HELP-SEEKING FOR SUICIDALITY IN WOMEN WHO HAVE EXPERIENCED INTIMATE PARTNER VIOLENCE: A FEMINIST GROUNDED THEORY & PHOTOVOICE STUDY

by

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ABSTRACT

Intimate partner violence (IPV) has been found to contribute to suicide thoughts and behaviours in women (Lamis et al., 2017). Seeking help for suicidality with a history of violent trauma is difficult within a society that stigmatizes these experiences. This study sought to discover the process of women’s help-seeking for suicidality in the wake of IPV. Feminist ethical theory, the philosophical underpinning for this multiple method qualitative design of grounded theory (GT) and photovoice (PV), provided a lens in understanding women’s journey. Transcripts from individual interviews with 32 women, seven of whom participated in the PV portion of the study, were analyzed using the constant comparative method of GT. The PV approach aligned with the philosophical underpinning of the study, feminist ethical theory, as the self-generated images and consciousness raising within the meetings helped to broaden the scope of the study. The multiple method qualitative design rendered socio-political constructs of women’s help-seeking.

_Hunting to Feel Human_ emerged as the basic socio-psychological process that manages the basic socio-psychological problem, _System Entrapment_. To _Feel Human_ is a sense of personal value and belonging, an aim that is sought in overcoming _System Entrapment_, feeling stuck within dehumanization as a result of feeling invalidated within the health care system. _System Entrapment_ exists within the context of past _Abuser Entrapment_, being stuck within IPV, and _Trauma Entrapment_, feeling stuck within suicidality. _Feeling Human_ is attained through _Hunting_ and several sub-processes, including _Distancing, Grasping for Help, Applying Counter-Pressure, Enduring System Entrapment, Soaking in Validation_, and _Letting Go_. The sub-processes are a way of
Taking the Path of Least Disempowerment, a journey that is guided by Gauging Validation opportunities. Depending upon the ratio of System and Trauma Entrapment that is Gauged, the Hunt will retreat or move toward the system. This substantive theory helps to fill in the gaps on understanding chronic suicidality and trauma in women.

Implications of this study involve a movement toward a Recovery Model through which services are adapted to clients’ needs. Ultimately, health care providers’ ability to validate suicidality by sharing their mutual humanity is the most powerful contributor to Feeling Human.
DEDICATION

I owe this to Aaron,

who lead me

homewood to home

tomorrow to now

ed to us.
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Chapter One: Introduction to the Research

The Problem

Women who have experienced intimate partner violence (IPV) often feel hopeless about their lives and sometimes wish to end their psychological pain through suicide (Smith et al., 2016; Wolford-Clevenger & Smith, 2017). Abusive relationships cause an immeasurable amount of psychological distress for women through a complex tapestry of power and control (Zarling, Orengo-Aguayo, & Lawrence, 2016; Stark, 2009). IPV contributes to a substantial portion of women’s health problems worldwide (Lim et al., 2012), intruding on their lives at varying levels including social, economic, emotional, physical, spiritual, sexual, and other dimensions (Edwards, Neal, & Rodenhizer-Stämpfli, 2017; Woods & Gill, 2011; World Health Organization [WHO], 2016a; Wuest, Ford-Gilboe, Merritt-Gray, & Berman, 2003). Perceiving a lack of support due to the isolation that accompanies IPV relationships (Anderson et al., 2003; Arnault & O'Halloran, 2016; Dixon, Hamilton-Giachritsis, Browne, & Ostapuik, 2007; Hall, Walters, & Basile, 2012; Kyriakakis, Dawson, & Edmond, 2012; Nicolaidis et al., 2011; Ragusa, 2017; Reina, Lohman, & Maldonado, 2014; Ting & Panchanadeswaran, 2016) and being overwhelmed by the stress of experiencing violence, women may respond with suicidal thoughts and behaviours. Feeling trapped with few perceived options to cope with the trauma of being abused, women may feel that there is no other option to improve their situation besides ending their lives.

As a psychiatric clinical nurse specialist working with women who are experiencing suicidality, I understand that obtaining help for these thoughts, feelings, and behaviours is critical to avoid self-harm or death. Providing the right kind of help
requires an examination of women’s perspective on how to provide care that will meet their needs. Specifically, evaluating care received within psychiatry is vital because it has taken ownership of suicidal treatment. Fittingly, due to the stigma of suicide and a deficiency of knowledge on managing people’s suicidal behaviour, clinicians from other sectors of the health care system aside from mental health services often avoid treating suicidality and have an expectation that they will be managed within mental health services. Evaluating how women who have been abused receive help within the mental health system is also important considering the fact many experience mental health problems (Golding, 1999; Hegarty, 2011; Larsen, 2016; WHO, 2013a).

Unfortunately, the psychiatric treatment for suicidality that I have witnessed within my practice and those of my colleagues across Canada is often less therapeutic than desired and can even be harmful, a finding also supported within the literature (Double, 2011; Cutcliffe & Happell, 2009; Cutcliffe, Santos, Kozel, Taylor, & Lees, 2015). Instead of an integrated and seamless system that provides continuity of care, mental health services are fragmented and operate in silos (Mental Health Commission of Canada, 2014). In other words, mental health services are very specialized and focused on the client’s present psychiatric symptoms only, ignoring the larger social, emotional, economical, or political aspects of the person’s mental health status. For example, focusing the treatment of a single mother’s depression on medication therapy is of limited value without addressing her living conditions and ability to pay for the medications.

Neglecting to see the person holistically, health care providers (HCPs) often do not integrate other services into the care of the person with a mental health problem. Treating one aspect of people’s mental health condition at a time may lead to missing
important aspects of their lives that influence their health outcomes. Furthermore, compartmentalizing different health conditions of a person minimizes their humanity and relationships since others may not fully understand the depth and extent of their health challenges. Fragmented services and failing to appreciate the person as a holistic human being are barriers to recovering from suicidality that I have found in my practice. For example, a woman admitted to the psychiatry unit after disclosing suicidal thoughts and a history of abuse in her family physician’s office may not even be assessed for IPV during her hospital admission. While her immediate physical safety is prioritized within the psychiatric unit, the conditions that relate to the suicidality are not addressed. The extent of the abuse and how this trauma has impacted her health may be ignored and she would most likely be discharged back into the community without any safeguards to lessen the risk of further negative health consequences related to her abuse.

The way people are treated within mental health services has resulted in much controversy. For instance, the delivery of care is criticized for being coercive and unethical (Andersen & Nielsen, 2016; Barker, 2009; Barker & Buchanan-Barker, 2012; Bowers, 2014; Cutcliffe & Links, 2008; Fioritti & Marcacci, 2016; Heumann, Bock, & Lincoln, 2017; Kwok, Matorin, & Kahn, 2012; Potter, 2015). Having worked within diverse mental health settings in the community and institutions, I have observed that services that cause the most controversy are in psychiatric in-patient units where treatment is often delivered in a custodial or punitive manner. A large portion of the treatment provided on a psychiatry unit involves providing a safe physical environment; therefore, the work becomes task-orientated so as to prevent self-directed bodily harm.
While maintaining physical safety is critical, doing so in a coercive manner is harmful because clients’ dignity is violated, their sense of self is disrupted, and their sense of power over their lives is decreased (Paterson, 2011; Johansson, Skärsäter, & Danielson, 2006; Luciano et al., 2014; Stenius & Veysey, 2005). Coercive treatment is also unethical because the right to autonomy or self-determination is violated and the professional neglects to uphold their responsibility to provide non-maleficence or to do-no-harm toward the clients (Barker, 2009; Paterson, 2011; Steinert, 2017; Zolnierek, 2007). Moreover, focusing on the woman’s immediate physical threat of self-harm without addressing the underlying causes of the suicidality, including past abuse, does little to prevent problems from recurring in the future. For example, Stenius and Veysey (2005) found that psychiatric in-patient treatment was unhelpful to women’s mental illness recovery due to the lack of attention to their emotions related to past abuse, the focus on medication adjustments, and the constant effort to control their behaviour. Alternatively, facilitating the enhancement of women’s insight into their own problems and sense of empowerment through connections with the staff and the greater community may help women to live more fully into the future.

Few have written on the effectiveness of services for women who have experienced both IPV and suicidality. The literature regarding women who have been abused demonstrates that services around the world are inadequate (Djikanovic, Celik, Simic, Matejic, & Cucic, 2010; Ellsberg, 2006; WHO, 2016a) as they ignore the wider complex psychological, cultural, and socio-political factors that influence women’s health needs (Dobash & Dobash, 1992; Koshan & Weigers, 2007; Postmus & Hahn, 2007; Stockman, Hayashi, & Campbell, 2015). Neglecting critical aspects of women’s
health is unethical as there is a high potential for doing harm. In this way, it is ironic that the very health services aimed to treat suicidality in women who have a history of IPV can further victimize them. Discovering new ways of providing health care services for women is needed to reduce the harmful effects of violence and to increase their sense of hope for the future.

**Power dynamics.** Due to power imbalances within IPV relationships (Jansen, Nguyen, & Hoang, 2016; Kelly, Gonzalez-Buarda, & Taylor, 2011) and the feelings of powerlessness in people who are suicidal (Auerbach, Millner, Stewart, & Esposito, 2015; Edmonson, 2002; Fogarty et al., 2015; Sark, 2006), it is crucial to take a closer look at power dynamics in order to help women. Power, the application of pressure by those who are dominating onto those who are being dominated, is inherent within social relationships and ingrained within all aspects of social life (Foucault, 1977; Heizmann & Olsson, 2015). In this way, power is considered a “social relation” (Tew, 2006, p. 39) among different levels of society, impacting people’s identity and how they perceive themselves. Imbalances of power within society benefit dominant groups at the expense of marginalized groups (Magnusson & Marecek, 2017; Tew, 2006). For example, women have an entrenched history of oppression through varying levels of violence and other social injustices (Delphy, 2016; Kelly et al, 2011).

Power imbalances in abusive relationships leave women to struggle both in managing the effects of being marginalized and acquiring equitable opportunities in order to thrive. Stark (2009) and others (Bograd, 1988; Wolford-Clevenger & Smith, 2017; Zarling et al., 2016) relay how the IPV relationship is characterized by coercive control where an abusive partner, often a man, uses his power to harm and take advantage of his
intimate female partner. Moreover, unequal power dynamics within society interfere with the woman’s ability to protect herself while experiencing the short and long-term effects of IPV.

While the literature regarding power dynamics in relation to IPV focuses on the interrelationships among the women, her abuser, and the rest of society, the focus of power dynamics in relation to suicidality brings greater insight to the individualized or internalized effects. That is, people experiencing suicidality have a low sense of self-efficacy, (Pompili, Girardi, Lester, & Tatarelli, 2007), feel hopeless about changing their situation (Stewart, 2007), and thus, feel powerless to improve their situation. Although most of the discussions around the concept of power within the suicide literature refer to the individual, some of the literature indirectly refers to society’s abuse of power over people who are suicidal through stigma. Indeed, people experiencing suicidal behaviours experience serious social stigma (Corrigan, Sheehan, & Al-Khouja, 2017; Lester & Walker, 2006; Rogers & Soyka, 2004; Schwenk, Davis, & Wimsatt, 2010).

People in society exert a sense of entitlement over individuals who are suicidal through their judgmental attitudes and misunderstandings about suicidality. Stigma may also create self-doubt and shame in people feeling suicidal, making it difficult to reach out for support (Marsh, 2010) and thereby contributing to the sense of powerlessness. Added to the stigma of suicide is that of having been abused by an intimate partner (Eckstein, 2010) and being female (Hesse-Biber, Leavy, & Yaiser, 2004; Kelly et al., 2011). Negative implications are created through a multiplicity of intersectins with unique effects dependent upon those interactions (Kelly et al., 2011; Morrow, 2007),
including the stigma of mental health combined with the stigma of violence, gender, and poverty.

Power dynamics even exist within mental health services aimed at helping people who are suicidal. Psychiatric in-patient services are often insufficient and the provision of care is limited to restrictive measures including observations and seclusion with the purpose of controlling the person’s behaviours (Cutcliffe & Barker, 2002; Hörberg & Dahlberg, 2015). Moreover, mental health services provided outside the walls of the institution often involve the misuse of power to get clients to do what is seen as best for them based upon objective criteria of the professional while ignoring the clients’ perspective. For example, clients are discharged from community mental health services when they miss a certain number of group therapy sessions, despite the possibility that their low attendance is a result of having a mental health problem in the first place. That is, depression and other mental illnesses can result in reduced motivation, social anxiety, and low energy, symptoms that make leaving the house and interacting with others very challenging (American Psychiatric Association, 2013).

Persistent and intense feelings of hopelessness and despair in clients may eventually lead to clinicians questioning their ability to help. Frustrated with these difficulties and advantaged regarding power, service providers exert control over the client by playing the expert while the client plays the sick role. Without critically analyzing these power dynamics, ineffective and unethical treatment for people who are suicidal will continue.

**Purpose and objectives.** Wuest (2012) writes, “the starting point in grounded theory is not a focused research question, but rather exploration of a domain of human
behaviour” (p. 230). The focus of inquiry in this study was the nature of help-seeking among women with partner abuse histories who are suicidal. The purpose of this study was to develop a theoretical rendering of how power relations affect women’s help-seeking from the mental health system when they are suicidal and in the context of a history of partner abuse trauma. Another research objective was to better understand how the mental health care system might improve in its ability to build capacity for women who have experienced IPV when they seek help for suicidality.

This study involves a multiple method grounded theory (GT) and photovoice (PV) methodology, an exploratory qualitative research approach through which women’s perspectives can be seen and heard. GT is a research approach amenable to capturing what is most problematic about help-seeking for women and a theoretical understanding of how they manage this experience. The incorporation of PV, a participatory research approach where people tell their stories through self-generated photography, allowed for enhanced participant engagement and provided another vehicle for women to share what has been meaningful to them. Offering photography as a means of data collection enabled the women in the study to express themselves about experiences that are difficult to put into words, yielding data that reflects the complexity of their journey.

Clarification of Terms

The term suicide is defined within this study as the act of purposefully killing oneself (De Leo, Burgis, Bertolote, Kerkhof, & Bille-Brahe, 2006). The term suicidality encompasses the following: (a) thoughts or ideations of killing oneself; (b) planning suicide; (c) practising or rehearsing suicide by going through the motions of the planned suicide without actually harming oneself; and (d) attempting suicide or surviving an
intentional effort to kill oneself. Parasuicide, a term that encompasses self-injurious behaviour without intent to die (Kreitman & Foster, 1991), is not included in the definition of suicidality within this study. The occurrence of suicidality was determined based on the women’s self-report of suicidality.

The term intimate partner violence (IPV) is defined within this study as any controlling behaviour by a current or past intimate partner that causes harm to the individual’s physical, sexual, or psychological well-being (Heise & Garcia-Moreno, 2002). The occurrence of IPV was the women’s account of having experienced physical, sexual, or psychological harm from a past intimate partner. The term power relations refers to an application of pressure or relationships involving dominance and subjugation (Foucault, 1977) within and among people, institutions, the community, and society as a whole.

The words “to seek help” within the purpose statement imply that the women desire assistance for their suicidality and are engaged in thinking about or taking actions to accomplish this. Help-seeking includes isolated events or ongoing efforts to ascertain aid for suicidality from the mental health care system. The mental health care system is made up of various sections of the health care system that address a person’s emotional, cognitive, and psychological health. These services may include mental health clinics, psychiatric departments, and addictions services; however, they are not limited to services that are exclusively designed to treat mental health issues. Primary HCPs, for example, family physicians, and public health professionals are included in the definition of the mental health system because the goal for primary health care is to offer care for all of people’s basic health needs, including mental health (WHO & UNICEF, 1978).
Chapter Two: Literature Review

Some authors caution against reviewing the literature before conducting GT research because it may obstruct the researcher’s ability to see the theory emerge from the data (Beck, 1999; Glaser, 1992; Glaser, 2004). As GT has evolved, however, it is not uncommon to include a primary review of the literature in the beginning of a GT study to ensure that the topic has not been adequately researched and to obtain an idea of the theoretical knowledge in the area of inquiry (Cone & Artinian, 2009; Cutcliffe, 2000; Hutchinson & Wilson, 2001; Stern, 1980; Stern & Porr, 2011; Wuest, 2012). Reviewing the literature also illuminates knowledge gaps that help to justify the research purpose and question.

The State of Knowledge

There is very little written on how women who have experienced IPV seek help for their suicidality; however, there is literature that separately describes suicide, IPV, and treatment for these experiences. There are many research studies that describe the reasons for and consequences of suicide, but fewer studies on how people seek help for suicidality or how women who have experienced IPV access help. Reviewing the literature on these different topics helps gain a sense of the state of knowledge on suicide treatment and IPV. Identifying the gaps within the literature also illuminates areas of inquiry to learn how to better assist women.

Suicides account for 1.4% of deaths worldwide (WHO, 2017) and the link to IPV is clear. One study found that 17% of over 4,000 people who died by suicide in the US had experienced IPV (Comiford, Sanderson, Chesnut, & Brown, 2016) and another reported that 20% of women in a domestic violence shelter had thought of suicide within
the past two days (Wolford-Clevenger & Smith, 2017). The magnitude of the problem is highlighted when considering that at least 15% of women around the world and up to over half of the women in some countries have been abused by an intimate partner (Bott, Guedes, Goodwin, & Mendoza, 2012; Garcia-Moreno, Jansen, Watts, Ellsberg, & Heise, 2006), averaging 35% of women who have experienced sexual or physical IPV (WHO, 2013). Rates of IPV in Canada are underestimated. While 93,000 women within 2017 reported IPV to the police in Canada (Statistics Canada, 2018), up to 70% of IPV is not reported (Statistics Canada, 2016). Despite this disturbing evidence, little exists within the literature on how women who have experienced IPV and suicidality attain help.

