judgment—this might include the loss of a job or career, financial struggles, or the loss of a relationship (DeMartini, 2014). In addition to loss, societal stigma perpetuates the isolation of someone who is experiencing suicidal thoughts: “there is a taboo of silence around the topic that keeps individuals trapped in their ideas and fantasies of death rather than sharing their fears and inner desires” (DeMartini, 2014, p. 25). Societal stigma reinforces the negative beliefs that individuals are unworthy or a burden, which can further isolate these individuals from themselves and others (DeMartini, 2014; Soole, Kõlves, & De Leo, 2014).

Isolation was the second largest theme found in the present study: out of 25 documents, 6 documents stated isolation as the reason for suicide (Oliffe et al., 2019; Levi-Belz & Apter, 2015; Stoor, Kaiser, Jacobsson, Renberg, & Silviken, 2015; DeMartini, 2014; Gvion, Horesh, & Turnbull, 2014; Soole et al., 2014). The majority of research explains that a compilation of factors leads to isolation as opposed to one specific reason. These intersecting factors include limited access to mental and physical health care, limited financial resources, substance use, absence of social supports, and social stigma associated with accessing mental health care (Oliffe et al., 2019; DeMartini, 2014; Soole et al., 2014). Oliffe et al. (2019), professors from the University of British Columbia, found six themes specifically underpinning social isolation: family, school and work, self-care, health care, idealized identity, and society. Oliffe et al. (2019) claim that dysfunction and family estrangement contributed to participants’ feelings of social isolation and pathway to suicidal thoughts:

My parents fought a lot. My dad drank a lot. I think they were just bored, and that caused a lot of friction. Then, of course, there was my brother and sister complaining that they’re
getting teased at school because I’m gay . . . I basically felt rejection even from my own family. (Oliffe et al., 2019, p. 318)

External isolation comes from a perception of being different from those around you (DeMartini, 2014). Thus, family is an essential facet to connection and estrangement from family can also lead to isolation (Oliffe et al., 2019; DeMartini, 2014). Families can be considered mini societies wherein a person learns what is acceptable and not acceptable: the process of isolation from family is varied and may look like “a wide range of silences, stigmas” in how they attempt to produce adherence to familial and societal norms (Oliffe et al., 2019, p. 319). Society dictates what is “normal” and “accepted”—families either reinforce or break down those normative ideals when faced with a member who is different (Oliffe et al., 2019).

Much like the mini society of a family, living in a rural community can also contribute to greater social isolation among individuals who feel different from their larger community (Soole, Kõlves, & De Leo, 2014). Living in a rural area can contribute to greater feelings of both internal and external isolation due to reduced access to care, increased feelings of stigma associated with accessing mental health services, or for being different (Soole et al., 2014). Feeling externally isolated due to perceived differences may lead individuals to question and alter their identity—this process may result in disconnection between the individual, their authentic selves and others (Soole et al., 2014). Oliffe et al. (2019) state that men in particular find ways of managing their suicidality, meaning how they attempt to decrease their ideation, such as self-harm and/or isolation instead of seeking help from others. They hypothesize that the masculine ideals, such as stoicism and emotional restraint, have a strong connection to social isolation, which then plays a role in the risk of suicide (Oliffe et al., 2019).
In researching the reasons for suicide, five themes were found: depression, shame, burdensomeness, escape from pain and isolation. In chapter five, each theme is explored through the lens of Alexander’s (2008) dislocation theory.
Chapter Five: Discussion