Not only is the literature on suicide treatment sparse regarding how women who have experienced IPV attain help, but the research on suicide treatment is usually not differentiated between men and women; therefore, women’s unique experiences are not captured. Furthermore, little research exists on receiving help for IPV experiences within mental health services, settings that frequently treat women who have been abused. Despite these gaps, the literature on how women seek help within the health care system when they have experienced IPV or are feeling suicidal will be explored here. Discussing suicide and IPV in the wider socio-political context of women’s lives will also help piece together what is known about women’s suicidality when they have a history of IPV.

Within this literature review, studies on suicide risk factors are reviewed; firstly, a body of research that represents the bulk of the literature on suicide will be examined. Secondly, the evidence within the literature on how IPV relates to suicide and a decline in mental health functioning are discussed; and thirdly, influences of suicide care, including
stigma are delineated. Finally, the literature on suicide care of women is reviewed and knowledge gaps identified.

**Suicide risk factors.** Suicide is a complex and multifaceted phenomenon that is often misunderstood despite having been empirically studied for over 60 years. Durkheim (1951), a modern sociologist, was one of the first people to perform epidemiological studies on suicide. He found that suicide risk increased in people who were single, were without children, lived in a Scandinavian country, or had fought in a war. Most of the research on suicide reviewed for this study were quantitative correlational studies. Risk factors are helpful in identifying people who might become or are currently suicidal; however, they cannot predict if or when a person will die by suicide (Large, Smith, Sharma, Nielssen, & Singh, 2011; Oquendo, Currier, & Mann, 2006; Nock, Millner, Deming, & Glenn, 2014; Powell, Geddes, Deeks, Goldacre, & Hawton, 2000; Franklin et al, 2017).

Suicide cannot be attributed to a single cause; however, some risk factors carry more weight than others. For example, a past suicide attempt places a person at a much higher risk than other factors (Bolton, Pagura, Enns, Grant, & Sareen, 2010; Choi, Park, Yi, & Hong, 2012; Clark et al., 2013; Fowler et al., 2012; Ongeri et al., 2018; Uebelacker, Weisberg, Millman, Yen, & Keller, 2013). Other suicide risk factors include: (a) hopelessness (Boffa, King, Tureki, Schmidt, 2018; Gooding et al., 2015a; Langhinrichsen-Rohling, Lamis, & Malone, 2011; Lazary et al., 2012); (b) identification as a sexual minority (Peter & Taylor, 2014; Swannell, Martin, & Page, 2016); (c) unemployment (Huikari & Korhonen, 2016; Mäki & Martikainen, 2012; Schneider et al. 2011); (d) mental illness (Maguen, Skopp, Zhang, & Smoleinski, 2015; Mu et al., 2016;
Shelef et al., 2015); (e) family history of suicide (Lopez-Castroman et al., 2012; Rodante et al., 2016; Tidemalm et al., 2011); and (f) ineffective coping skills (Li & Zhang, 2012; Panagioti, Gooding, Taylor, & Tarrier, 2012; Tang, Xue, & Qin, 2015).

Men die by suicide more often than women (Statistics Canada, 2014; WHO, 2014; 2017); however, being a woman may be a risk factor for having suicidal thoughts and behaviours because women attempt suicide (Elisei, Verdolini, & Anastasi, 2012; Pavarin et al., 2014; Sadeh & McNiel, 2013; Stevovic & Vodopic, 2017), have suicidal ideation (Brownson, Drum, Smith, & Denmark, 2011; Nowotny, Peterson, & Boardman, 2015; Scott et al., 2012), seek help from a mental health professional for suicidal ideation (Cox, 2014; Encrenaz et al., 2012; Gontijo & Vasilliadis, 2016; Wang et al., 2015), seek help in the emergency department (ED) for suicidal behaviour (Atay, Backik Yaman, Demegrda, & Akpinar, 2014; Eroglu et al, 2014; Larkin, Smith, & Beautrais, 2008; Simsek, Demir, Er, & Munir, 2013; Wei et al., 2013; Zeppenno, et al., 2015), and are hospitalized for suicidality (Narishige, Kawashima, Otaka, Saito, & Okubo, 2014; New Brunswick Department of Health, 1999; Tsirigotis, Gruszczynski, & Tsirigotis-Maniecka, 2014) more frequently than men. Women also experience depression (Borooah, 2010; Ntountoulaki et al., 2016; Rahme et al., 2016), anxiety (Chang, 2018; Bitsika, Sharpley, & Melhem, 2010; McLean & Hope, 2010), post-traumatic stress disorder (PTSD; Ditlevsen & Elklit, 2010; Mason et al., 2017), and IPV (Statistics Canada, 2018; WHO, 2010) more often than men; all factors that are associated with suicide. The frequency of these risk factors in women reflects the gendered-nature of suicidality.

Adverse childhood experiences are risk factors for suicide (Fuller-Thomson, Baird, Dhrodia, & Brennenstuhl, 2016), including physical abuse (Low, Kwok, Tam,
Yeung, & Lo, 2017; Kokouлина & Fernández, 2014) and sexual abuse (Afifi et al., 2008; Angst et al., 2014; Bedi et al. 2011; Cankaya, Talbot, Ward, & Duberstein, 2012; da Cruz Pires et al., 2012; Daray et al., 2016; Devries et al., 2014). Another correlation to suicide is lifetime abuse in women (Clements-Nolle, Wolden, & Bargmann-Losche, 2009; Fuller-Thomson, Baird, Dhrodia, & Brennenstuhl, 2016), including sexual abuse (Angt et al., 2014; Cankaya et al., 2012; daCruzPires, Raposo, Pires, Dougey, & Filho, 2012; Devries et al., 2014; Lamis et al., 2017; Lara, Navarrete, Lourdes, & Le, 2015; Power et al., 2016). A common type of abuse in women, IPV, has also been researched and documented within the literature in relation to suicide.

**Intimate partner violence.** IPV is the most common form of violence against women (Garcia-Moreno et al., 2006; Statistics Canada, 2018) and accounts for a sizeable impact of negative health effects for women globally (Johnson, Ollus, & Nevala, 2008; Lim et al., 2012; WHO, 2013a). IPV occurs mostly to women at the hands of their male partners (Howard et al., 2010; Statistics Canada, 2018; WHO, 2010) and is characterized by coercive control or the use of force and manipulation to dominate (Bograd, 1988; Kelly et al., 2011; Stark, 2009; Wolford-Clevenger & Smith, 2015). One of the more serious consequences of IPV is that it is associated with suicidality (Alhusen, Frohman, & Purcell, 2015; Antai & Anthony, 2014; Cavanaugh, Messing, Eyzerovich, & Campbell, 2015; Ellsberg, Jansen, Heise, Watts, & Garcia-Moreno, 2008; Falb, McCormick, Hemenway, Anfinson, & Silverman, 2013; Lamis et al., 2017; Leiner, Compton, Houry, & Kaslow, 2008; Nahapetyan, Orpinas, Song, & Holland, 2014; Naved & Akhtar, 2008; Ongeri et al., 2018; Renner & Markward, 2009; Shamu, Zarowsky, Roelens, Temmerman, & Abrahams, 2016; Sharhabani-Arzy, Amir, & Ben-Yacov, 2002;
Smith et al., 2016; Wolford-Clevenger & Smith, 2017; Wong & Philips, 2009; Yanqiu, Yan, & Lin, 2011). Not only does suicidality associate with IPV, but 36% of women receiving treatment in the ED after attempting suicide reported that IPV was the number one reason for their suicide attempt (Simsek et al., 2013). Indeed, IPV is related to a decline in mental health functioning in several different ways that may contribute to being overwhelmed and eventually feeling suicidal.

To begin, IPV is associated with substance use problems (Cafferky, Mendez, Anderson, & Stith, 2018; Gilbert, 2010; Smith, Homish, Leonard, & Cornelius, 2012) and between 40-70% of women who have experienced IPV have been found to be depressed (Craparo, Gori, Petruccelli, Cannella, & Simonelli, 2014; Flanagan, Sullivan, & Connell, 2015; Golding, 1999; Kastello et al., 2016; Woolhouse, Gartland, Hegarty, Donath, & Brown, 2012). IPV also leads to PTSD (Aupperle et al., 2016; Martinez-Torteya, Bogat, von Eye, Levendosky, & Davidson, 2009; Sullivan, Cavanaugh, Buckner, & Edmondson, 2009; Svavarsdóttir, Orlygsdottir, & Gudmundsdottir, 2015), an intrusive anxiety-based psychiatric condition that can result from experiencing a highly threatening event evoking intense fear, helplessness, or horror (American Psychiatric Association, 2013). The cumulative effects of repeated lifetime of abuse worsen depression (Charak, Berkmoes, Ndayisaba, & Reis, 2017; Hedtke et al., 2008; Wanklyn, Day, Hart, & Girard, 2012), PTSD (Agorastos et al., 2014; Charak et al., 2017; Cloitre et al., 2009; Hedtke et al., 2008), and substance abuse (Clements-Nolle, Larsen, Buttar, & Dermid-Gray, 2017; Hedtke et al., 2008). While suicide is directly associated with IPV, it may also be indirectly associated with IPV because depression (Davidson, Wingate, Grant, Judah, & Mills, 2011; Ongeri et al., 2018; Brown & Vinokur,
PTSD (Calabrese et al., 2011; Ongeri et al., 2018; Panagioti et al., 2012) and substance abuse problems (Bagge & Sher, 2008; Harned, Najavits, & Weiss, 2006; Miller, Histchfeld, Lineberry, & Palmer, 2016; Sundin, Spak, Spak, Sundh, & Waern, 2011) increase the risk of suicidality.

The consequences of IPV also include chronic pain (Humphreys, Cooper, & Miaskowski, 2011; Tiwari, Fong, Chan, & Ho, 2013; Wuest et al., 2010), a condition associated with hopelessness (Matthias, Miech, Myers, Sergent, & Blair, 2014; van Heeringen, Vervaet, Soenen, & Audenaert, 2010). Hopelessness, an important risk factor for suicide (Tang, Beckwith, & Ashworth, 2016), is also directly associated with IPV (Arnault & O’Halloran, 2016; Lamis & Kaslow, 2014). Suicidality in relation to IPV is a critical issue due to the pervasive nature and frequency of this type of abuse. Statistics Canada (2015) reports that IPV occurs to 72,000 women a year, the most frequent violent crime against women reported to police. In a multi-country study by the WHO, 30-60% of women had experienced physical and/or sexual violence by an intimate partner (Garcia-Moreno et al., 2006). These statistics do not represent the full extent of IPV because the study excluded other forms of psychological harm that are included in WHO’s definition of IPV. Indeed, the rates of violence against women are often underestimated (Kelly et al., 2011; McMillan, 2007; WHO, 2010), in part due to women’s underreporting as disclosure often places their emotional and physical safety at risk (Alaggia, Regehr, & Jenney, 2012; Andersson et al., 2009).

There are a few studies on suicide risk factors in women who have experienced IPV. One found that in women who experienced IPV, a family history of drug abuse and having witnessed a mother being battered compounded the suicide risk (Ragin et al.,
Kaslow et al. (2002) found that suicide risk factors in low-income African American women who had experienced IPV include stressful life events, child abuse, psychological pain, depression, hopelessness, and drug abuse. Further, Leone (2011) noted that the suicide risk for women who experienced coercive control was twice as high as for women who experienced episodic physical abuse with no coercive control. This finding suggests that the aspect of IPV that is associated with suicide may be coercive control or women having a low level of empowerment (Leone, 2011). Similarly, studies have found that the association between suicide attempts and IPV may be due to feelings of powerlessness related to social isolation (Reviere et al., 2007) and the inability to forgive oneself for having been abused (Chan, Kahle, Yu, & Hirsch, 2014). Finally, literature on trauma indicates that a traumatic experience, including IPV, shatters a woman’s view of the world and sense of meaning (Harris & Fallot, 2001; Herman, 1992), a process that may reinforce the relationship between IPV and suicide. However, women who experienced IPV were found to have a reduced suicidal risk if they had good coping skills and accessibility to appropriate resources (Kaslow et al, 2002). Other protective factors against suicide in women who have experienced IPV are social support and feelings of hope (Kaslow et al, 2002; Meadows, Kaslow, Thompson, & Jurkovic, 2005).

Although IPV is associated with increased help-seeking (Ford-Gilboe et al., 2015) and cumulative violence is associated with increased help-seeking for mental health problems (Cho & Kwon, 2017), health professionals are ill-equipped with skills and resources on providing care to women who have experienced IPV (Colombini, Mayhew, & Watts, 2008; Djikanovic et al., 2010; Hamberger & Phelan, 2006; Heise & Garcia-Moreno, 2002; Herz, Stroshine, & Houser, 2005; Kasturirangan, 2008; Kim & Motsei,
For example, health professionals often neglect to detect IPV (Abu, 2016; Colombini et al., 2008; Olive, 2006; Plichta, 2007; Rhodes et al., 2007; Sylvester, 2018) and when IPV is detected, they feel that they do not know how to help (Djikanovic et al., 2010; Ellsberg, 2006; Rose et al., 2011). In particular, ED nurses have been found to be dismissive and avoid addressing the needs of women who have experienced IPV (Fay-Hillier, 2017; Rhodes et al., 2007; Varcoe, 2001; Zijlstra, van de Laar, Moors, Lo Fo Wong, & Lagro-Janssen, 2017), despite the finding that women want these issues to be explored in the ED (Olive, 2006). Negligent care results from a lack of knowledge about IPV and negative attitudes and beliefs toward women who have experienced IPV (Goldblatt, 2009; Locke, Wan, & Hayter, 2012; Keeling & Fisher, 2015; Stenius & Veysey, 2005). Specifically, women with abuse histories report health professionals’ lack of trauma sensitivity deteriorates their sense of safety (Bender, 2016; Keeling & Fisher, 2015; Lugo, 2016; Stenius & Veysey, 2005) and prevents them from disclosing IPV (Catallo, Jack, Ciliska & MacMillan, 2012).

Part of the negative attitudes toward women who have experienced IPV derive from the belief that women can simply choose to leave an abusive partner (Clement, 1996; Edwards, Dardis, Sylaska, & Gidycz, 2015; Hankivsky & Varcoe, 2007; Loue, 2002), a belief that may impinge on their access to support when they are help-seeking. When women stay in the abusive relationship they are blamed for their distressing situation (Adelman, Rosenberg, & Hobart, 2016; Eckstein, 2010; 2011; Friedman, 2003; Meyer, 2016) while oppressive socio-political pressures preventing them from leaving
are ignored (Tessman, 2001). A woman experiencing IPV exists within a complex interrelationship where the abuser exerts control over her and she is manipulated in complex ways so that reaching out for help (Newman, Seff, Beaulaurier, & Palmer, 2012) and leaving the abusive relationship becomes difficult or dangerous (Anderson et al., 2003; Kelly et al., 2011; Madhani et al., 2017; Nicolaidis et al., 2003). This relationship is made even more complicated through societal tolerance of violence against women (Corvo & Johnson, 2012), making the process of leaving more strenuous (Ford-Gilboe, Varcoe, Wuest, & Merritt-Gray, 2011; Kelly et al., 2011). For example, law enforcement personnel have been found to minimize women’s safety needs when they seek help for protection against their abusive intimate partners (Durfee & Fetzer, 2016; Pattavina, Hirschel, Buzawa, Faggiani, & Bently, 2007; Tang & Tam, 2003).

Improving services for women who have experienced IPV involves integrating culturally safe interventions into the provision of care. For example, health care professionals “should understand how the dominant culture shapes violence in their particular contexts” (Ford-Gilboe et al., 2011, p. 145). More effective services are provided through the following: (a) identifying women’s history of abuse, not only the present incident of IPV; (b) discussing strategies on how to create a safety plan; (c) partnering with women, other HCPs, and domestic violence services; (d) helping women to manage symptoms related to experiencing IPV; (e) helping women find their way through the different systems of care through case management, and (f) participating in political advocacy for programs and policies that prevent violence against women and support women who have experienced IPV (Ford-Gilboe et al., 2011). Ford-Gilboe et al. (2017) emphasize the importance of offering services that “maximize choice and control”
In addition, supporting traumatized children who witness IPV is crucial as their sense of safety and trust in the world has been damaged (Berman, Hardesty, Lewis-O’Connor, & Humphreys, 2011). Examples of how to support women and their children include: (a) identification and referral for all family members; (b) crisis intervention; (c) provision of support groups and counselling in shelters; (d) child-rearing programs; and (e) assistance in marital and/or child custody disputes (Berman et al., 2011). Remaining aware of the dangers of IPV, providing a non-judgmental stance, and providing interventions within a therapeutic relationship should enhance the success of services for women who have been abused.

**Suicide Care**

A considerable amount of literature describes ways of caring for or treating someone who has suicidal thoughts and behaviours. The social conceptualizations of suicide and stigma are important factors that have an impact on the perceptions and assumptions about someone who is suicidal and can influence the quality of interventions.

**Impact of social conceptualizations.** Conceptualizations of suicide that influence the services and care of people who are suicidal are described in the literature. To begin, the literature has historically reflected the belief that suicide is wrong. Since the middle ages, suicide has been considered a sin within Christianity, the dominant theology of Western societies (Clemons, 1985; Joiner, 2010; Minois, 1999; Phipps, 1985). In fact, suicide is denounced in all major religions (Khan & Mian, 2010). The sanctity of life is highly valued in Western culture (Haber, 1997; Horrobin, 2006), contributing to the belief that ending one’s life is immoral. Suicide is also historically conceptualized as
being reprehensible within philosophy as Plato (Cholbi, 2017; Novak, 1975), Aristotle (Minois, 1999), and Kant (Cooley, 2013; Kant & Ellington, 1981) denounced suicide, a condemnation that influences clinical practice to this day (Khan & Mian, 2010). The most significant contribution toward suicide conceptualizations within philosophy is the idea that the existence of suicide symbolizes the “intrinsic limitedness of man” (Novak, 1975, p. 127) or that suicidality implies that the individual is limited and inadequate. The person with suicidality is perceived to be the sole culprit involved in this behaviour as suicide by definition is an act of killing oneself that is carried out by the individual (De Leo et al., 2006).

The culpability of suicide is reflected in how it was punishable by law in Western countries until recently (Mishara & Weistubb, 2005). The treatment of suicidality parallels this punitive attitude, reflecting an underlying assumption that suicide is a “unitary act with a singular meaning: pathology” (Marsh, 2010, p. 66). In other words, health care professionals may consider the suicidal individual to be defective in some way. Further, many mental illnesses are highly correlated with suicide (Maguen et al., 2015; Mu et al., 2016; Qin, 2011; Saugstad, 2000; Shelef et al., 2015; Viilo et al., 2005) and are considered to be “internal aspect[s] of the individual” (Marsh, 2010, p. 51). In this way, the person is thought to be responsible for his or her problems (Marsh, 2010).

Suicidality is considered evidence of a psychiatric problem; therefore, the management and treatment of suicidality is seen as the responsibility of psychiatry and mental health clinicians. In this way, acknowledging the beliefs and assumptions about suicidality within the field of psychiatry and how these beliefs influence treatment is important. Historically, the discipline of psychiatry enabled women’s oppression and
maintained traditional feminine roles with the belief that women were weak and incapable of managing difficult emotions (Halliday, 2005; Morrow, 2007; Potter, 2015; Ussher, 1991). Pathologizing women within a psychiatric context dates to the late 19th century when Freud realized that talk therapy with women who presented with intense fear, despair, and uncontrollable emotions was important for their treatment (Anleu & Hornosty, 2012; Herman, 1992; Ussher, 1991). He labeled them as being hysterical, a condition that was believed to have derived from the female sexual organs (Anleu & Hornosty, 2012; Herman, 1992; Ussher, 1991), but has since been acknowledged as PTSD (Chesler, 2005; Herman, 1992). To this day, violence against women is pathologized, medicalized, and conceived as being an individual problem instead of a “manifestation of relationships between men and women as they are constructed in their society” (Wilkerson, Sherwin, & Batt, 1998, p. 21). In light of this hostile ideological environment, it is clear that women are not only blamed for their suicidality, but also for the trauma that may have contributed to it.

The most revered suicide prevention and treatment practices are founded on the idea that suicide behaviour is cognitive in nature (Beck, 1979; Ellis, 2006; Wenzel, Brown, & Beck, 2009). The psychiatric literature reflects the general idea that people who are suicidal are cognitively debilitated or deemed to be irrational and incompetent (Leeman, 2009; Marsh, 2010; Werth, 1998). The focus of best practice treatment for depression and suicidality is cognitive behavioural therapy (CBT; Beck, 1979; Ellis, 2006; Wenzel et al., 2009) and dialectical behaviour therapy (DBT; Gratz & Tull, 2011; Linehan, 1993a, 2015; Salsman & Linehan, 2006). Studies consistently show that DBT helps to decrease suicidality (Coyle, Shaver, & Linehan, 2018; Low, Jones, Duggan,
Power, & MacLeod, 2001). It was originally created to help women with the diagnosis of borderline personality disorder (BPD; Linehan, 1993a; Robins, Zerubavel, Ivanoff, & Linehan, 2018), a psychiatric illness characterized by a pattern of unstable relationships, intense anger, a diffuse sense of identity, and chronic suicidality (American Psychiatric Association, 2013). The central aspect of DBT is a balance between accepting and receiving empathy for one’s painful realities while also making changes to improve the situation (Linehan, 1993a; 2015). The concept of change focuses on eliminating symptomatology and autonomously taking action to do things differently in order to effect different health outcomes. The concept of acceptance includes an acknowledgment of social connectedness and collective accountability. The ideology within DBT is to balance changing suicidal behaviour with validating distressing experiences (Kelly, Robinson, & Gerardi, 2018), whereas the basis for treatment within the medical model focuses solely on the former.

While learning problem solving skills has been found to be helpful in the recovery from suicidality (Asarnow, Hughes, Babeva, & Sugar, 2017; Bennett, Coggan, & Adams, 2002; Paulson & Everall, 2003), people may experience a sense of blame while undergoing some of these therapies (Ruiz, 2015). The focus of cognitive behavioural therapies and other types of counselling is on the individual to improve mood by changing thoughts while avoiding socio-political factors that influence depression in the first place (Ruiz, 2015). The belief that suicide is selfish (Joiner, 2010; Pompili, Girardi, Lester, & Tatarelli, 2007) is another conceptualization reflecting the idea that suicide is a choice. Indeed, Novak (1975) concluded that suicide is “egocentric narcissism in its most radical manifestation” (p. 127).
Another belief that underlies the therapies used to treat suicidal people is that suicide is behavioural. The idea is that suicidal people ought to change their behaviours associated with suicide (Marsh, 2010), such as using substances, being in an abusive relationship (Devries et al., 2011; Renner & Markward, 2009; Wong & Philips, 2009), and non-compliance with medication for mental illness (Ward, Ishak, Proskorovsky, & Caro, 2006). The assumption is that suicidal people are to blame for their condition because they are supposedly choosing to engage in risky behaviours and that if they were only to act differently they would be healed. Considering that suicide is a complex multifaceted phenomenon, expecting people to fix their behaviours is unrealistic, unsupportive, and ineffective.

**Impact of stigma.** Like mental illness, suicide is largely stigmatized within the wider society (Raingruber, 2002; Scocco, Preti, Totaro, Ferrari, & Toffol, 2017); however, while mental illness has slowly become more accepted in recent years, the level of stigma surrounding suicide has remained nearly the same (Sudak, Maxim, & Carpenter, 2008). In a Nova Scotia study, media coverage on suicide was more likely to be portrayed inappropriately as compared with coverage on mental illness (Kisley & Denney, 2007). Journalists emphasize the idea that suicide is an individual mental health problem and is “disassociated from other cultural meanings” (Marsh, 2010, p. 47), a myth that leads to blaming the suicidal person. For example, colonialism and racism contribute to Aboriginal women’s suicidality, while disconnecting them from traditional healing practices (Bohn, 2003; Paproski, 1997); however, society tends to blame Aboriginal people for their problems while ignoring oppressive or harmful socio-political factors that influence their well-being (de Leeuw, Greenwood, & Cameron, 2010; Nelson, 2013).
People who engage in behaviour that is viewed as immoral are considered tainted and discriminated against, as in the case of those living with HIV/AIDS, (Duffy, 2005a).

The stigma of suicide is so intense that even family members of a suicidal person suffer from its effects and ensuing shame. Families are pressured to conceal the cause of death when a loved one dies by suicide due to the stigma and judgments from others (Sveen & Walby, 2008). Further, people who have survived suicide attempts suffer the stigma of the attempt leading to feelings of embarrassment and isolation (Joiner, 2010; Lester, 1992; Lester & Walker, 2006). Youth also feel the stigma of suicide as they resist getting help, fearing others would think they were crazy (Curtis, 2010; Freedenthal & Stiffman, 2007; Gilchrist & Sullivan, 2006; Tingey at al., 2014). Stigma results from a lack of understanding and begets fear, disgust, contempt, and lack of compassion (Joiner, 2010).

These socio-cultural values are very powerful as they impact health professionals’ belief systems and negatively influence the way suicidal people perceive themselves (Horsfall, Cleary, & Hunt, 2010). People are expected to be strong by having a *stiff upper lip*, creating the belief that reaching out for help is a sign of weakness. In summary, these reports highlight general societal misunderstanding around suicide that can negatively influence help-seeking and ensuing interventions.

**Help-seeking.** Receiving care for suicidality often begins with a help-seeking process. Most people who died of suicide had seen a mental health professional or other health care provider within the last few months before their death (Deisenhammer, Huber, Kemmler, Weiss, & Hinterhuber, 2007; Kisely, Campbell, Cartwright, Bowes, & Jackson, 2011; Leavey et al, 2016; Lee, Lin, Liu, & Lin, 2008; Smith, Craig, Ganoczy,
Stanley, Horn, and Joiner (2015) found that 50% of people from a US national
represented sample who had suicide ideation within the past year had sought help from a
mental health service in that same year. Among those who died by suicide in New
Brunswick, 20-35% sought professional help one month before their death (Government
of New Brunswick, 2005; Sequin, Lesage, Turecki, Daigle, & Guy, 2007). Another study
found that 30% of people with suicidal behaviour went to the hospital for help (De Leo,
Cerin, Spathonis, & Burgis, 2005) and Ono et al. (2001) found that 15 out of 44 elderly
men who died by suicide had sought help for their problems. Cerel et al. (2016) found
that over 10% of people who died by suicide accessed help within the ED two weeks
before their death. In addition, while youth usually contact their peers for help, when
youth do access help from professionals, they are more likely to disclose their suicidality
than with their peers (Barnes, Ikeda, & Kresnow, 2001).

Not all people who are suicidal reach out to a professional as suicidality is
associated with an aversion to seeking help (Ahmedani, 2012; Calear, Batterham, &
Christensen, 2014; Han, 2015; Scheel, Prieto, & Biermann, 2011; Tingey et al., 2014).
Aboriginal college students surveyed reported that they would not seek help from a
professional if they were suicidal (Scheel et al., 2011). Studies have demonstrated that
people purposefully avoid seeking help (Chu, Hsieh, & Tokars, 2011; Freedenthal &
Stiffman, 2007; Pagura, Fotti, Katz, & Sareen, 2009) for various reasons, including the
perception that they do not need it (Brook, Klap, Liao, & Wells, 2006; Czyz, Horwitz,
Eisenberg, Kramer, & King, 2013; Hom, Stanley, & Joiner, 2015). Having greater
difficulty managing negative emotions is also associated with low levels of help-seeking
(Ciarrochi & Deane, 2001). People have been found to feel shame about seeking help for suicidality (Han & Olliffe, 2015; Kageyama, 2012); implicating stigma in lower levels of help-seeking (Downs & Eisenberg, 2012; Eagles, Carson, Begg, & Naji, 2003). The stigma of seeking help from a mental health professional may be the reason that youth have been found to seek help from their peers more often than from professionals (Barnes et al., 2001; Michelmore & Hindley, 2012). Difficulty accessing help also influences help-seeking. Access barriers to help for suicidality include lack of access to information, clinicians being unavailable at the time when help is needed, lack of transportation, lack of child care (Pagura et al., 2009), and being a part of a minority group (Brownson, Becker, Shadick, Jaggars, & Nitkin-Kaner, 2014). For people who do seek help and receive services, this is a vital opportunity for health professionals to engage in suicide prevention and care.

**Type of care received.** When people receive services for their suicidality they often experience care that is not helpful. One of the first points of contact is the ED. Unfortunately, many ED clinicians have been found to demonstrate judgemental and hostile attitudes toward clients seeking help for suicidality (Frey, Hans, & Cerel, 2016; Sethi & Uppal, 2006), including psychiatric clinicians working in the ED (Suominen, Suokas, & Lönnqvist, 2007). Another study demonstrated that 60% of the clients in the ED who attempted suicide felt they were not taken seriously and 50% felt that they were stigmatized or punished (Cerel, Currier, & Conwell, 2006). Similarly, standard psychiatry practices are critiqued in the literature as being rigid, impersonal, and custodial (Barker, 2009; Barker & Buchanan-Barker, 2006; Foucault 1965; Hall, 2004; Ladrido-Ignacio, Tan, & Quiring, 2017). For example, some people who were suicidal on an in-patient
psychiatric unit felt neglected and disrespected, were treated like children, and felt they were not being listened to by the clinicians (Samuelsson, Wiklander, Åsberg, & Saveman, 2000).

An example of a custodial treatment measure within psychiatric units is formal observation, an intervention to secure the safety of people at risk for self-harm. This safety strategy involves the psychiatric provider visually *eye-balling* the person at set intervals to make sure that he or she is not self-harming; however, it has not been found to be effective (Flynn et al., 2017; Manna, 2010; Sullivan, Barron, Bezmen, & Rivera, 2005). Since HCPs are not required to talk to suicidal people or engage them in any way during the observations, clients are denied emotional sanctuary where they feel safe to explore their emotions (Cutcliffe & Barker, 2002; Scotland National Health Service, 2002). Another hospital-based psychiatric practice used to manage suicidality is seclusion or locking the person alone in a room. While the purpose is to maintain safety, this can leave them feeling disconnected and powerless (Frueh et al., 2005; Iversen et al., 2011; Mayers, Keet, Winkler, & Flisher, 2010; Sambrano & Cox, 2013; Strike et al., 2008).

Physical restraints that secure clients’ arms and legs to a bed to prevent them from hurting themselves are also overused, considered to be punitive, and unnecessary (American Psychiatric Nurses Association, 2007; Brophy, Roper, Hamilton, Tellez, & McSherry, 2016). Being physically restrained may trigger a woman to re-live a trauma experience from past abuse. Finally, no-suicide contracts or pressuring clients who are suicidal to verbalize that they will not harm themselves is a practice sometimes used instead of applying risk assessment skills or teaching the person coping skills (Farrow, 2002; Lineberry, 2011; Miller, 2014; Trimboli, Keenan, & Marshall, 2016) and are not
used effectively (Davis, Williams, & Hayes, 2002; Hansen, Williams, Fox, Hudnal, & Bledose, 2012; Lewis, 2007; Potter, Vitale-Nolen, & Dawson, 2005; Maltsberger & Stoklosa, 2012; McMyler & Pryjmachuk, 2008). Other aspects of care found to be unhelpful from the perspective of the person who is suicidal is being discharged from a psychiatric unit when feeling unprepared to cope in the community (Cutcliffe et al., 2012), lack of knowledge regarding available resources, and not being taken seriously unless the person has a clear suicide plan or had a recent suicide attempt (Strike, Rhodes, Bergmans, & Links, 2006). Alternatively, other literature is focused on supporting the person who is suicidal through health care professionals’ responsive care. For example, providing professionals with education on suicide prevention has been found to be effective in enhancing their knowledge on how to respond to people with suicidal ideations (Botega, Silva, Reginato, & Rapeli, 2007; Brunero, Smith, Bates, & Fairbrother, 2008; McCann, Clark, McConnachie, & Harvey, 2007; Neville & Roan, 2013; Ramberg & Wasserman, 2003; Samuelsson & Asberg, 2002; Shea & Barney, 2012; Stanley et al., 2016). Assisting people in enhancing self-determinism or their ability to make personal life decisions and finding reasons to live is also effective (Bennett et al., 2002; Paulson & Worth, 2002).

Only one study could be found on mental health services provision specifically to women who have experienced IPV and who are also suicidal. Taha et al. (2015) evaluated a culturally informed intervention group that aimed to increase protective factors in African American women who recently attempted suicide while experiencing IPV. The group helped to increase women’s self-esteem only slightly and was not successful at increasing their sense of hope and access to resources (Taha et al., 2015).
Another study noted that African American women who had experienced IPV and who were participating in a culturally safe recovery program in the ED were less distressed and suicidal than the women in the control group who received medical treatment-as-usual (Kaslow et al., 2010; Davis et al., 2009). The new program used a harm reduction model; therefore, the clinicians validated the difficulties in leaving the abusive partner, accepted the women’s level of readiness for change, and worked with them in a collaborative manner (Davis et al., 2009; Kaslow et al., 2010). Women were also helped through learning about suicide risk factors and coping skills (Kaslow et al., 2010; Davis et al., 2009). Another study found that distrust and having difficulty relating to others were barriers for women who had experienced IPV in receiving help in group therapy for their suicidality (Ilardi & Kaslow, 2009). Lastly, spirituality has been found to help women who experienced IPV to heal from their suicidality (Arnette, Mascaro, Santana, Davis, & Kaslow 2007). The remaining literature on how women receive help when they are suicidal is limited to groups of women that were not specifically identified as having experienced IPV.

**Gender issues.** Gender influences stigma and how mental health service provision is conducted (Kornstein & Clayton, 2002) and suicide care is delivered (Jaworski, 2016). Suicide attempts are perceived as being feminine and a sign of weakness due to failing to use a lethal suicide method, a judgment attributed to women since they attempt suicide more often than men (Canetto, 2015; Jaworski, 2016). In comparison, the act of dying by suicide is perceived as strong and masculine, characteristics that are ascribed to men considering they die by suicide more than women (Canetto, 2015; Jaworski, 2016). In this way, Gomes, O’Brian, and Nakano (2009)
contend that gender and other intersecting factors have a greater impact on women’s suicidal behaviour as compared to men. Psychiatric and mental health services, however, are presented in a gender-neutral fashion (van Voorhis, Wright, Salisbury, & Bauman, 2010; Willging, Salvador, & Kano, 2006), ignoring the specific needs of women and further deepening gender inequalities (Jaworski, 2016; McKay, Milner, & Maple, 2014; Payne, Swami, Stanistreet, 2008; Salmon et al., 2006).