Before engaging in discussion of the results, there are three issues to note. First, while my searches produced overwhelming results in the thousands; the data was limited in answering the thesis question, in terms of stating a specific reason for suicide. This may suggest that the data on reasons for suicide may be more complex than I first thought, consisting of an intersection of multiple reasons rather than one particular reason for suicide (Money & Pridmore, 2017; Pridmore, 2015). Second, much of the research done on suicide is conducted on individuals who are inpatients in psychiatric facilities (Tillman et al., 2017; Martin, Vujanovic, & Day, 2017; Zimmerman et al., 2014). For this reason, the research may be skewed to present mental disorders as the main reason for suicide because the populations being studied have already been diagnosed with a mental disorder (Pridmore, 2015). It should be noted here that because someone is an inpatient in a psychiatric facility, helping professionals are automatically looking through the diagnostic lens of care due to the fact that a diagnosis is criteria for admission (Money & Pridmore, 2017; Pridmore, 2015; Turnbull, 2014). Third, the stigma associated with mental health topics, in particular suicidality, may discourage individuals from participating in research (McIntosh, 2009; Turnbull, 2014), thereby providing a full picture.

My original thesis question asked: How can the lens of dislocation theory further understanding of why people contemplate suicide? In order to answer this question, I conducted a thematic analysis to find themes in the literature on reasons for suicide. What is clear from the data is that though suicide is a widely researched topic, there are few documents that outline a specific reason for suicide. Instead many of the papers claim multiple intersecting reasons as contributing to suicide (Pridmore, 2015; Money & Pridmore, 2017). As explained in chapter four, five themes were found as a reason for suicide: depression, shame, burdensomeness, escape
from pain and isolation. Before looking at each theme through the lens of the dislocation theory, I want to outline how suicidal individuals resist suicide and highlight their resiliency as well as further explain the lens of the dislocation theory.

**Resiliency and Resistance Among Suicidal Individuals**

From my research, it is clear that the reason for suicide can be split into two distinct categories: underlying mental disorders as a reason for suicide and a reason for suicide that does not include an underlying mental disorder. A diagnosis inherently places blame upon the individual experiencing suicidal ideation, it assumes that a problem exists within themselves, caused by their underlying mental disorder which leads to an internalization of the diagnosis. This approach ignores the broader social context of an individual’s suicidal ideation. From a Response Based Therapy perspective, when people are badly treated, they inherently resist that mistreatment (Wade, 2000). Resistance is physical, emotional, spiritual and intellectual—it occurs both overtly through physical acts of resistance and co-overtly in the minds of individuals (Bonnah, 2014). In order to further explore the concept of resistance, below is an example of how a woman named Gina who was in an abusive relationship was diagnosed with depression and resisted violence:

Rather than being viewed as a cause, the violence would be viewed as a “stressor” which “triggered” a latent, probably inherited predisposition toward clinical depression. Thus, Gina’s resistance to Gus’s dominating and abusive behavior – her refusal to be contented with mistreatment, her objections to his aggressive parenting, her refusal to respond erotically to rape, her refusal to devote herself solely to household chores, and so on – were portrayed as symptomatic of her clinical depression. (Wade, 2000, p. 46)
At first glance, it may appear that Gina was not an active responding agent in her abusive relationship – others may think that she is accepting of the violence because she continues to stay with her partner. The fact is that abusive individuals employ numerous strategies to prevent a person from leaving the relationship (Wade, 2000). Upon closer examination, multiple acts of resistance are named, each one highlighting the enormous capacity this woman possesses to keep herself safe. Many times in oppressive and abusive situations, individuals resist their abuser/oppressor by seeking safety in their mind, by contending their situation in their mind because it is not safe to do so outwardly (Bonnah, 2014; Wade, 2000). Individuals have created safe spaces in their mind where they can escape the torment of their current situation through dreams, imagination, mentally leaving their body, having conversations with the abuser in their head, and making grocery lists while being raped, for example (Wade, 2000). In order to elucidate those points of resistance, therapists, psychiatrists, doctors, police, nurses and psychologists need to ensure they are asking questions around what the victim does in those moments to keep him or her self safe (Wade, 2000). These questions are guided through the principle that each person who experiences violence and oppression, is constantly resisting their situation (Wade, 2000). This perspective can also be used to understand how individuals chose suicide as a point of resistance as opposed to something that is disordered in their mind (Alexander, 2008). Through the perspective of Response Based Therapy, diagnoses, such as Gina’s diagnosis of clinical depression, serve to dismiss and conceal violence (Wade, 2000). To illustrate, Wade (2000) explains exactly how Gina’s diagnosis does this:

The example of Gus and Gina illustrates how professionals (in this case a physician and psychiatrist) can inadvertently enable violence and inequality through asocial diagnosis. The belief that Gina’s behavior was the result of something occurring in her mind or
brain displaced any sustained examination of the forms of domination and inequity she lived with on a daily basis. Gus’s dominating behavior was effectively concealed and, from Gina’s point of view, was implicitly condoned. Moreover, the professionals echoed in a more impressive language what Gus had been telling Gina all along, namely, that she was the one with the problem. It is not at all difficult to understand how depressing this collusion between the professionals and her husband was for Gina. (p. 45)

Imagine being a woman in an abusive relationship, despite the many risks associated with seeking help, you courageously do so and then being told, inadvertently, that there is something wrong with you – not your abuser. In the passage above, Wade (2000) emphasizes how the process of diagnosis serves to reinforce the abusive behavior and further isolate the victim. Instead, to highlight Gina’s points of resistance, which are many, Response Based Therapy as well as dislocation theory, would explore how this woman continues to keep herself safe through conversation that does not focus on symptoms for a checklist. Wade (2000) states that after a few sessions of counselling, Gina no longer exhibited any symptoms of depression and eventually left the relationship. If Gina were truly depressed – her depression would continue even after her situation changed (Wade, 2000). Gina was responding to her social context with “symptoms” that mimicked depression (Wade, 2000). The picture of Gina’s presenting problem appears much differently when looking at each response to violence as resistance versus a checklist to fit a diagnosis of depression.

**The Lens of Dislocation Theory**

Dislocation theory is based on the premise that individual respond to their pain, their situation, and their lack of connection through substance misuse (Alexander, 2008). However, instead of placing blame on these individuals for addiction, Alexander (2008) identified
addiction as an adaptive response to a social context that they experience as unbearable.

Alexander (2008) further explains dislocation:

Dislocation can have many causes. For example, it can arise from an earthquake that destroys a village or from an individual idiosyncrasy that society cannot tolerate. It can be inflicted violently by abusing a child, ostracizing an adult, or destroying a culture. It can be inflicted with the best of intentions, by inculcating an unrealistic sense of superiority that makes a child insufferable to others or by flooding a local society with cheap manufactured products that destroy its economic basis. (p. 60)

Dislocation theory is similar with Response Based Therapy in that they both focus on how an individual is responding to their social context (Alexander, 2008; Wade, 2000). This outlook seems logical, considering that people generally do not exist in isolation where they do not interact with the world around them – therefore how can you understand someone’s pain, sorrow, joy, sadness, anger, frustration, etcetera, without considering what is happening in the broader context of their life? For example, if an individual was fired from their job, broke up with their partner, and got kicked out of their apartment and felt sad, hopeless, tired, angry and had felt this way for more than two weeks – without knowing the social context they are responding to, you would merely think they met criteria for many DSM-V diagnoses.

In the following section this idea will be explored in relation to the five themes: depression, shame, burdensomeness, escape from pain, and isolation.

**Depression and Dislocation Theory**

People who experience depression, experience a wide range of emotions that can be best understood when placed in the context of their situation (Money & Pridmore, 2017; Pridmore, 2015; Bonnah, 2014; Wade, 2000). The language surrounding a diagnosis of depression often
places the diagnosis within the individual experiencing it, placing blame on the individual themselves and essentially concealing the responses and resistance of each individual. Wade (2000) explained that: “oppression is depressing, and depression paradoxically is often the strongest protest that people can muster in a dehumanizing situation.” (p. 40). Therefore, the symptoms of depression could be thought of as a way that an individual is resisting the current circumstances of their life. To illustrate, here is the same quote used by Cerel, Frey, Maple, & Kinner, (2016) in their research with suicidal individuals who have been diagnosed with depression:

I tried to call my daughter ... and whoever answered the phone was some girl had said [my daughter] did not want to talk to me and I heard my daughter’s voice in the background saying ... ‘I don’t want anything to do with her.’ And I felt so bad, like I don’t deserve to live. (p. 2333)

In examining this statement through the lens of dislocation theory it becomes important to determine how this person came to believe she was depressed and undeserving of life, and how she has come to feel guilt surrounding her relationship with their child. Through the lens of dislocation theory, it is apparent that this person is in turmoil over her disconnection with her daughter. As Alexander (2008) states: “psychosocial integration is experienced as a sense of identity, because stable social relationships provide people with a set of duties and privileges that define who they are in their own minds” (p. 58). It is possible that, like for many women, motherhood is part of identity and meaning. With this in mind, this woman’s identity as a mother is in question because she hears that her daughter wants nothing to do with her. There may be countless circumstances that lead to the quote above. The daughter may have understandable
reasons for not wanting to talk to her mother, yet this mother clearly attributes her meaning in this life to her connection to her daughter.

Another example of how depression can be connected with dislocation is taken from research associated with depression following a stroke. It was found that post-stroke individuals were at increased risk of suicide due to depression categorized by feelings of hopelessness, helplessness and social isolation (Pompili et al., 2015; Enzlin, 2014). It has been said that individuals who have experienced a stroke must undergo a process of reconciling what has been lost and redefining a new meaning from life (Pompili et al., 2015; Enzlin, 2014). Dislocation would occur as a stroke sufferer might feel hopeless about their redefined life, helpless by their physical limitations and their increased dependence on others, and isolated from people they love (Pompili et al., 2015; Enzlin, 2014). Using the lens of dislocation theory, it is possible to see why an individual post-stroke would be suffering a loss of identity as they underwent a process of loss and grief that mirrors disconnection (Enzlin, 2014; Alexander, 2008). Dislocation theory would assert that any change, such as loss of employment or loss of independence, that disconnects a person from their body physically, emotionally and psychologically is dislocation (Alexander, 2008).

Additionally, since not all individuals who are diagnosed with depression are suicidal, then how can depression be the largest risk factor contributing to suicide? Where does the difference lay between someone who has been diagnosed with depression and having suicidal ideation and someone who has also been diagnosed with depression and no suicidal ideation? Some researchers have stated that depression combined with other factors such as family stressors, burdensomeness, and/or anxiety that contribute to high suicide risk (Chen, Kang, & Lin, 2017; Li et al., 2017; Cerel, Frey, Maple, & Kinner, 2016). If this is the case, then why is
depression consistently named as the highest risk factor? The symptoms that equal a diagnosis of depression overlap with many themes discussed in the research, such as hopelessness. It is possible that depression is an easier choice as a reason for suicide due to its ability to encompass many other factors (Money & Pridmore, 2017; Pridmore, 2015). However, a diagnosis of depression fails to distinguish between these factors, so that the social context is not highlighted, and instead focusing on the perception that the depressed individual is lacking in some way.

**Shame and Dislocation Theory**

An essential part of human life is the psychosocial integration of an individual with society. Enduring a lack of psychosocial integration (dislocation) is extremely painful and destructive to any person (Alexander, 2008). Shame is created in society but suffered in private, most often created through negative social responses from other people which reinforce negative feelings about one’s self (Crowder & Kemmelmeier, 2018; Keats, 2012). When the feeling of shame is experienced, a person is not permitted to satisfy their fundamental individual needs and the need for community – shame ensures a person feels separate from their community and in turn questions who they are as an individual (Money & Pridmore, 2017; Alexander, 2008).