**Borderline personality disorder.** An example of a gender issue in relation to suicidality is BPD, a psychiatric illness in which 75% of those who are diagnosed with the condition are women (American Psychiatric Association, 2013). Indeed, many women who have chronic suicidal behaviour are diagnosed with BPD (Aaltonen et al., 2016; Oquendo et al., 2007; Qin, 2011; Sansone, 2004). BPD represents a “stereotypical woman at her most extreme - emotionally labile, relationally dependent, and self-destructive” (Tseris, 2013, p. 155). Over half of the people treated for suicidality on an in-patient psychiatric unit were diagnosed with BPD and most of them were women (Hayashi et al., 2010) while 20% of women who sought help in the ED for a suicide attempt had a BPD diagnosis (Rahme et al., 2016). Although BPD clearly affects more women than men, assessments and interventions within the literature that are aimed at helping women are gender neutral. Carrying out a more contextual analysis of BPD is important considering the risk for dying by suicide in an in-patient setting is higher for people with BPD as compared to other psychiatric illnesses (Ajdacic-Gross, Lauber, Baumgartner, Malti, & Rossler, 2009; Tidemalm, Elofsson, Stefansson, Waern, & Runeson, 2005).
Women with BPD are often found to have grown up in an invalidating environment where their emotional needs were not met; therefore, they did not learn effective problem solving, distress tolerance, and emotional regulation skills (Arens, Grabe, Spitzer, & Barnow, 2011; Hong, Ilardi, & Lishner, 2011; Sturrock, Francis, & Carr, 2009). Specifically, they were not permitted to express difficult emotions, learned to suppress how they felt, and discovered that only extreme emotional outbursts captured others’ attention and compassion (Linehan, 1993a). They have difficulty regulating intense emotions and frequently express these overtly by cutting and other self-harming behaviour (American Psychiatric Association, 2013; Crowell, Yaptangco, & Turner, 2016; Linehan, 1993a). Professionals, family, and friends may judge women with BPD as being incapable and weak because the situations creating distress are perceived by others as being insignificant.

A classic example of judging women with BPD as being overly emotional and irrational is when women report that they intend to kill themselves in order to convince a romantic partner not to end the relationship, leading to the belief that they are manipulative. Judged as being more attention seeking, women’s suicidality is a way of communicating a wish to die and they are trying desperately to manage the unbearable pain of perceived abandonment (American Psychiatric Association, 2013; Linehan, 1993a; Tseris, 2013). In reality, suicidal women with BPD live with an intense fear of abandonment due to past abuse or other forms of trauma (Linehan, 1993a; Oldham, Skodol, Gallager, & Kroll, 1996), events that erode trust in others (Herman, 1992). Indeed, a causal relationship has been found between childhood abuse and BPD (Bornovalova et al., 2012; Rogosch & Cicchetti, 2005). In another study, it was found
that 65% of people with BPD in treatment for suicidality experienced childhood abuse and those who experienced sexual abuse were 10 times more likely to attempt suicide (Soloff, Lynch, & Kelly, 2002). In this vein, some authors purport that symptoms of BPD are signs of ongoing PTSD related to past abuse (Herman, Perry, Christopher, & van der Kolk, 1989; Lewis & Grenyer, 2009; Lonie, 1993) that is “deeply embedded within a sociopolitical context of inequality” (Tseris, 2013, p. 156). Patriarchal social structures sustain the role of gendered violence in BPD, creating barriers for treatment (Swartz, 2013). Acknowledging the effect of past abuse facilitates a more compassionate treatment of suicide.

Women with BPD may be judged as being overly dependent and incapable when others perceive their distress as not being significant, resulting in minimization of their suicide risk and contributing to grave social stigma (Aviram, Brodsky, & Stanley, 2006; Nehls, 1998; Rusch et al., 2006; Trippany, Helm, & Simpson, 2006). Caring for people who are suicidal is very difficult and frustrating for psychiatric professionals (Bohan & Doyle, 2008; Cureton & Clemons, 2015; Cutcliffe & Stevensen, 2007; Gilje, Talseth, & Norberg, 2005; Hoffman & Kress, 2010; Larsson, Nilsson, Runeson, & Gustafsson, 2007; Oriyama & Watanabe, 2009; Sun, Long, Boore, & Tsao, 2006), especially caring for women with chronic suicidal behaviour or BPD (Dickens, Lamont, & Gray, 2016; Evans, 2007; Maltsberger, 1999; Mishne, 2004; Stone, 2006; Woollaston & Hixenbaugh, 2008). Clinicians caring for women with BPD often feel helpless and frustrated; emotions that they may redirect back onto the clients (Dickens et al., 2016; McIntyre & Schwartz, 1998; Woollaston & Hixenbaugh, 2008).
Support. The theme within the literature that underlies effective interventions for women who are suicidal is support. Listening to clients’ perspectives and offering other forms of support within the clinician-client relationship can enhance care because the most effective aspect of receiving help for suicidality is having a positive relationship. A therapeutic relationship with a counsellor is one of the most important factors in the treatment of suicidality (Cureton & Clemens, 2015; Cutcliffe, Stevensen, Jackson, & Smith, 2007; Jobes, 2011; Jobes, Kahn-Greene, Greene, & Goeke-Morey, 2009; Paulson & Everall, 2003; Sun et al., 2006). Clients have been found to heal from their suicidality through HCPs’ validation (Barker, 2009; Larsson et al., 2007; Paulson & Worth, 2002; Sun, Long, Boore, & Tsao, 2005) and openness (Beschell, 2008). The importance of connecting with others is evidenced in a study that demonstrated psychiatric in-patients’ desire to open up and share their thoughts and feelings about their suicidality (Talseth, Gilje, & Norberg, 2003). In addition, clients who were suicidal on an in-patient psychiatric unit communicated the need for nurses to listen to them non-judgmentally, accept their feelings, be open with them, and foster hope (Talseth Lindseth, Jacobsson, & Norberg, 1999). Moreover, sending a follow up caring letter to clients who were discharged from a psychiatric unit after being treated for suicidality helped to decrease their suicidal behaviour (Carter, Clover, Whyte, Dawson, & D’Este, 2005; Hassanian-Moghaddam, Sarjami, Kolahi, & Carter, 2011) and improved their overall mental health (Robinson et al., 2012).

Besides positive relationships with professionals, studies indicate that social support is helpful in preventing suicidality (Handley et al., 2012; Kleiman, Riskind, Schaefer, & Weingarden, 2012; Li & Lei, 2010; Lieberman, Ginsburg, & Solomon, 2005;
McLaren & Challis, 2009; Robins & Fiske, 2009), including family support among African American women (West, Davis, Thompson, & Kaslow, 2011). Specifically, long-term and close relationships in which teens felt encouragement and emotional acceptance helped to lessen their suicidal ideation (Bostick & Everall, 2007). In addition, more concrete or tangible forms of support, such as helping an overwhelmed student organize their busy schedule, assisted in protecting against suicidality (Hirsch & Barton, 2011).

Teens’ perception of parents’ support (Cheng & Chan, 2007; Winfree & Jiang, 2010), especially in females (Kerr, Preuss, & King, 2006) and perceiving social support through sports activities (Babiss & Gangwisch, 2009) are also protective factors against suicidality. Other age groups benefit from social support as well, for example, feeling useful to family and friends and experiencing positive interactions with others decreased suicidal ideation in the elderly (Rowe, Conwell, Schulberg, & Bruce, 2006). Finally, the importance of connecting with others is evidenced in a study that found most of the people experiencing suicidality who call a crisis line are seeking social support (Watson, McDonald, & Pearce, 2006).

Knowledge Gaps

Substantial knowledge gaps have been revealed within this literature review. This study contributes to addressing these gaps. The majority of the literature on suicide includes quantitative correlational studies related to risk factors. Deficient in the literature are qualitative studies that yield a contextual in-depth understanding of suicide and people’s strategies in managing these thoughts and feelings; therefore, a qualitative methodology was used within this study. Seeking a more meaningful understanding of suicidality is important in learning how to meet people where they are, a vital factor in
their healing process. Treatment strategies are less evident within the literature, especially treatment measures specifically for women. The exploration within this study on how women seek and attain help will inform policy and clinical practice on how to more effectively meet women’s needs when feeling suicidal after leaving an abusive partner. Capturing a process of how women with abuse histories manage what most is problematic about seeking help for suicidality moves beyond the identification of risk factors.

Well established treatment modalities within the literature are mainly cognitive-behaviour based therapies, such as DBT. The gap within the literature about suicide care for women is how different therapies and other services within the mental health system are effective or not. Few women with suicidal behaviour are able to access DBT programs because the entrance criteria are very specific and not all women who are suicidal have BPD. In addition, therapy is meant for long term treatment, eliminating women in crisis or requiring help for suicidal behaviour on a situational basis. I sought to understand within this study how women receive help from various mental health services at different points in their suicidal experience.

Another gap within the literature is the nature of the help-seeking process for suicidality among women who have experienced IPV. Discovering how HCPs influence the recovery of suicidal women who have experienced IPV and their help-seeking experiences helps to fill this gap. Furthermore, I provided a safe forum for women in this study to voice their help-seeking experiences, a voice that is missing in the literature (Hesse-Biber et al. 2004). In summary, the purpose of this study was to understand
women’s help-seeking, reducing the gap within the literature on how to help women who are suicidal and have experienced IPV.
Chapter Three: Philosophical, Theoretical, and Methodological Approach

Philosophical Perspective: Feminist Ethical Theory

The philosophical perspective of this study, feminist ethical theory influences how women’s help-seeking is understood. A theory is a “conceptual basis of a subject or area of study” (“Theory,” 2017) and a way of explaining a set of related ideas on a particular subject. Theories, however, do not function as guiding frameworks for a grounded theory research study, but rather as a philosophical underpinning or a lens that allows the researcher to pick up on the particular perspective only if it is present within the data (Wuest, 2000). The researcher remains open to what is happening in the data in order to create a substantive theory instead of forcing predetermined ideas onto the data (Artinian, 2009a; Stern, 2009; Walls, Parahoo, & Fle, 2010). I used feminist ethical theory as a lens to understanding women’s help-seeking, allowing me to uncover the complexities of women’s suicidality and interactions with the health care system, including socio-political factors that make finding help difficult. A feminist approach also sensitizes the researcher to power imbalances while conducting a study with participants who have experienced intersecting levels of oppression related to IPV (Morrow, Hankivsky, & Varcoe, 2004; Varcoe, 1996).

Unpacking the concepts within feminist ethical theory and exploring their meanings within the context of women’s help-seeking for suicidality after IPV helps situate this framework within this study. Ethical theory and feminist theory are explained, followed by an exploration of the core principles of feminist ethical theory: minimizing power imbalances, autonomy, and dignity. Autonomy is broken down further with descriptions of coercion, consent, and a critical view of autonomy. Detailed accounts of
these concepts within historical and present-day contexts lessen the risk of making assumptions about women’s seeking help and opens the landscape for discovering their realities. An ethical approach to this study provides a heightened awareness of the moral dilemmas within women’s help-seeking and how service provision might need change in order to meet their needs.

**Defining ethical theory.** The overarching subject matter of the philosophical perspective in this paper is ethics, the study of morality or how one ought to live (Waluchow, 2003). Ethical theory, therefore, is moral philosophy (Nobis, 2005) or a way of explaining moral practice (Waluchow, 2003). The aim of ethical theory is to interpret, understand, and guide the reflection of the foundations of rightness and wrongness of life decisions (Copp, 2006; LaFollette & Persson, 2000), an important process considering how different perspectives of ethical theory yield different ethical judgments (Waluchow, 2003). Not all decisions require the same level of moral consideration, for example, choosing the time of day to book a therapy session with a client does not carry the same ethical implications as deciding whether or not to provide known effective treatment to the client. Many factors influence decision-making including values and beliefs on what is considered to be moral. Ethical theory helps in choosing which circumstances require moral guidance and which set of guiding principles ought to be used in making the right decisions (Copp, 2006). Examples of ethical concepts help to clarify the differences between them. Morality is the state of whether it is right or wrong to place a client in locked seclusion. An ethical judgement is the HCP’s decision that placing a client in locked seclusion is wrong. An ethical theory is the set of principles, including the least restrictive standard or the right to freedom, that guide the HCP’s decision.
There are different types of ethical theory. Metaethics is an approach that explores the state and quality of the principles that make up ethical theory or how ethical theory guides what is right or wrong (Shafer-Landau, 2007), whereas applied ethics includes practicalities or what to do in a specific situation (Birsch, 2014). Normative ethics is an organized way of applying a set of guidelines that guide ethical judgments involving figuring out which set of guidelines are the right ones to use (LaFollette & Persson, 2000). While abstract theoretical considerations of morality do not direct which actions are best for specific situations, these conceptual frameworks provide a basis from which to approach a situation that may help in making sound ethical decisions (Copp, 2006). Ethical theory can help in identifying what influences moral judgment and which set of ideas or conceptual frameworks ought to be used to make ethical decisions (Copp, 2006) and inform strategies on how to carry out the decisions (Birsch, 2014). Different philosophies, values, rules, and other ideals that provide the basis for moral decision-making can be used to improve the quality of the ethical decision-making process (Waluchow, 2003). Most importantly, ethical theory provides a framework for evaluating a decision or action as right or wrong (Waluchow, 2003). Ethical theory plays a big role in how one intends to live or living according to one’s values; therefore, has significant application to understanding women’s help-seeking for suicidality. Theories that address the realities of women’s disempowerment related to mental health and violence are a good start.

**Defining feminist theory.** Feminism is a movement dedicated to social justice and ending inhumane social norms (Haslanger, Tuana, & O’Connor, 2017), in particular preventing the subjugation of women or marginalized people by targeting power
imbalances with political activism (Beasley, 1999; Kim & McCann, 2013). Feminists seek to dismantle oppressive ideology and redefine values within society that are more empowering for women. For example, autonomy is perceived within a Western worldview as a representation of self-sufficiency void of the influence of relationships or emotions, whereas feminists conceptualize autonomy within a social context (Stoljar, 2015). Feminist *theory* is a way of explaining how forces contribute to the oppression of women and other marginalized groups and aims to deconstruct these power imbalances (Sherwin, 1992a). A political philosophy that uses knowledge of women’s subjugation to raise awareness of their disempowerment, feminist theory works toward correcting injustices that limit women (Kim & McCann, 2013). Feminist political philosophy is a pragmatic form of feminist theory that seeks to change the way women’s political issues are neglected (McAfee, 2016). “Equality, freedom, liberation, building coalition, and resisting oppression” are core elements of feminist theory (Andrew, Keller, & Schwartzman, 2005, p. 1). Analysis of how socio-political factors influence women’s lives and roles within society is also central to feminist theory, an examination that provides a framework for action in improving women’s lives (Benhabib, 1986; Little, 1996; Radtke, 2017). Feminist philosophers’ aptitude for self-reflection and critique results in diverse viewpoints within feminist theory (Andrew et al., 2005); however, all feminist thought critiques power imbalances and gender stereotypes.

Gender is recognized within feminist theory as influencing well-being based upon its association with power dynamics where women’s gender roles and so-called feminine characteristics are considered less valuable than men’s thereby, placing women in a position of less power. Historically, men were considered to be the *standard* human and
women as the other, an assumption that continues to permeate social and political consciousness today (Tavris, 1993; 2005). Despite the reduction in gender stereotypes over the past few decades, gender essentialism or the idea that men and women have distinct identities continues to be a problem that feminist theorists challenge (Alcoff, 2005). Feminists seek to dismantle the judgement that women are too emotional and dependent (Sherwin, 1996; Thompson, 2006), whereas men are considered to be strong and independent (Goicoechea, 2013). The idea that gender is understood objectively by assuming that men and women have natural and exclusive characteristics based upon their sex is challenged within feminist theory (Alcoff, 2005; Disch & Hawksworth, 2016). Alternatively, the standpoint of the person’s unique perspective and understanding everyday life through women’s experiences is central to understanding the issues within feminist theory and using this perspective for political activism (Disch & Hawksworth, 2016). Feminist theory seeks to explain the unjust measurement of women against men, how gender fallacies have been created throughout history, and how women’s subjugation influences societal structures, political rules, and people’s everyday lives (Tavris, 1993; 2005). Layers within a gender category are added when race, privilege, class, and other stigmatizing labels are implicated, adding complexity to the power dynamics and increasing women’s subjugation (Disch & Hawkesworth, 2016). Intersectionality, therefore, is used within feminist theory to identify how socio-political factors including gender, sexuality, class, and race intersect in the oppression of women and other marginalized groups (Disch & Hawkesworth, 2016).

Foundational to all forms of feminist theory is acknowledging how marginalized groups have been ignored or underrepresented in research, a process that recognizes the
importance of people’s experiences and elevates women’s realities within research (Kushner & Morrow, 2003; Parr, 2015). A feminist approach recognizes social oppression, challenges unequal power relations within the research process, and questions knowledge that is based on the perspective of privileged social groups, thereby rendering knowledge construction that is more inclusive (DeMarco, Campbell, & Wuest, 1993; Dunphy & Longo, 2007). A more inclusive creation of knowledge within the feminist theory is a relational approach that “refers to how people and their contexts or environments are constantly shaping one another” (Varcoe & Einboden, 2011), influencing the way ethical concepts are understood (p. 381). For example, a conceptualization of autonomy is shifted from being individualistic to relational (Donchin, 2001; Stoljar, 2015). Rejecting the idea of individualism, feminist theorists seek to uncover the ways people are influenced by others within society, the political climate, different cultures, and interpersonal relationships (Disch & Hawkesworth, 2016).