Psychiatrists and researchers from the Department of Psychiatry at the University of Toronto, Ontario, Furqan, Sinyor, Schaffer, Kurdyak, & Zaheer (2019), examined 36 suicide notes left by individuals who completed suicide. While attempting to privilege the voices of these individuals, their study focused on the influence of mental illness in the completion of suicide (Furqan et al., 2019). They found that in these suicide notes, the person and their illness were not separate entities; the individuals wrote about their illness as if they were one and the same (Furqan et al., 2019):
I am exhausted from trying to fix everything. No one understands, not even doctors or my family, and I keep trying to get help. I feel like I’m a dead man walking for a long time. I’ve been judged by society and have been made to feel ashamed. I’m burned out and tired and trying to find some way to rest. (Furqan et al., 2019, p. 103)

Through the lens of dislocation theory, this quote might be interpreted without focusing on mental illness as a reason for suicide. From this perspective the disconnection of the person from the people around them becomes apparent (Alexander, 2008). For example, the statement, “no one understands” (Furqan et al., 2019, p. 103), speaks to the absence of connection this person feels from every person around them (Alexander, 2008). The statement: “I’ve been judged by society and have been made to feel ashamed” (Furqan et al., 2019, p. 103), could be interpreted to show how society plays an essential role in how individuals evaluate themselves as human beings and how powerful society can be in isolating a person through the experience of shame (Alexander, 2008).

In examining the research on shame related to adverse experiences in hospital after a suicide attempt, it is apparent how deeply rooted the stigma of suicide is in every institution (Chung, Ryan, & Large, 2016, Alexander, 2008). Individuals go to the hospital following a suicide attempt and are met with more negative social responses from caregivers, health care providers and strangers (Chung, Ryan, & Large, 2016). These negative social responses again reinforce the already negative beliefs a person holds about themselves that led them to their attempt in the first place, and thus supports their own notion that they indeed should be ashamed of themselves as they can no longer be remedied in the eyes of society (Crowder & Kemmelmeier, 2018; Chung, Ryan, & Large, 2016; Alexander, 2008; Wade, 2000).
**Burdensomeness and Dislocation Theory**

Alexander (2008) states: “human beings are not psychologically self-sufficient. From early childhood until old age, individuals in every culture devote themselves to establishing and maintaining a place in their society” (p. 58). Imagine feeling unwanted and expendable from the people around you and from society as a whole, that you have no place in society. The excruciating pain that comes from feeling as though one is a burden to others leads individuals to take their lives by suicide:

I hate myself. I’m terrible. I’m not good at anything. There’s no point in me hanging around here ruining other people’s lives. I’ve got to get out of here. I’ve got to figure out a way to get out of my life. (Joiner & Silva, 2012, p.6)

Through the lens of dislocation theory, rather than pathologizing this individual as depressed, a therapist, for instance, would explore how this person is adapting with suicidal thoughts to the overwhelming feeling of burdensomeness. Since human beings create their identity from interactions with stable relationships such as their family (Alexander, 2008), it would make sense then that if someone believes they are a burden, that perhaps these stable relationships were not as stable as they thought (White et al., 2016; Wade, 2000). The difference, as Wade (2000) states, is how people such as counsellors, respond to that language, what they pick up on, what they choose to magnify and what they choose to ignore. Applying the concepts from Alexander’s (2008) dislocation theory would highlight and explore how this person is responding to the disconnection from their community, their family, and themselves as a person, and translate their suicidality as an attempt to preserve their dignity after being oppressed by a damning diagnosis. Often times in therapeutic work with individuals who are experiencing crises of suicide, individuals state that growing up they had “no one,” that they were “abandoned” and “unloved”
from important people in their lives such as their mother or father (Oliffe et al., 2019; White et al., 2016; Wade, 2000). Providing a space for individuals to express their negative feelings without blame or shaming them for their suicidal response and understanding it from the perspective of their social context, has been said to be an essential aspect to healing (White et al., 2016; Bonnah, 2014; Wade, 2000).

What is noteworthy is that when these individuals courageously reveal these thoughts and feelings to individuals in their lives, they are often times met with negative social responses that act to emphasize their burdensomeness and suicidality (Frey, Hans, & Cerel, 2017). To illustrate and further examine the quote from chapter four of this thesis:

I felt even more misunderstood … They put the blame on me, and that even gives me more validation to end my life. It just doesn’t help. It validates those negative points on how I feel about myself. You don’t get blamed for having cancer, but you get blamed if you end up dying by suicide because you just couldn’t deal with it anymore, and to me, that is very unfair. (Frey, Hans, & Cerel, 2017, p. 164)

Negative social responses from others place blame, shame, pathology and illness onto the person instead of shining a light on the broader social context. This individual also speaks to the societal belief that physical illnesses are accepted without question and carries fewer stigmas than mental illnesses (Pridmore, 2017; White et al., 2016). For example, society would generally be less inclined to blame or stigmatize the family of someone who has died from cancer (McMenamy, Jordan, & Mitchell, 2008; Sveen & Walby, 2008). Yet the research done on families that survive a member who has suicided concludes that they are highly stigmatized and often feel they are not given the support they need due to the circumstances of their loved one’s death (Cerel, Schnell, & Spencer-Thomas, 2017; McMenamy, Jordan, & Mitchell, 2008; Sveen & Walby, 2008).
Escape from Pain and the Dislocation Theory

Suicide is often labelled selfish, or lacking control (Crowder & Kemmelmeier, 2018; Money & Pridmore, 2017; Joiner & Silva, 2012). Through the lens of dislocation theory, suicide is not a question of control or selfishness; instead it would be seen as an adaptive response to dislocation: “dislocation is dangerous and painful in the extreme and dislocated people adapt to it as well as they can” (Alexander, 2008, p. 70). Through this lens, adaptive behavioral processes are not a question of being voluntary or not; they are understood in terms of what purpose they serve – in this situation to escape from pain (Alexander, 2008). To clarify, saying suicide is adaptive is not to say that it is desirable; it is to say that it is the “lesser evil, it may buffer a person against the greater evil or unbearable dislocation” (Alexander, 2008, p. 63). Through this lens it is understood that people adapt to painful experiences of prolonged dislocation with a multitude of responses: depression, addiction, suicide, apathy, murder, or mental unpredictability (Alexander, 2008).

Isolation and Dislocation Theory

Psychosocial integration has been used interchangeably with many names: “belonging, community, wholeness, social cohesion, or simply culture” (Alexander, 2008, p. 59). It’s opposite can be thought of as isolation or alienation, (alexander, 2008, p. 59). Forced isolation in the forms of excommunication and solitary confinement has been used as a successful punishment and form of torture from ancient times until now (Alexander, 2008). This type of punishment is only successful because belonging and connectedness to others is an essential part of human life (Alexander, 2008). Since psychosocial integration begins in the subgroup of families, it is essentially the most fundamental aspect in establishing the stable social relationships that individuals need to create their identity (Alexander, 2008). For this reason,
when someone is “different” from, or not accepted by their family, if they are ostracized, abused, and isolated, it makes sense that they respond with suicide (Alexander, 2008). In support of this notion, the research done by Soole, Kõlves, & De Leo, (2014), on living in a rural community and the increased suicide and isolation is important to revisit. For example, growing up in a small rural town, being heterosexual was considered the norm. Anything different than that was deemed “wrong” or “bad.” Messages that anything different was unacceptable were subtle and overt all at the same time (Soole, Kõlves, & De Leo, 2014). The quote below, the same one used in chapter four of this thesis, shows how communities act to socialize what is right and wrong and what is and what is not accepted among the community:

My parents fought a lot. My dad drank a lot. I think they were just bored, and that caused a lot of friction. Then, of course, there was my brother and sister complaining that they’re getting teased at school because I’m gay . . . I basically felt rejection even from my own family. (Oliffe et al., 2019, p. 318)

Looking at this quote through the lens of dislocation theory, Alexander (2008) would highlight how this individual is isolated from, and rejected by their family by a sense of otherness, and also from their community in the form of indirect teasing of their siblings, because they were gay. Instead of blaming the individual for being suicidal, the dislocation theory would aim to understand what led the person to become disconnected with their family and community (Alexander, 2008). In this case, the fault lay not in the individual’s inability to “take” the abuse, but rather an understanding that this person’s “vital need for social belonging” was not being met (Alexander, 2008, p.58).