**Defining feminist ethical theory.** Feminist ethical theory, the philosophical underpinning of this study, stems from feminist theory (Sherwin, 1992a). While feminist ethics is informed by feminist theory (Grenholm & Kamergrauzis 2003), defining the two as separate entities is tricky as ethical intention is implicit within feminism (Jaggar, 2000). Feminist ethics is defined as an approach that deconstructs the dominant and male-orientated ethical framework that does not consider societal power imbalances and the unique needs of women (Grenholm & Kamergrauzis, 2003; Robb, 1981; Tong & Williams, 2016). Feminist ethical theory, therefore, is a way of explaining how dominant moral philosophy oppresses women or other marginalized groups and guides the reformulation of a moral framework that equalizes power imbalances (Jaggar, 2000).
Feminist ethical theory is particularly focused on relating theoretical concepts to women’s realities and their everyday problems (Jaggar, 1989).

Core principles of feminist ethical theory. Core principles of feminist ethical theory central to this study are: (a) minimizing power imbalances; (b) autonomy; and (c) dignity. Minimizing power imbalances includes preventing oppression by promoting social justice and challenging patriarchy. An important way of minimizing power imbalances is to promote autonomy, a core principle that entails avoiding coercion, obtaining consent, and challenging individualism. Minimizing power imbalances and obtaining autonomy may lead to dignity, a concept that is central to human value.

Minimizing power imbalances. Feminist ethical theory is grounded in an awareness of power imbalances among marginalized populations with the aim of dismantling the socio-political structures that sustain them. Disparities in the acquisition and distribution of power, notions important in the ability to effect change in one’s life (Lukes, 2002), is responsible for all kinds of social injustices and harms. With limited power and little capacity to influence outcomes, groups of people may become oppressed. Oppression is defined as a “prolonged cruel or unjust treatment or exercise of authority, control, or power” (“Oppression,” n.d.). Oppression is considered to be a socio-political phenomenon based upon a hierarchal structure through the domination of one group over another wherein the former benefits from the latter’s subjugation by way of greater access to power and resources (Chen, 2017; David & Derthick, 2013; Taylor, 2016). Power imbalances based upon differences in race, ethnicity, religion, gender, sexual identity, economic status, and education contribute to exploitation and subjugation (Chen, 2017).
Minimizing power imbalances entails exposing socio-political forces related to people’s subjugation, including patriarchy. Patriarchy is a social structure enabled by gender inequality in which men are dominant (Griffin, n.d.) and is the basis upon which the morality of the Western world is founded that contributes to women’s subjugation (Bearman & Amrhein, 2013; Grenholm & Kamergrauzis, 2003; Jaggar, 2000; Hekman, 1995; Thompson, 2006; Walker, 2002; Whisnant, 2003). Women’s domestic role outside of socio-political life was considered to be beneficial to society for centuries and to a lesser extent continues to this day (Williams, 2006). This role allowed men’s superiority to increase (Edmundson, 2013). Sacrificing women’s place within civil society in order to serve men was considered to be a means to an end (Schröder, 1997), a moral duty according to Kant’s utilitarian ethics (Kofman & Fisher, 1982). Alternatively, J. Mill and H. Mill (2009, p. 29) recognized that women have been coerced into the “resignation of all individual will into the hands of a man” as a result of men’s “instinct of selfishness.” They believed, “the adoption of this system of inequality was never the result of deliberation, or forethought… to the benefit of humanity or the good order of society.” (p. 10-11). These early writings relate to the feminist recognition that women are socialized to forgive others (Potter, 2015) and put others’ needs before their own (Gilligan, 1982; Sulik, 2005).

Help-seeking for suicidality with greater frequency (Canetto, 2015; Jaworski, 2016) and judged as being more emotional, irrational, and illogical than men, women are expected to measure up to men. To this end, patriarchy is sustained by the inherent androcentrism and misogyny within some ethical theories (Doppelt, 2002; Grenholm & Kamergrauzis, 2003) and social psychology (Magnusson & Marecek, 2017). Feminist
Ethicists aim to deconstruct gender biases that oppress women with the goal of emancipation and social transformation (Disch & Hawkesworth, 2016; Halliday, 2005; Kim & McCann, 2016), especially within the health care system (Baylis & Sherwin, 2003). A gendered aspect of coercion was recognized in 1869 when J. Mill and H. Mill (2009) wrote that as a result of men’s “instinct of selfishness” (p. 29) and a cultural belief that women are inferior.

Patriarchy is also represented in authority figures from different groups of people including, politicians, medical professionals, or abusive partners, many of whom are men. Authority figures assume the position of who-knows-best or paternalism, which can be defined as “interfering with another person's liberty or freedom in the belief that one is promoting the good of that person” (“Paternalism,” 2004). The word paternalism derives from the idea of a father who rules based on knowing what is best for the family (“Paternalism,” 2004). The ethical principle to do good or beneficence (Audi, 2014) is sometimes misused due to HCPs’ insistence that they know what is in the best interest of the client (Beauchamp, 2010; O’Neill, 2002; Proctor & Keys, 2013), a phenomenon Bond (2003) calls “paternalistic beneficence” (p. 80). While Mill believed that the use of coercion might be legitimate in preventing harm in some cases (Beauchamp, 2010), it is important not to assume that the HCPs’ interpretation of harm is the same as the client’s. HCPs have an obligation to protect the client; however, are not to assume that their knowledge and opinions are of greater value. In all, challenging the socio-political structures that have created and sustained a “patriarchal organization of society” (Johnson, 1996, p. 21) is a relevant approach for this study due to the relationship between IPV and patriarchy (Dobash & Dobash, 1992; Morrow, 2006).
Patriarchy and other features of oppression within feminist ethical theory is resisted through social justice movements, a collective responsibility for each other’s liberties. Social justice is an approach to tackling power imbalances by striving for equality and basic human rights (“Social justice,” n.d.) and reconciling the inconsistencies among those who benefit from or are harmed by the socio-political reality (Reeve, 2009). Distributive justice, a way of evaluating outcomes of how people are treated with fairness, equity, and reliability, (“Distributive justice,” 1996) contributes to social justice. Egalitarianism is a way of fighting against inequalities by ensuring that social and political rules do not get in the way of human rights (Bunnin & Yu, 2004). Equality must account for individuals’ perspectives on what equality entails or the ability to determine just and fair outcomes for themselves.

*Autonomy.* Autonomy, the ability to be self-determined (Roth & Deci, 2009), is another way of avoiding oppression and inequity (Baum, 1998; Hay, 2011). As opposed to forces external to the person, a common conception is that the inner self guides the autonomous person and her outcomes (Roth & Deci, 2009). Kant believed that one’s will or intention to act and make decisions allows for true self-governance (Caygill, 1995). Choice contributes to autonomy; however, it does not guarantee it because the options from which one is choosing must align with one’s values (Roth & Deci, 2009). Coercion, consent, and an alternate meaning of autonomy are explored.

*Coercion.* Coercion interferes with autonomy through persuasion and control (“Coercion,” n.d.). Aristotle wrote that despite the way external coercion makes the act of choosing more difficult, making the right choice that leads to flourishing is possible in any given circumstance (Mason, 2014). Nielsen (2007) wrote that Aristotle also
recognized some coercion is voluntary because a choice is made to act based on the “fear of greater evils” (Aristotle, 2000, trans. p. 24). This view speaks to present-day assumptions that when given a choice between two undesirable options, the appearance might be that the person is acting autonomously. However, this may be a subtle form of coercion where the person may feel forced to choose in order to avoid a more negative consequence (Lamond, 2010); therefore, the choice is not truly made autonomously (“Coercion,” n.d.). An example of coercion is an abusive partner’s intent on isolating a woman by withholding finances from her if she sees her friends, whereas she is permitted to have money if she avoids her friends. The partner is not preventing her from seeing her friends by barricading the door per se; however, the risk of danger for disobeying her partner prevents her from choosing autonomously. She may require the money to feed the children and has no other choice than to avoid her friends. In short, “threats coerce, offers do not” (“Coercion,” n.d.).

Aristotle contended that humans are naturally autonomous organisms (Pérez & Ziembe, 2007) and that autonomy is a moral virtue (May, 2010). Pressure to adopt a particular characteristic may feel coercive. A person who is severely anxious within a work environment that demands autonomous productivity and yet is in need of assistance to function day-to-day, may continue to push herself in fear of appearing incapable and missing job enhancement opportunities. Kant provides an alternate solution with the belief that an autonomous will to do good is moral; otherwise, an action with external motivators without good intentions is not moral (Cayhill, 1995). Expanding the definition of autonomy beyond an action to choose or to self-govern, Mill’s definition focuses on the function and outcome of autonomy, self-development and self-protection (Donner,
Detaching action from the pressure to be autonomous may lessen blaming when a person is not behaving autonomously, reducing the pressure to be moral. Mill believed that self-development is a human right (Donner, 2000) and both he (Scarre, 2001) and Kant (Williams, 2006) wrote that self-development and protection contribute to human liberty. Mill also believed that coercive social factors might contribute to the inability to self-develop (Donner, 2000; Hamburger, 2001) or to cultivate one’s “capacities in accordance with one’s true values” (Chen, 2017, p. 435). From a utilitarian standpoint, autonomy is good based on the idea that it helps people, rather than its moral status. In this way, Rawls did not believe that autonomy was moral in and of itself, but rather that it was moral within political life because it was good for the collective (Dworkin, 1995).

Overriding a person’s autonomy is often justified in the context of suicide risk. While Mill believed that autonomy was required for well-being (Berger, 1984), Kleinig (2017) interpreted Mill’s (1871) passage, “It is not freedom to be allowed to alienate his freedom,” to indicate that upholding autonomy may be harmful if it is self-degrading (p. 199). Mill believed that people intent on harming themselves should not have the right to autonomy or ought to have their decision-making rights removed for protection (Kleinig, 2017). This idea may be based on subjugated knowledge. Those in power make the assumption that preventing self-harm justifies the use of coercion, a judgement made without the client. Indeed, coercion has been flagged as a problem within the mental health system (Fioritti & Marcacci, 2016; Hannigan & Cutcliffe, 2002; O’Brien & Farrell, 2005; Tingleff, Bradley, Gildberg, Munksgaard, & Hounsgaard, 2017).

Consent. Consent is an authorization permitting others to do something that affects the person giving consent that they otherwise would not have a right to do
(“Consent,” n.d.). Consent is a social contract (“Consent,” 2004) with moral intentions and just outcomes (“Contract,” 1995). Depending upon the definition of what constitutes consent, differing levels of autonomy or coercion may be involved. In his book Nicomachean Ethics, Aristotle refers to loss of consent with the term *involuntary actions* that are caused by external forces including “men [who] have him in their power.” (Aristotle, 2000, trans. p. 24). According to Aristotle, others’ position of power is not always bad as he thought giving control over to politicians was good for strengthening society (Edmundson, 2013; Rosler, 2005), an action that Plato justified as being a form of consent (Wright, 1988).

Consent may include a compromise in how the outcomes are fairly distributed depending upon the consenter’s desires, intentions of the person seeking consent, and the distribution of power between both parties (Chen, 2017). Used with mal-intent, consent may be falsely obtained through coercion (O’Neill, 2002). Oppressors may withhold information in an effort to manipulate the person into consenting, a thwarting the principle of autonomous consent (Chen, 2017; O’Neill, 2002). Transparency, therefore, is crucial in avoiding coercion. Mill also wrote about invisible forces on the capacity to consent (Bromwich, Kateb, & Mill, 2003), including the “moral coercion of public opinion” (Mill, J., 1871, p. 23). Likewise, Nietzsche believed that autonomy is impossible due to influential unconscious forces (Doyle, 2011). For these reasons, women might consent to being admitted to a restrictive psychiatric unit for suicidality believing that they are deserving of punishment. Due to factors outside of an individual that impact self-governance, deciphering the point at which the influence of social factors nullify an autonomous action is complicated.
A critical view of autonomy. Feminist ethical theory challenges Kant (Gregor & Timmermann, 2012; Secker, 1999; Stroud, 2014) and Hobbes’ (Tucker, 2016) individualist beliefs that a person is an autonomous single entity. Some feminists believe that individualism is radical, asserting that it is merely an illusion because human beings are interdependent and relational (Barclay, 2000; Clement, 1996; Liaschenko, 1993; Machold, Ahmed, & Farquhar, 2007; Proctor & Keys, 2013; Sherwin & Parich, 2002). Individualist ideology has direct implications for mental health treatment as the discipline of psychology has been founded on the notion that people are separate from others and detached from their social environment is (Magnusson & Marecek, 2017). As such, autonomy is revered (Twomey, 2015) and interference of people’s independence is considered an impingement on their rights (Mackenzie, 2000; Parekh, 1992).

A common assumption of autonomy is that people make decisions independently and that they are solely accountable for their actions. The person is responsible to change self-harm behaviours since suicide is the result of one’s own doing; there is no one else to blame. As a result, suicide treatment involves little consideration of others’ responsibilities (Khan & Mian, 2010). Conceptualizing women as being free to choose gives the false impression that they are in control of their abusive relationship or that they can change their depression. Feminist ethical theory acknowledges the reality of interdependence, helping to differentiate between external pressures versus ones’ values in decision-making and providing opportunities to include others in one’s self-determination. An HCP may encourage a depressed client to enlist the help of a trusted friend to become informed on and make a decision about whether to have a potentially intrusive procedure, such as electroshock therapy.
Relational autonomy, “adapt[ing] the concept of autonomy to the social view” (Meadow, 2014) is a critical approach to self-determination (p. 3060). Relational autonomy not only recognizes the influence of social (Grainger, 2015) and political (Jennings, 2016) factors, but also how relationships with others and society are “essential element[s] to autonomy in the first place” (Pritchard-Jones, 2017, p.76). In other words, dependence on others is foundational to self-determination (Johnston, 2017). Self-worth (Potter, 2015) and decision-making capacities (Metze, Kwekkeboom, & Abma, 2015; Proctor & Keys, 2013; Ruhe, De Clerq, Wangmo, & Elger, 2016) increase with relational autonomy. Fittingly, the focus within feminist ethical theory is on attending to others, demonstrating affection for others, and taking responsibility for oppressive forces that restrict people from reaching their potential (Cole, Wellard, & Mummery, 2014; Katzenstein & Laitin, 1987; Meyers, 2000). To this point, feminist ethical theory embraces an ethic of care (Brennan, 1999; Dodds, 2000; Friedman, 1987; Held, 2006; MacDonald, 2006; Neysmith, 2003), a relational approach by Carol Gilligan (1982) where people’s needs are met while connecting to self, others, and society (Hankivsky, 2004; Ramdas, 2016).

The ethic of care is in direct contrast to “The liberal model of citizenship [that] assumes that, for the most part, autonomous individuals are able to attend to their own basic needs” (Hankivsky, 2004, p. 5). Rather, the ethic of care is a move away from responding to individual needs within the private sphere toward responding as a collective to the needs of groups within a political sphere (Brannelly, 2016; Hankivsky, 2004; Held, 1999; O’Brien, 2005). The ethic of care is also in contrast to universal principles that may limit people within different contexts and have varying levels of need,
but rather adopts a discursive approach where people’s unique realities and past histories are considered (Hermsen & Embregts, 2015; O’Brien, 2005). The ethic of care also promotes empathy, facilitating self-discovery and living according to one’s values (Terkelsen & Larsen, 2016). In all, the ethic of care recognizes that not everyone wants or needs autonomy during the beginning stages of seeking help and that depending upon someone or being cared for can lead to greater independence or responsibility for one’s problems (Scott & Doughty, 2012).

**Dignity.** The purpose and ultimate outcome of avoiding coercion and promoting consent is to gain human dignity (“Dignity,” 2004). The meaning of human dignity has been most influenced by Kant’s ethical philosophy to avoid using people as a means to an end and instead to treat people as ends in themselves (Ucheaga, 2005). Kant’s philosophy draws awareness to the inherent value of human beings, a sense of dignity and respect (“Humanity,” 1995). Respect is essential to a positive identity and yields human dignity as it entails bestowing worth and value to another’s thoughts and feelings (Hendrick & Hendrick, 2009). People’s desires and needs are taken into account when their feelings and thoughts are respected, upholding their sense of agency (Dillon, 2016).

Dignity is written throughout the literature as a feature inherent in all people due to having unconditional worth (Oprisko, 2012). Kant believed that human dignity is an indicator of moral authenticity (Hill, 2006; Kleinig, 2017; Sensen, 2009) and deserving to all persons or rational beings regardless of their personal characteristics or status (Dillon, 2016; van Holthoon, 1971). Even when degraded or being violently controlled, the implication is not that the person no longer has dignity, but rather that the person’s dignity is under attack (Streiffer, 2015). Kant’s ideals remain within contemporary
society as dignity is thought of as the basis for human rights (Hurlbut, 2010; Gallagher, 2004). Dignity is also central to the meaning of being human and finding purpose in life (Hurlbut, 2010), a feature that decreases suicidality (Marco, Pérez, & García-Alandete, 2016; Tan, Chen, Xia, & Hu, 2017).

Christian social teachings instil the belief that to act in a dignified manner toward the common good is inherently human as people were created in the likeness of God (Gushee, 2014; Smith, 1995). Aristotle indicated that dignity is a virtue (Oprisko, 2012), believing that it comes from within and is not dependent upon others’ praise (Aristotle, 1992), for example, promoting justice without seeking reward in return (White, 1992). Aristotle (Smith, 1995), Kant (Dillon, 2016; Streiffer, 2015), and Christianity (Smith, 1995) convey that dignity requires rationality, a belief that can be interpreted in two ways. First, reasoning ability might be a characteristic assigned to human dignity because it is the feature that distinguishes humans from animals, thereby, is universal among people (Streiffer, 2015; Ucheaga, 2005). Secondly, it might be interpreted as saying that people are more deserving of dignity if they think rationally and behave in ways that are based upon logic. The idea that dignity is earned with good behaviours contributes to feelings of inadequacy and shame when the person is not perceived to have measured up to social and political moral expectations. Suicide is traditionally considered to be immoral; therefore, people thinking about killing themselves may feel undeserving of human dignity. Understanding the pain and reality of the person’s suicidality may lessen paternalism and improve dignity.