The five themes that have been documented in this chapter through the lens of dislocation theory highlight many important aspects of the reasons for suicide that may not have been
considered otherwise (Alexander, 2008). Through this lens, the five themes seem like understandable reasons why someone would respond with suicidal ideation (White et al., 2016; Alexander, 2008; Wade, 2000). Suicide can be seen as an act of resistance against oppression, an attempt to persevere dignity, self-respect and identity (Valach, Young, & Michel 2011; Alexander, 2008; Wade, 2000). As Alexander (2008) has stated, individuals who seek suicide as a way to resist dislocation are doing so because suicide may be a less painful than the experience of their current dislocated life.

**Limitations**

There are several aspects to this study that could be considered limitations. One of the biggest limitations of thematic analysis, its flexibility, is also an advantage (Braun & Clarke, 2006). As a limitation, this flexibility means the potential interpretations of the data can be broad which makes it limited in developing guidelines for further analysis (Braun & Clarke, 2006). In order to mitigate this limitation, the steps to conducting a thematic analysis were closely followed in Chapter three of this thesis to ensure my interpretations of the data were documented (Braun & Clarke, 2006). Another limitation is that the articles in the dataset and results section were selected through the selection criteria for this thesis and is limited due to the fact that I, as the researcher, chose them (Braun & Clarke, 2006). For this reason, my choices of literature may differ from another researcher. This may also be considered an advantage in bringing multiple perspectives to the research on suicide, as my perspective may differ from other researchers, and could act as a possible starting point for future research to critique, support or argue the research that was done in this thesis.
Future Research

The majority of the research on suicide is done using individuals who have been admitted to inpatient psychiatric facilities (Tillman et al., 2017; Martin, Vujanovic, & Day, 2017; Zimmerman et al., 2014). It may be valuable to engage in future investigation of the reasons for suicide with individuals who are accessing community resources where individuals do not require a diagnosis to be in care.

It has been said that a positive sense of self and belonging to a valued group of others (community, family, friends) is among the strongest protective factor against suicide (Hope & Smith-Adcock, 2015). Therefore, it would make sense that increasing psychosocial integration would be a significant protective factor against suicide. The problem is that psychosocial integration requires the cooperation of society, starting from the top down (Alexander, 2008). This means elected representatives, policy makers, laws and literature would need to broaden their stance to include non-diagnostic reasons for suicide (Pridmore, 2015). Through the widely accepted medical model of suicide that attributes 90% of suicides as related to mental disorders, the community of professionals associated with helping these individuals have been taught that one precipitates the other (Pridmore, 2015). This also influences how monies are distributed and directed regarding suicide prevention and education and therefore reinforces the above belief (Pridmore, 2015). It starts here, to begin to make changes that eventually trickle down to influence how individuals are understood in the context of their situation. A more preferred message could potentially be that a reason for suicide may include a mental disorder or could be due to a reason listed in this thesis, and is more often a combination of multiple intersecting reasons (Pridmore, 2015). This may be an area for future investigation.
Additionally, the current approach of categorizing negative emotions as mental disorders has saturated much of the research on suicide (Money & Pridmore, 2017; Pridmore, 2015). Therefore, it would be equally as important to include other reasons for suicide, as well as the importance of psychosocial integration, for future investigation into the social causes of suicidality. This could be beneficial in providing a broader sense of the social context these thoughts are occurring in (White et al., 2016; Alexander, 2008).