**Summary of feminist ethical theory.** Feminist ethical theory is the philosophical perspective for this study. Ethical beliefs on suicide influence how others understand and
treat people who are suicidal, including health care professionals (Khan & Mian, 2010).
An ethics approach sensitized my role as a researcher to how women with abuse histories ought to be cared for when they seek help for suicidality and, in combination with a feminist lens, how gender expectations, socio-political structures, and other features of power disparities are illuminated. An exploration of the core principles of feminist ethical theory provides a solid grounding into the meaning of the underlying philosophical approach to this study. These concepts thread throughout the study situating women’s help-seeking within an ethical and critical lens. In all, a feminist lens that focuses on power relations and the intersection of oppressed groups helps to hear marginalized women’s voices that have been silenced far too long (Hesse-Biber et al., 2004).

**Methodological Approach**

The methodology for this research is an integration of GT and PV using a feminist ethical theory lens. To begin, the epistemological views of feminist ethical theory and how that influences the methodological approach for this study is discussed. An outline of how the feminist ethical theory lens is used with GT and with PV is also provided.

**Epistemological considerations.** Feminist ethical theorists seek to reformulate moral discourse by challenging the way that women’s voices have been left out of knowledge creation (Disch & Hawkesworth, 2016; Jaggar, 2000) as a result of privileged and oppressive ideologies (Sherwin & Franklin, 1984; Walker, 2001). Underlying assumptions within traditional Western ideology include an ontology that is absolute and epistemologies that are linear, ideas that have shaped the culture, the conceptualizations of human experience, and how people ought to behave (Sherwin, 1989). The resulting fixed reality or one truth creates a rigid framework for understanding the complexities of
people’s lives and their dynamic experiences. The positivist paradigm reflects these assumptions and can restrict research by objectifying and separating subjects from their origins, describing their behaviour in a one-dimensional manner, and neglecting to explore the social aspects of the area of study (Rogers, 1985; Ruiz, 2015; Smith, 1999). Data from many traditional or positivist studies are often privileged, one-sided (Christians, 2018; Sherwin, 1998), missing the participants’ subjective experience (Ruiz, 2015; Smith, 1999). Although quantitative research is often misunderstood as being within the positivist paradigm and qualitative research assumed to reject this worldview, positivism is not method-specific. As such, I did not assume that my qualitative study was immune to restricting women’s knowledge. I was conscientious of women’s different ways of knowing and how my own biases or influences as a researcher might restrict knowledge creation.

Researchers who misunderstand women’s experiences may have misleading conceptualizations of how to frame their study, possibly limiting the evaluation process (Graham & Campbell, 1991). Fonow and Cook (1991) wrote that care needs to be taken as not to exclude women’s realities by steering their answers into pre-established frameworks within questionnaires or tools. Assuming the role of the expert researcher, subjects are sometimes represented as being one unit of study the same as the other subjects, overlooking possible underlying inequities among the respondents that may skew the meaning of the findings (Graham & Gamarnikow, 1983). In an effort to mitigate this risk, feminist researchers, Kelly, Regan, and Burton (1992), created open-ended questions attached to a questionnaire about sexual assault so that they might avoid swaying the responses with “pre-defined concepts of what counts as abuse” (p. 152).
Awareness of potential underlying patriarchies that may be hidden within the design of the study is also important when using interview-style research methods, including creating questions that do not steer the participant in a particular direction and responding non-judgementally to women’s sharing of difficult experiences.

Feminist ethical theory informs this study’s research method by facilitating a broader understanding of women’s help-seeking and is a good fit due the limitations in traditional research on suicidality. Indeed, dominant epistemologies yield methodological risks common within suicide research (Rogers & Lester, 2010). Suicidality has mostly been studied quantitatively by examining suicide risk factors (Cutcliffe, 2003a; Rogers & Lester, 2010), a practice that may separate individuals from their lived experience (Rogers & Soyka, 2004; Smith, D., 1999). Basing services solely on researchers’ and clinicians’ expertise and overlooking women’s perspectives enables paternalistic attitudes and ignores what works for the people for whom the services are targeted. To avoid reinforcing restrictive, privileged, and oppressive ideologies within research, it is prudent to seek an understanding of women’s experiences from their unique perspectives. Knowledge of their unique and diverse experiences is important in countering historical assumptions about women that are considered to be unethical. This study, therefore, is an in-depth exploration of women’s experiences on how they seek help for their suicidality. Understanding a person’s sense of meaning in life, connection to others, sense of the future, and their reasons for living and dying may be more effective way of preventing suicide than quantifying the suicidal person’s experience (Jobes, 2011; Jobes, Moore, & O’Connor, 2007; Ramsay, 2004).
A feminist study grounded in women’s experiences moves beyond a list of factors that relate to IPV, suicide, and health care and into dynamic processes that exist when people are in crisis and seeking help. Research approaches open to discovering larger societal, cultural, and political forces capture the essence of suicidality (Jobes & Nelson, 2006; Mental Health Commission of Canada, 2009) and IPV (Harris & Fallot, 2001; Herman, 1992). Studies that describe people’s help-seeking experiences are needed to comprehend more fully how they receive and perceive help.

**GT philosophical underpinnings.** Feminist theory lends itself well to GT (Brine, 1994; Gergen, 2008) as both approaches share similar epistemological underpinnings (Plummer & Young, 2010; Wuest, 1995). GT is rooted in symbolic interactionism (Corbin & Strauss, 2008; Kendall, 1999; Lowenberg, 1993), a philosophical position where behaviour is based upon the meanings that people acquire through interacting with others (Baker, Wuest, & Stern, 1992; Blumer, 1969; Reynolds & Herman-Kinney, 2003). The importance of women’s perspectives of their social environment in the construction of knowledge, the focus on relationships, and the focus on meaning are consistent with feminist theory (Plummer & Young, 2010; Wuest, 1995). As well, in both feminist theory and GT dichotomies are resisted and the contextual and relational nature of reality is embraced, processes that are key to developing an emerging theory grounded within the person’s experience (Plummer & Young, 2010; Wuest, 1995).

Research based upon feminist theory is a process of discovering new areas of knowledge, rejecting the ideal that one single truth exists and acknowledging multiple consciousnesses (Hesse-Biber & Leckenby, 2004), and includes characteristics inherent within GT research (Licqurish & Seibold, 2011; Wuest, 1995). In addition, GT
researchers use reflexivity, a technique employed by feminist theorists that may contribute to increased validity by continually and critically analyzing the research process and the researcher’s response to it (Hesse-Biber, 2007; Mays & Pope, 2006). Feminist research shares power and develops knowledge collaboratively (DeMarco et al., 1993; Hesse-Biber & Leckenby, 2004), characteristics shared with GT (Brine, 1994; Keddy, Sims, & Stern, 1996). Collaborative engagement is important to avoid replicating power imbalances that are experienced through IPV (Morrow, 2006) and in the mental health systems. Acknowledging potential power influences from the researcher and within the women’s lives more accurately depicts the reality of their experiences (Hesse-Biber & Leckenby, 2004; Smith, D., 1999).

The factor that creates the best fit between the philosophical foundations of both approaches is minimization of power imbalances, a core principle of feminist ethical theory (Jaggar, 2000), and the capacity to pick up on power imbalances within GT (Charmaz, Denzin, Lincoln, Thornberg, & Keane, 2018). The purpose of feminist ethical theory within this study is not to frame women’s stories in a particular way, but rather to increase the researcher’s ability to recognize power imbalances and moral discrepancies within women’s help-seeking experiences. Knowledge of feminist ethical issues informs GT analysis by influencing the researcher’s theoretical sensitivity. Theoretical sensitivity is the ability of the researcher to generate new knowledge through developing concepts, finding meaning in the data, and being aware of how dimensions, variables, or contextual factors connect, a process that leads to the development of theory (Giske & Artinian, 2009; Glaser, 1992; 2002). Theoretical sensitivity involves researcher creativity in order to remain open to the data and not be tied to existing ideas or principles (Glaser, 1978).
Glaser (1998) cautions against forcing one’s own interpretations onto a participant, but instead to listen to “his genuine meanings, to grasp his perspectives, to study his concerns and to study his motivational drivers” (p. 32). In this way, feminist ethical theory heightens the researcher’s awareness of power dynamics, contextual issues, and ethical dilemmas if it exists within the data. Finally, GT is congruent with feminist research by the way that opportunities for social change are identified within both approaches (Wuest, 1995).

While feminist ethical theory complements GT, there are foundational differences between the approaches. Feminist ethical theory specifically critiques the dominant theories of morality and how this relates to the treatment of women; a process that is not foundational to GT. Understanding feminist ethical theory core principles, for example, autonomy and the way that it is socially determined, is a lens that is brought to data collection and analysis. A heightened awareness of how autonomy is taken for granted as being an individualist concept and that subtle coercion is mistaken for consent is accessible to the researcher’s mindset so that she might recognize it if it comes through the data. While autonomy is not necessarily a core principle of GT, any data captured that relates to self-determination will be discovered both through the subjective experience and also how other concepts relate to this process. Any processes of being autonomous will be grounded in the person’s detailed experience and tied in to the greater socio-political surroundings. Feminist ethical theory offers a reminder of the importance of autonomy within health care and GT delivers a detailed and a theoretical account any autonomy related processes. The respective roles of both approaches can also be applied to dignity, another core principle of feminist ethical theory.
**PV philosophical underpinnings.** Feminism is part of the philosophical underpinning of PV that gives credence to the participant’s interpretation of reality by recognizing women’s experiences and identities (Wang, 1999; Wang et al., 2000), acknowledging power imbalances, and creating opportunities for participants to make positive change in their lives (Hergenrather, Rhodes, Cowan, Bardhoshi, & Pula, 2009; Wang & Burris, 1994). While women have historically have been absent from research and societal discourse (Hesse-Biber et al., 2004; Smith, D., 1999), PV aims to create opportunities where participants can empower themselves through deconstructing power imbalances and challenging forces that block communication and expression of their knowledge (Frohmann, 2005).

Empowerment education, a concept derived from Freire’s (1970) theory for critical consciousness (Wallerstein & Bernstein, 1988; Wang & Burris, 1994; 1997) is also a part of the philosophical underpinnings of PV. Empowerment education relates to feminism through the criticism of traditional ways of understanding the world and through the epistemological belief that knowledge is created (Wang & Burris, 1994). In addition, the aim of feminist research is the emancipation of women or women’s acquisition of power (Acker, Barry, & Esseveld, 1983; Mies, Bowles, & Duelli-Klein, 1983), a characteristic implied within the term empowerment education. The idea behind empowerment education is that new knowledge is created through critical dialogue between people with differing levels of social and political power and where no one form of knowledge is better than another (Freire, 1970). Marginalized people’s interpretations of reality that are traditionally silenced have epistemological value through reflection and
mutual learning between community members and the researcher within a PV project (Park, 2001; Rhodes, Hergenrather, Wilkin, & Jolly 2008).

Outcomes of most PV research are grounded in feminism, critical consciousness, and other critical theory to promote attitudinal or discursive shifts within the area of study. Researchers conducting PV studies aim to enhance empathy and respect for people living in unjust circumstances (Duffy, 2010), communicate cultural meaning (Haines-Saah, Oliffe, Botorff, & Poland, 2010), and promote awareness of social and political power imbalances (Gosselink & Myllykangas, 2007; Poudrier & Mac-Lean, 2009). PV outcomes include a transformation in participants’ perception of their situation and how they view options for change (Whyte & Greenwood, 1991).

**Philosophical approach summary.** Feminist ethical theory corresponds with GT as feminism parallels symbolic interactionism, the philosophical underpinning of GT. A feminist perspective has been used within GT studies in efforts to avoid women’s oppression (Merritt-Gray & Wuest, 2001). Feminism is also a philosophical underpinning of PV and fits within the empowerment education theory of PV. In all, a commonality between GT and PV is the feminist acknowledgement of the relational, contextual, and experiential aspects of human behaviour. Feminist ethical theory helps to capture the diverse experiences of women’s help-seeking informed by an ethical lens that involves being aware of potential moral issues related to the services they receive.

**Synopsis of Findings**

A synopsis of the findings is offered here to allow the design section to read more comprehensibly. Findings in grounded theory, the primary analysis approach for this study, are discovered using an emergent process. Concepts and relationships surface from
the data as a result of constantly comparing pieces of data with other data findings. As such, the integrity of the analysis must be explained using exemplars from the emerging findings. Although it is not usual to present a summary of the study’s findings before a description of how the researcher arrived at the findings, familiarity with the study’s theory will help the reader to follow explanations of the methodology.

**Hunting to Feel Human: An introduction.** A theory on how women seek help for suicidality after leaving an abusive relationship was discovered in this study. *Hunting to Feel Human* is the basic psycho-social process that aims to manage the central problem, *System Entrapment*. While *Feeling Human* is the goal of the *Hunt*, it is not a pinnacle of healing. *Feeling Human* rather, is an ongoing fight for interpersonal connection and personal worth. Different sub-processes are used in the *Hunt* depending upon the opportunities to *Feel Human* and the risk for *System Entrapment* within each help-seeking context.

*System Entrapment*, one of the three forms of *Entrapment* in the *Hunt to Feel Human*, is a sense of being trapped and dehumanized within the healthcare system. Overall, *Entrapment* is about being stuck in a situation with a low sense of control, self-worth, and belonging, leading to a feeling of dehumanization. *Abuser Entrapment* entails feeling trapped within a violent relationship with little agency to escape the coercive control. *Trauma Entrapment* represents feeling hopeless and suicidal as a result of depression, PTSD, and other mental health consequences of having experienced trauma. All three forms of *Entrapment* influence the other. *Abuser Entrapment* is the greatest contributor of *Trauma Entrapment*. *Abuser* and *System Entrapment* have striking similarities. Feeling mistreated by the HCPs is reminiscent of having been abused within
the IPV relationship. Feeling invalidated and not taken seriously System Entrapment leads to worsening suicidality.

*Feeling Human*, attained through health care providers’ (HCPs) validation, is to have a sense of belonging and a sense of self-worth that protects against suicidality. Validation comprises having been taken seriously, believed, and acknowledged for suicidality, IPV, and the painful experiences related to trauma. *Feeling Human* does not equate recovery from mental health problems, but rather is a powerful sense of connection to others or the world that contributes to feeling deserving of help and to live. Levels of *Trauma* and System Entrapment are weighed against the other by Gauging for Validation opportunities throughout the entire journey. Actions taken toward Feeling Human depend upon the determination of whether Trauma Entrapment needs to be abated due to feeling overbearing pain of suicidality or whether System Entrapment must be avoided due to feeling dehumanized while seeking help. This process is named *Taking the Path of Least Entrapment*.

*Hunting* sub-processes either move toward or away from the system depending on the level of hope that the system will be validating. *Distancing from Help* or avoiding professional help, occurs in the context of higher levels of System Entrapment in relation to Trauma Entrapment. Hope that the HCPs will be helpful is at the lowest level during Distancing. *Grasping for Help* is an attempt at obtaining urgent help and occurs during higher levels of Trauma Entrapment in comparison to System Entrapment. A sense of deservingness and hope in receiving help contributes to the devastation of feeling invalidated, the most frequent outcome of Grasping. If suicidality worsens or levels of Trauma Entrapment raise to the highest levels, *Applying Counter-Pressure* is employed.
as a desperate attempt of accessing help. *Applying Counter-Pressure* involves trying to prove the urgency of the crisis, including harming oneself as a way of altering others of the high need for help.

When hope and deservingness are low during higher levels of *Trauma Entrapment* in comparison to *System Entrapment*, *Enduring System Entrapment* occurs. This sub-process is a way of tolerating invalidation or conforming to *System Entrapment* in exchange for receiving access to services and HCPs’ validation. In fact, the most frequent outcome of *Enduring* is validation. Once a trusting relationship with the HCP is created, *Soaking In Validation* occurs, an active process of accepting others’ empathy and integrating it internally. This leads to a sense of self-worth and belonging, allowing for a pause in self-harm or an engagement in living. Sharing mutual humanity with HCPs or connecting with HCPs on a personal level triggers a process of *Letting Go*, the final *Hunting* sub-process. An increased sense of control during *Letting Go* enables a comfort level with HCPs’ guidance and direction. While *Trauma Entrapment* may persist during recurrent suicidality and *System Entrapment* may occur sporadically among different HCPs, having a connection to at least one HCP fosters enough *Feeling Human* to persist in recovering from suicidality and the intrusive consequences of IPV.

**The Design**

The research methodology for this study is a multiple method feminist GT and PV research approach. The similarities within GT and PV facilitate their consolidation and the differences are complementary as they augment the research outcomes of each approach. Within this section, I will review GT and PV separately, followed by a discussion on their integration. An overview of the sample population, inclusion and
exclusion criteria, data collection, and data analysis is included, followed by ethical considerations and dissemination of the findings.

I have selected a feminist GT/PV methodology for the study due to the oppressive nature of violence against women and the historical power differentials involved with women’s mental health and suicide care. A contextual research approach allows for a broader understanding of women’s suicidality and their help-seeking. A feminist lens also fits within the study because a critical awareness of power relations is possible within both GT and PV. The way that feminism informs the research approach is woven throughout the following sections.

**Grounded Theory.** GT “involves a process of research” (Glaser & Strauss, 1967, p. 6), with a theory generated from the data through a constant comparative analysis method (Creswell, 2007; Glaser & Strauss, 1967). Theory about a particular phenomenon emerges inductively (Gergen, 2008; Shepard & Hack, Gwyer, & Jensen, 1999) by constantly comparing concepts within the data, grouping these concepts and interpreting them to form relational statements (Strauss & Corbin, 1994; Wuest, 2007). The theory also emerges deductively through theoretical sampling where further data is collected in order to check on hypotheses that have been emerging inductively and to further develop the emerging theory (Glaser & Strauss, 1967; Wuest, 2007). GT involves the study of human behaviour (Morse, 2001; Stern & Porr, 2011) with the intent of developing a theory that describes a basic social or psychosocial process (Glaser & Strauss, 1967; Stern, 1980). The generation of theory fits with the overall purpose of this study to understand how power relations influence the nature of women’s help-seeking.
The goal of GT is to create theory by raising the analysis beyond description to a higher level of abstraction through a constant comparison of data (Strauss & Corbin, 1998; Wuest, Merritt-Gray, Berman, & Ford-Gilboe, 2002). While GT involves abstractions, the theory is driven by the data (Dick, 2007) or is tightly connected to the descriptive field notes and interviews with the participants (Kirby, Greaves, & Reid, 2006; Montgomery & Bailey, 2007) as “GT is a detailed grounding by systematically analyzing data sentence by sentence” (Glaser, 1978, p. 16). Like all theories, “theory is abstract, but it is unique in that it makes the synthesis of descriptive data readily apparent through its concepts and relational statements” (Morse, 2001, p. 2). Considering that literature is sparse in how power relations affect women’s help-seeking for suicidality in the context of an abuse history, GT is an effective research design because it involves exploring an area of interest where little is known (Pollio, & Graves, & Arfken, 2006; Holloway & Todres, 2010). GT allowed me to capture the course of events and to discover what was going on beneath the surface of women’s help-seeking. Furthermore, the substantive theory that emerges in GT is rich and meaningful as it is grounded in the participant’s reality (Glaser & Strauss, 1967; Rodgers, 2009). The need for holistic research within suicidality is addressed with GT as it “ties the varied perspectives together through the conceptualization of the data and its implicit social organization of processes and problems” (Glaser, 1992, p. 18).

**Photovoice.** PV is a qualitative, visual method where participants identify their individual and community strengths and challenges through participant-generated photography (Downey, Ireson, & Scutchfield, 2009; Wang & Burris, 1994). Social and political issues are discovered through visual images (Moffitt & Vollman, 2004) and
represent a unique and dynamic way of influencing policy (Hergenrather et al., 2009; Lorenz & Kolb, 2009; Wang et al., 2004). The three phases of the PV process; selecting, contextualizing, and codifying (Wang & Burris, 1997); are described in the PV analysis section. The goals of PV are to describe the needs, strengths, and concerns of a community (Wang & Burris, 1994) and to stimulate change through critical reflection and empowerment (Clements, 2012; Wang & Redwood-Jones, 2001). The term community in relation to this study refers to the women as a collective group who have experienced IPV and suicidality concurrently. In addition, the women are also considered to be a part of a community due to the social and political oppression they experience as women, victims of abuse, and mental health clients. PV is also a community-based participatory research (CBPR) approach (Duffy, 2010) in which particular focus is placed on the participation of the community or population engaged within the research (Israel, Schulz, Parker, & Becker, 1998; Israel et al., 2010). CBPR involves an awareness of the potential power differentials within the research process; therefore, its goal is to partner with the participants to increase their sense of empowerment (Baker et al., 2012; Freedman, Pitner, Powers, & Anderson, 2014). CBPR has been successful in engaging disadvantaged populations who are excluded from traditional health research (De Las Nueces, Hacker, DiGirolamo, & Hicks, 2012). Women with histories of childhood abuse found healing benefits to having an active or participatory role within the research process (McClain & Amar, 2013). In CBPR, the well-being of the participants is considered as important as the researchers’ interests (O’Brian & Whitaker, 2011), learning from each other is valued, and social inequities are considered (Israel, Schulz, Parker, & Becker, 2001; Israel et al., 2010). Participatory action research is grounded in
promoting empowerment (Wuest & Merritt-Gray, 1999), is particularly compatible with a feminist approach (Gustafson & Brunger, 2014), and is critical for use in research involving gender inequalities (Duffy, 2005b; Singh, Richmond, & Burnes, 2013); therefore, CBPR was an appropriate match for this study. A participatory approach with engaged participants represents the means through which knowledge construction and change occur within PV (Wang & Burris, 1994).

PV involves an acknowledgment of the participants’ voice as an indicator of reality (Wang, 1999; Wang & Redwood-Jones, 2001) and is based upon the person’s everyday experiences (Rhodes et al., 2009; Stevens, 2006;). Valuing people’s interpretations and perspectives of their lives is a founding principle of PV (Wang & Burris, 1994), as “images have multiple meanings and different audiences with different values and individual experiences will adopt their own interpretation” (Prosser, 2008, p. 46). Where people with mental health problems are often isolated and stigmatized, people with mental health problems are engaged in their own advocacy within the PV research approach (Becker, Reiser, Lambert, & Covello, 2014). Through discussions of the photo images, participants generated and derived meaning from their interpretations, enriching the study with more information about the contexts of their lives (Wang, Cash, & Powers, 2000; Wang & Redwood-Jones, 2001). Specifically, the photos act as a catalyst to understanding participants’ reality and their individual and community concerns.

**Integrating GT and PV.** This study uses a qualitative multiple method design by combining GT and PT. It is important to determine the structure of a research design in order to achieve validity of a research approach. A qualitative multiple method guideline from Morse (2012) was used to frame the structure of the GT and PV methodology. In
their description of how qualitative methods legitimately mix within a single study, Morse and Niehaus (2009) write that there is a core and a supplementary component to the new research method. The core or standard component represents the complete method and the supplementary component represents research strategies from another qualitative method that can be used at the same time as the core component (Morse, 2012). GT functioned as the core component and PV represented the supplemental component.

Although GT and PV were amended in the making of a new multiple method study, there are key aspects of each approach that were not changed so as to maintain their integrity. The non-negotiable component for GT is theory development; therefore, the core component of the research method was the GT research analysis that raised the data to an abstract level. The non-negotiable component for PV is participant-generated photographs and women’s critical reflections of these photos. PV data was used within the GT analysis along with the interviews (Appendix A). The use of photographs is methodologically feasible with the GT research process because Glaser (2001) makes it clear that “all is data” (p. 145), including a combination of interviews, documents, and observation (Artinian, 2009b; Glaser & Strauss, 1967). Adding participant-generated photos, therefore, to GT data collection is appropriate and enhances the quality of the research. Photos reflect participants’ reality; therefore, has validity and applicability in using the images to promote their issues or concerns (Riley & Manias, 2004; Wang & Redwood-Jones, 2001).

The purpose of adding photos to the data collection was to deepen the understanding of women’s help-seeking. Visual images enrich interviews (Frohmann,
2005) because they ground the analysis in the everyday experiences of participants’ lives and provide a perspective of reality that only a visual image can reveal (Harrison, 2002; Mahmood, Chaudhury, Michael, Campo, Hay, & Sarte, 2012). Visual images “slow down observation and encourage deeper and more effective reflection” (Prosser, 2008, p. 4) on people’s senses, communication, and other human experiences. Combining images and interviews in data collection can enhance the validity of the research as it decreases the risk of “misinterpretation, and the process allows the possibility of moving beyond awareness as participants become catalysts for social change” (Duffy, 2010, p. 795). Combining interview and images is also a way of discovering commonalities and differences between the researcher’s and the participants’ observations (Cannuscio et al., 2009).

The other non-negotiable to maintain the integrity of PV within this study was to include women’s collective critical reflections of the images within the data analysis. Indeed, PV data collection did not end with capturing images, but continued with the women’s critical reflections of their own and other participants’ images. The PV analysis included individual interpretation of personal images and added further interpretations from the collective. The findings created within PV are more than the sum of its parts; that is, the PV process yielded critical reflections resulting from a collective analysis of the images. The sharing and dialogue that occurred while analyzing the images was transformative, a collective sharing where one idea expanded on another.

During her last PV meeting, one of the participants, Jesse, reflected upon the participants’ images that had been organized into themes and displayed on posters. Struck by the level of trauma they all had experienced, Jesse made a comment with exasperation
and a chuckle, “I can’t believe we are all sitting here!” Reflecting upon the collective experiences of the group, Jesse became acutely aware of the injustices they endured and pain that they managed, an awareness that the group shared. Discussing their experiences within a group setting allowed them to see the extent of their own pain by seeing it in others. Jesse’s comment highlighted the importance of not underestimating the urgency that the women perceive about their suicidality while help-seeking.

The group’s acknowledgment of the urgency of their help-seeking deepened my comprehension of the extent to which the trauma affected their lives and the level of skill they used in getting help. I had not had this level of understanding during the interviews as the participants downplayed the effects of their trauma while sharing their experiences individually. Had I not witnessed the women’s acknowledgement of the extent of their collective trauma within the PV meeting, I may not have fully understood the urgency and level of risk they experienced. This helped me to remain sensitive to the intensity of the women’s distress and sense of entrapment while recollecting their experiences during subsequent interviews.

When differing ideas or interpretations arose within the data, the PV participants deconstructed them and found meaning from the differences, deepening understanding of their experiences. Differing perceptions arose while reflecting upon Carrisa’s photo of a pile of peanuts, helping to uncover how gender, trauma, and mental illness intersected in minimizing their problems. A note on top of the peanuts reads “Nuts,” signifying that people with mental health problems are considered crazy. Carrisa explained that stigma created a fear of being judged, leading to an avoidance of the health care system (Figure 1).
Other PV participants interpreted the image as a representation of the belief that women are weak in comparison to men. They also believed that they were seen as weak because their trauma symptoms, including suicidality, are an indication of being crazy. PV participants discussed the myth that the male abuser never “messes up,” whereas the woman is needy and does everything wrong. The feeling of being judged while seeking help is intersectional based upon being a woman, having experienced IPV, and living with mental illness or suicidality. This intersection amplifies the invalidation received within the system. Critical reflections on the differing perceptions of the images within the collective voice of the PV groups created a transformative understanding of stigma.

Differing interpretations of Carrisa’s depiction of herself about to ingest a handful of pills resulted in a broader understanding of substance use and managing pain (see Figure 2).

Figure 1. The peanuts signify being labeled as nuts or crazy.

Figure 2. Carrisa enacting an intended overdose of pills.
According to Carissa, the image of overdosing on pills represented escaping her painful life in response to poor access to support. Jesse related to this image as well because she also took a “bunch of pills” to escape pain. Whereas Carissa used the pills to escape her painful life, Jesse used pills to escape her abuser’s violence by “passing out.” Jesse’s experience prompted Gabrielle to share that she also overdosed on pills to avoid her abuser, a fact that Gabrielle had not disclosed during the individual interview before the PV groups began. Gabrielle also shared while analyzing the image that she overdosed on pills to avoid the feeling that she was not being taken seriously within the health care system. Gabrielle’s intent was that overdosing on pills would alert the HCPs of her urgent need of help. Women’s interpretations spoke to differences in how they used pills as a strategy to escape pain. They found creative ways of managing risk when they did not have access to supportive services or safer options to manage their pain.

Analyzing the image of the pills, as a PV group raised the individual interpretations of the image to a deeper level of understanding. One interpretation expands on the other, transforming the meaning of how they seek help within the health care system. The pills represented gaining power during a time when they felt trapped or had no sense of control. The energy of the women in the PV group rose during the group discussion about the ‘overdosing on pills’ photo as they eagerly shared how they used pills to gain some control of their situation, a sign of their determination and persistence. Women in the PV group recognized that their persistence in taking some control over their lives in the face of hopelessness was evidence of their strength. Identifying that experiencing IPV and lack of access within the health care system is unjust, the women in
the PV group felt pride that they were able to protect themselves somewhat by escaping their pain through an overdose.

Through the collective voice on the photo of the pills, light was shed on the continuous process of help-seeking. They never relented around taking control or finding what they needed to survive while seeking help within the health care system despite their degree of hopelessness, danger, or low level of agency. The transcripts from the collective voice within the PV groups were later constantly compared to subsequent interview transcripts contributing to the help-seeking process. Help-seeking for suicidality after IPV emerged as a persistent fight that crossed various contexts, revealing the strength and capacity of women during high levels of trauma and distress.

In all, the PV analysis created an elevated consciousness within the group that was translated into the discussions and captured within the transcripts; therefore, the critical transformative aspect of PV was not lost within the GT analysis. It is for this reason that this study refers to having used a true PV approach that was integrated into GT, instead of simply having used the photos as data within the constant comparative analysis. The aspect of this study’s GT/PV integrated approach that distinguishes it from pure PV is that the descriptive PV data was raised to a higher level of abstraction through the GT constant comparative analysis.

An example of how the PV findings were raised to a higher level of abstraction is observed through the integration of a theme from the PV analysis into the GT analysis. The PV analysis yielded the themes of being controlled, unaccepted, judged, and shunned. Jesse’s image of a brick wall represents what it felt like to come up against the barriers within the emergency department (ED; Figure 3). Similarly, Carissa’s image of
the detour sign reflected how health services would not help, but instead would redirect
her to another service that would inevitably block access once again (Figure 4). Cassidy’s
image of mental health books illustrates her feelings of being “alone, isolated, and
intimidated” because the people in the stories were able to get help for their problems,
something that she was unable to attain within the health care system (Figure 5).

![Figure 3. Jesse felt like she had to get through a brick wall in the ED.](image)

![Figure 4. Carrisa felt that she constantly hit a detour sign when seeking help.](image)

![Figure 5. Cassidy felt alone reading about others receiving help.](image)

The images represented ‘feeling rejected’ when blocked from receiving help from the
health care system, especially when they felt extremely vulnerable. The concept of
rejection was integrated within the GT analysis and emerged as GT categories that included ‘feeling isolated’ and ‘stuck’ while ‘fighting for help;’ themes that contributed to the discovery of being trapped within the health care system or System Entrapment.

Finally, the participatory underpinnings of PV were integrated within the core GT component, an integration that occurs naturally with the participatory nature of GT. The transition from the PV participatory analysis into the GT analysis occurred smoothly as the latter involves returning to the participants, eliciting their feedback on the emerging findings. This method is called member checking and helps to ground the collective voice from the PV findings within the data. Constant comparison allowed for emergence of the PV findings within the interview data. The participatory approach of PV, including the women’s leadership, collective sharing, and ownership of the photo collection and analysis significantly promoted a more collaborative, emancipatory, and critical research approach.

In summary, GT is the core component of this multiple method study where theory was generated on how power relations influence women’s help-seeking for suicidality in the context of a history of intimate partner violence. The GT process remained intact with the addition of PV data collection, analysis, and a participatory approach integrated throughout. The evolution of the study is demonstrated below by describing the GT process including specific indications of the way that PV influenced the research.
Participant Sampling

Participants were invited to take part in the study through advertisements in psychiatrists’ offices, community mental health centres, social media, and a snowball approach. See Appendix B for a synopsis of the participant recruitment process.

Inclusion criteria. The following criteria were assessed when women made the initial contact by phone in response to the study Letter of Invitation for Interviews (Appendix C) or Recruitment Advertisement (Appendix D). Eligible participants were women who spoke English fluently, 19 years or older, and had self-reported having experienced IPV at any point during their lives. Past abuse was identified using a modified Abuse Assessment Screening within the Eligibility Screening Form, Stage 1 (Appendix E). To be eligible, women self-reported that they had been apart from or no longer in an intimate relationship with the abusive partner for at least six months prior to responding to the advertisement. Having been out of the relationship no less than six months decreases women’s risk of harm by the past abusive partner, as evidenced by the finding that more than two thirds of men who abused their ex-partner after the relationship had ended, did so within the first six months (Gondolf, 1997).

Eligibility also included that women had sought or attempted to seek help for suicidality from the health care system within Horizon Health Network, an English/Bilingual health authority in New Brunswick, Canada. Suicidality was self-identified by the woman in the study and included having experienced one or more of the following: (a) self-inflicted behaviours with the intent to end life, (b) plans to end her life, or (c) thoughts of ending her life, to “end it all,” going to sleep forever, or wanting to escape from life permanently. Only women with a low risk of suicide were included in
the study, an assessment that I performed during the initial phone contact and again at the
beginning of the face-to-face interview using an Eligibility Screening Form, Stage 2
(Appendix F). Eligibility criteria stipulated that suicidality occurred sometime during or
*following* the woman’s experience of IPV. Finally, participants had sought help within or
around the greater surrounding area of Moncton, Fredericton, Saint John, or Miramichi.
Women within Moncton and surrounding area were invited to take part in the PV portion
of the study.

**Exclusion criteria.** Women were not eligible to participate if assessed to be a
moderate or a high suicide risk (Appendix F). The presence of suicidal ideations did not
automatically exclude women from the study, as chronic feelings of wanting to escape
life are an integral part of the personality structure in people living with BPD. Suicidal
ideation or thoughts of self-harm in people with BPD is a way of managing interpersonal
relationships (Sansone, 2004), a way of coping with psychological pain (Paris, 2004), and
can become “a way of life” (Paris, 2008, p. 211). Excluding women with chronic
thoughts of self-harm would have excluded a significant portion of the population with
important experiences that are critical to capture in order to understand how women seek
help.

Women with symptoms of a major psychiatric illness that was not well managed
and resulted in significant cognitive deficits were not selected. Women’s level of mental
health functioning was assessed based upon their ability to follow a casual conversation
and respond to simple directions upon initial phone contact. Women experiencing
psychosis or disorientation to person, place, and time were also excluded as they would
not have been able to comprehend the interview or group discussion process. My
extensive psychiatric nursing experience facilitated the assessment process and allowed for accurate detection of severe psychiatric symptoms. Finally, women who self-reported being in an abusive relationship or having left an abuser less than six months ago, were excluded from the study for safety reasons. Women not eligible for the study and who were seeking help for mental health problems were given information on crisis, addictions, and mental health resources.