Conclusion

Individuals who are experiencing crises of suicidal ideation demonstrate resiliency in their methods of survival including resistance and perseverance (White et al., 2016; Wade, 2000). Individuals from all cultures, ethnicities and genders continue to respond to issues of suicidality with dignity and resistance. The Canadian Code of Ethics of Psychologists and the British Columbia Association of Clinical Counsellors share four principles that represent the core values of this profession (Truscott & Cook, 2013). The first principle, is the respect for the dignity of persons and was given the highest weight of all the principles:

Psychologists accept as fundamental the principle of respect for the dignity of persons; that is, the belief that each person should be treated primarily as a person or an end in him/herself, not as an object or a means to an end. In doing so, psychologists acknowledge that all persons have a right to have their innate worth as human beings appreciated and that this worth is not dependent on their culture, nationality, ethnicity, color, race, religion, sex, gender, martial status, sexual orientation, psych or mental abilities, age, socio-economic status, or any other preference or personal characteristic, condition, or status. (Truscott & Cook, 2013, p. 11).
This principle guided my research and the lens through which I chose to view the reasons for suicide through, one that highlighted the dignity of all individuals. Through the lens of dislocation theory, suicide can be viewed as an act of dignity and resistance to oppression (Wade, 2000; Alexander, 2008). It is up to researchers to emphasize these aspects (Money & Pridmore, 2017; White et al., 2016; Wade, 2000). It is also up to anyone who is employed in mental health fields to learn to ask questions that explore how someone has resisted their current life adversities, there is an immense amount of information in the answers to those questions that allow people to be viewed through a lens of strength and understanding versus problem statured and pathologizing (White et al., 2016; Wade, 2000). For example, one could ask: “how did you respond when he yelled at you?” and “what did you do next?” these questions offer insight into how a person has resisted by drawing out exactly what that person has done to keep themselves safe (Wade, 2000).

As I near completion of my study, and reflecting on my own experience, I realize that it has been frustrating for me to consistently see the pathologizing language used when referring to dislocated people. It was equally as frustrating to see how this language is often used to place a problem inside an individual, as if they are the sole reason for their difficulties. My passion for seeking greater understanding comes from my suicidal ideation as a young girl, who was lucky enough to find a therapist who did not see my response to my situation as flawed, dramatic, problematic or insane. This person treated me with dignity, highlighting how understandable my response was to my experience of my father being more committed to his alcoholism than to his daughter. This validation from someone who did not know me was all I needed and shortly after about six sessions, my ideation dissolved. I can only imagine, how differently the course of my life may have been if I was treated otherwise. If someone were looking through a diagnostic lens,
they would have seen that I met all the DSM-V criteria for depression, hypothetically they would have possibly decided to put me on anti-depressants, conducted cognitive behavioral therapy and I ultimately would have internalized the problem as if it were part of me, continuing to blame myself more than I already did. For this reason, it was important for me to share my own experience with suicidal ideation in an effort to normalize this experience as something that does not just happen to people who are “mentally ill.” Mustering the courage to put my experience into words, for many to read, took immense vulnerability. This is best represented by the following quote by Brene Brown (2008), a social worker and researcher on the topics of shame and vulnerability who has published multiple best selling books:

> Courage is a heart word. The root of the word courage is cor – the Latin word for heart. In one of its earliest forms, the word courage meant ‘to speak one’s mind by telling all one’s heart.’ Over time, this definition has changed, and today, we typically associated courage with heroic and brave deeds. But in my opinion, this definition fails to recognize the inner strength and level of commitment required for us to actually speak honestly and openly about who we are and about our experiences – good and bad. Speaking from our hearts is what I think of as ‘ordinary courage’. (p. xxiii)

Essentially, there is no courage without vulnerability (Brown, 2008). My experience of conducting this research has been one that has motivated me to engage in conversations with many people about suicide, resistance and about dignity. These enlightening and transforming conversations sparked connection, and I was able to take pieces of these conversations with me as I further engaged with the research on reasons for suicide. It has also been enlightening to encounter individuals in these conversations, who meet the topic of suicide with distaste, fear, ignorance and stigma. If I am met with those negative social responses as someone who is
merely researching the topic of suicide, I can only imagine that the intensity of those negative responses only further increase with someone who is currently suicidal.

It is for every person that I have met, assisted, helped, spoken with, grieved and lost in relation to suicide that I write this thesis. I carry their voices and their stories with me every day in the hopes of greater understanding.
References


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