Sample. The aim originally was to collect data from approximately 25 women and in the end, 32 women were interviewed. Within GT research the exact number of participants is not predetermined (Wuest, 2007). Rather, theoretical sampling determines the number, a method within GT that involves the assessment and choice of what additional data is necessary, based on what is emerging while simultaneously coding, collecting and analyzing the data (Glaser & Strauss, 1967; Hoare, Mill, & Francis, 2011). Aiming for representation from across Horizon Health Network, the areas with lower responses were specifically targeted to engage more women. After several months into data collection, the numbers from Miramichi were lower than the other regions; therefore, I arranged additional advertisements to be displayed in this area.

Theoretical sampling also occurs by seeking out new participants as the analysis progresses in order to explore hunches and to test hypothesis that arise (Wuest, 2012); however, additional participants were not needed. After participants responded from all areas of Horizon Health Network, the data obtained exceeded the amount required for the basic social process to emerge. Hunches and hypotheses were tested among these transcripts.
**Demographic information.** Ages of the women were nearly evenly split between three age ranges. Eleven participants were between ages 19-35, eleven participants were between ages 36-50, and ten women were 51 years old or older. All participants identified as women, the sex and gender that they were assigned at birth. Only five women were from rural areas and 27 were from urban areas. One woman identified as being bisexual, whereas the others identified as being heterosexual. It had been between six months and one year since two participants left their abusive partner, between one and five years since ten women left, and more than five years since 20 participants left. Relationship status of the participants ranged from common law or married, separation or divorce, having a boyfriend, and being single. All but seven women had children and eight women had lost custody of their children. Two participants were students, five were employed, and 25 were unemployed at the time of the study. Three women reported that they completed some high school, 20 had graduated from high school or attained a GED, and nine had some post-secondary education. Finally, 24 participants were English Canadian, seven were French Canadian, and one woman identified as being both Caucasian and Asian Canadian.

**Data Collection**

Data collection included a mix of one-to-one interviews with all participants, group discussions with women in the Moncton and surrounding area involved with the photography data collection, and follow up conversations to check in with the women regarding the emerging theory. Data included transcripts from the recorded interviews, the photographs, and transcripts of the recorded group discussions where the women analyzed the photographs.
**Initial contact.** Upon initial phone contact in response to the recruitment advertisement to participate, I completed Stage 1 of the Eligibility Screening, containing basic inclusion criteria (Appendix E) and documented the information on the Participant Tracking form (Appendix H). If a woman was not eligible, I thanked her for her time and interest and offered her resources. If the woman met the initial criteria, I proceeded to Stage 2 of the Eligibility Screening by assessing suicide risk (Appendix F). The plan before the data collection began was that women scoring a moderate suicide risk or higher would not be eligible and I would provide support by collaborating with her on a plan of safety using the “Suicide Safety Protocol” (Appendix I). All participants scored a low suicide risk and were eligible to participate in the study. I discussed with each woman how she could access supportive help during the period that she was involved in the study if needed. In addition, if the woman was seeing a counsellor, I suggested that she might want to disclose to the counsellor that she was going to be participating in the study in order to fortify the amount of support accessible to her if needed.

I collected her preferred contact information and scheduled a meeting for the face-to-face interview at a time and place that was convenient, safe, and comfortable for her. Further safety guidelines were outlined in the IPV Safety Protocol (Appendix J), a document that helped to maximize women’s sense of security during meetings. Face-to-face meetings were held in various settings within the community including a private office at the Community Mental Health Center, my office at the Moncton Hospital, community centers of women’s choice, or the woman’s home. I explained that she would receive $30.00 as an honorarium for her time and paid in cash when we met for the interview.
**Interviews.** Before the interviews began, Stage 2 of the Eligibility Screening was completed for a second time, assessing for suicide risk (Appendix F). All women were determined to be a low suicide risk and the interviews proceeded with an explanation of the study and time allotted time for questions. The Stress Reaction Handout (Appendix K) was reviewed to help the woman recognize possible difficult reactions that she may have in response to discussing past abuse and suicidality and explored ways of dealing with these reactions. Upon asking each study participant if they were aware of crisis lines in their area or a 24 hour health care service that they could access in case of an emergency, they all responded that they had this information. All women wished to continue in the study, signed the informed consent form (Appendix L), and were invited to share their experiences at that time. The interviews were recorded and later transcribed.

As typical within GT research studies, the interview process allows for “conceptualization or for generation of concepts and hypotheses” (Glaser, 1998, p. 107). The interviews were semi-structured, an interview style that is common within a GT study (Britten, 2006; Swanson, 1986; Wuest, 2007) and helped to build a relationship with the participant (Hesse-Biber, 2007). Interview questions enabled participants to reflect on their experiences and to share detailed information about their perceptions. An interview guide with initial questions assisted with individual discussions (Appendix M) and encouraged the collection of data in the participant’s “own words” (Beck, 1999, p. 208). The interview questions were open-ended, which minimized the influence that I had on the direction and flow of the interview. The interview advanced at the women’s pace and provided support and breaks when the content became upsetting. While Jesse was
reviewing the PV themes on the posters during a follow up interview after a PV meeting, she became very quiet at which time I provided support:

   Researcher: Jesse you said that it is hard to realize that we are all here or that you have gone through this. Is it kind of stressful looking at this and accepting that, ‘Oh my gosh, this really did happen’ and it’s a reminder that it is uncomfortable?
   Jesse: Yeah
   Researcher: so it’s hard for you to see this.
   Jesse: (crying) Yes. Definitely.
   Researcher: …and at any time if you want to not partake and if it’s too hard then just let me know and you are free to take a break or go home or whatever you need.

After Jesse indicated that she wished to remain in the group, I elicited feedback from the others so that Jesse could feel their acknowledgement and support.

   Within feminist research, recognizing how one’s own personal background may influence data collection is important (Hesse-Biber, 2007). To avoid forcing my ideas onto the data collection, I was reflexive about how my background, past experiences, values, beliefs, and socio-political personal context influenced the way I interacted with the women. Reflexivity was carried out through memoing and keeping a journal that reflected insights derived throughout the research process and how these related to my own experiences and biases (Cutcliffe, 2003b). I remained cognizant of my bias from working within health care; in particular my nursing practice within a psychiatric unit. Over the course of my psychiatric nursing career, I have learned of clients’ desire to have more therapeutic connections while seeking help for suicidality and their discontent with some treatment interventions they perceive as being coercive. I frequently linked these perceptions to treatment interventions that I thought to be paternalistic, for example, generalizing that all forms of directive care or decisions made on behalf of the clients was disempowering.
Acknowledging my bias and remaining open to the emerging findings helped me to debunk the assumptions I had made regarding autonomy and providing direction for clients. I discovered that HCPs’ guidance or directive care including making decisions for them or keeping them in hospital on an involuntary basis could be supportive and healing. Feeling trapped or invalidated did not necessarily result from having lost autonomy. On the contrary, participants felt relief and support when receiving guidance within the context of a therapeutic relationship or when they were validated by the HCP. The need for the HCP to take over was especially important when women in the study were at the highest levels of crisis or suicidality.

Awareness of my own experience of IPV and depression was critical in separating my bias from the findings. As a part of relationship building with the participants, I briefly shared some of my feelings related to my personal experiences when self-disclosure was relevant to offering support and validation. I had to be careful with this use of self-disclosure as not to influence the participants’ telling of their experiences or to pressure them to repeat similar experiences to what I had shared. Self-disclosure was only used when my sharing matched theirs and after they had already expressed themselves. I checked-in with the participants after I self-disclosed to give them an opportunity to clarify how their experience coincided or differed, observations that were facilitated using a face-to-face interview format. The in-person interview also helped in establishing a trusting relationship and increased the participants’ comfort level in being honest and genuine while sharing their experiences. Insight about my own trauma and recovery helped in identifying the difference between my experiences and those of the participants.
After the interview, women who lived in the Moncton and surrounding area were invited to participate in the PV groups. Interviewing women separately before participating in the PV groups allowed for a greater level of comfort sharing with the other group members. Women who declined to participate in the self-generated photography portion of the study were thanked for their earlier contributions through interviews. At that time, plans were made to check in with them the next day and to follow up with them in the future to discuss the emerging theory.

**Participant generated photos.** Collecting data through participant-generated photos is an approach that aims to capture women’s experiences in a different way. Photos reflect participants’ realities; therefore, have validity and applicability in using the images to promote their issues or concerns (Riley & Manias, 2004; Wang & Redwood-Jones, 2001). The process and outcomes for each PV meeting is described.

**PV groups.** The purpose of the groups was to provide a forum where the sharing and dialogue with other women who had similar experiences could expand their own understanding of their help-seeking. After having read the Letter of Invitation for the PV Group (Appendix N), seven women participated, a size that helped to create a comfortable atmosphere for sharing. Although not essential to the GT process, the group setting is an important part of PV as it allows for an environment where education empowerment may occur (Wang & Burris, 1994, 1997). Education empowerment was achieved according to women’s reports of having learned from each other, obtained support, and gained a sense of self-agency as a result of their group participation. Discussion groups also have roots in feminist ideology in that a group setting may reduce
a researcher’s position of power (Morrow, 2006); therefore, my role in the group was to facilitate rather than to lead the discussion.

Meeting dates were agreed upon for each PV session and occurred in a private room at the Moncton Hospital, a space that all women identified as a comfortable location. The PV meetings were approximately three hours in duration and women agreed to taking a few weeks between meetings to work on their assignments. I provided transportation for those who required it and lunch was provided at each meeting. Due to conflicting schedules, not all women were able to attend each meeting; therefore, I added more meetings so that the women would not miss an opportunity to participate in each group discussion. Each of the four meetings described below were held twice or repeated, allowing for greater opportunity for more women to be a part of all three group assignments and discussions. Each meeting consisted of a different mix of approximately three to four women, some participants overlapping between groups or able to attend all meetings.

The different mix of participants at each meeting allowed for rich discussions and a more in-depth critical analysis of the images. Dr. Lynne Duffy, co-supervisor on the study’s research committee, attended a few of the meetings, providing support and structure that aided in staying true to the PV process. Finally, all PV participants received a list of crisis lines and mental health resources (Appendix G).

**First PV meeting.** The first PV meeting comprised reviewing the PV consent form (Appendix O), group confidentiality (Appendix P) and potential risks of participation. After consent forms were signed, the new digital cameras were distributed, training on their mechanical use was provided, and different ways of seeing through the
lens or how to capture different images was explored. We also reviewed maintaining confidentiality of people in the photos and other ethical considerations related to picture taking. Participants were given a consent form that they could use as a way of checking if the people who they intend to take a picture of are ok with being in the picture (Appendix Q). Finally, the first assignment was explained to the group; that is, to take pictures of people, places, or things that represent their help-seeking for suicidality and to have the photos ready to share with the group for the next meeting.

**Second PV meeting.** Women analyzed their photos from the first assignment during the second group meeting. Each photo that was brought to the meeting was chosen by the women to be used in the study. I had not seen the photos before the group began; therefore, the entire group saw each other’s picture for the first time. The women decided as a group the order in which the photos would be projected onto the screen and analysed. The photos were projected onto a screen one at a time and each participant chose which ones to discuss. Each participant explained what the photo meant to her before others’ input was added and no time limit was placed on the women to discuss their photo.

Using participatory research yields a high level of engagement with the participants, lessens the researchers’ bias, and enhances the variety of responses from the population under study (Dick, 2007). In this way, I allowed space for all women to feel comfortable participating within the group discussions; for example, using encouraging statements when women shared uncomfortable feelings and giving women who were quieter a chance to speak. Within this informal group environment, women took a participatory role as they critically reflected on their photos and dialogued with others about their meanings. Encouraging women’s participation allowed them to be a part of
the decision-making process and facilitated a sense of collaboration and belonging. The group decided on the next meeting date and determined that the second PV assignment was to take pictures that represent changes needed within the mental health care system. With the women’s permission, I phoned them before the next meeting to answer any questions they might have about the assignment.

**Third PV meeting.** Women analyzed their photos from the second assignment during the third group meeting. After they critically reflected on the photos, the women decided upon the third and final assignment, to capture images of what might be missing in the sharing of their help-seeking experiences. Again, with the women’s permission, I phoned them before the next meeting to answer any questions they had about the assignment.

**Fourth PV meeting.** In between meetings, all of the photos that the women chose to be included in the study were printed, arranged according to the women’s depiction of themes on poster boards, and attached the quote associated with the images that had been generated during the discussions. The group also reflected on the posters, integrated the findings from the past meetings, and made new insights and discoveries about the additional photos that were brought to the meeting. I facilitated a discussion about their thoughts on how to proceed with the research, including disseminating the findings within the community, the participants continuing to meet on a personal basis for support, and advocating for mental health with HCPs. I expressed my gratitude for their generosity in sharing their experiences. I also validated their contributions by relaying the significance of their work and how it will help to inspire others, inform policy through my workplace, and educate professionals on how to provide better mental health care.
With the women’s permission, I followed up by phone or email on the progress of the study and continued to seek their input on the analysis. Based upon theoretical sampling requirements, I clarified items within the emerging theory by refining and confirming conceptual relationships and variations within the findings. During each follow up interaction I continued to provide support through active listening, validation, and empathy about their past and emotional difficulties. Upon the women’s request, the group stayed in contact after the PV meetings had ended, providing support to one another and offering to volunteer in Addictions and Mental Health Program advocacy forums with me. A few women shared their experiences seeking help and educating clinicians on where improvements were needed within the health care system.

**Data Collection and Analysis**

Simultaneous data collection and analysis is foundational within GT research studies (Glaser & Strauss, 1967; Wuest, 2007). The decision about what further data to collect is “associated with the generation of theory” (Glaser & Strauss, 1967, p. 48), instead of allowing a particular set of rules to guide the data collection process (Glaser, 1992). As connections in the data began to surface in the analysis, theoretical sampling was used to collect further data as was deemed necessary by the emerging theory. Interview questions may be modified as relevant events begin to emerge (Corbin & Strauss, 2008), a process that was required in order to understand more about the sub-process *Distancing from Help*.

One of the study objectives was to understand how women seek help; therefore, one of the main research questions was about how women reach out to the health care system. Sub-questions were created to elicit help-seeking processes including how they
made decisions in help-seeking, what were they seeking, and how they attained help. After a few PV group meetings and interviews, it became apparent that not seeking help was just as important a concept as reaching out for help.

Women spent more time and energy purposefully staying away from the system or avoiding HCPs when they felt that they needed help than actively seeking help from the system. Women’s accounts about avoiding the system yielded a more complete understanding on help-seeking than would have been achieved by limiting the questions to how they reached out for help. I amended the interview questions to include ones about avoiding help or periods of time when they believed they needed help, but were not yet actively seeking services. An example of a new interview question was, “What was going on when you might have wanted help, but did not reach out to the health care system?”

The main category that emerged from analysing women’s responses yielded Distancing from Help, a way of protecting themselves from feeling dehumanized within the system. Distancing, a process that contributed to an extensive part of help-seeking, may not have been discovered had theoretical sampling not been used by amending the interview questions.

When no further information was obtained from the emerging categories, theoretical saturation occurs and the data collection process ceases (Holloway & Todres, 2010; Morse, 1995). Theoretical saturation is the “criterion for judging when to stop sampling the different groups pertinent to a category” (Glaser & Strauss, 1967, p. 61) and occurs when the researcher “sees similar instances over and over again” after searching for “groups that stretch diversity of data as far as possible” (Glaser & Strauss, 1967, p. 61). Theoretical saturation of the basic problem, System Entrapment, was reached when it
was recognized that all help-seeking problems encompassed aspects of the core problem, including *being invalidated, feeling isolated, and not being taken seriously*. Theoretical saturation of the basic social process, *Hunting to Feel Human*, was reached when all the help-seeking behaviours were recognized as a way of *Hunting*, including *Distancing* from the system and *Grasping for Help*. Everything that women were seeking included a form of *Feeling Human*, including validation and acceptance. Theoretical saturation was confirmed when no new information emerged after further constant comparisons for *System Entrapment* and *Hunting to Feel Human*. The result of a GT analysis, a theory describing what is going on in the phenomenon being studied, can be depicted in an illustration. The basic psychosocial process is demonstrated in the Hunting to Feel Human diagram (Figure 6), including the basic social process, *System Entrapment*, depicted in the blue section.

![Figure 6. The Hunting to Feel Human diagram.](image)

Figure 6 also includes sub-processes of *Hunting*, depicted within divided sections across the diagram from *Distancing from Help* on the left to *Letting Go* on the right. Other titles...
within the diagram are properties of Hunting to Feel Human that help to explain the depth of the theory. The following paragraphs outline how this theory came to fruition.

**PV analysis.** Simultaneous data collection and analysis also occurs with PV (Moffitt & Vollman, 2004). Photos are gathered, reflected upon, and analyzed simultaneously at the participants’ pace (Wang, 1999; Wang & Pies, 2004). That is, data collection occurred through the process of recording and transcribing the PV group discussions while the analysis, women’s critical reflection of the photos, occurred simultaneously. The analysis is guided by the acronym VOICE or Voicing Our Individual and Collective Experience, a framework that aids in contextualizing and expanding on the meaning of the photos (Wang, Morrel-Samuels, Hutchison, Bell, & Pestronk, 2004; Wang & Pies, 2004). The participants were considered research partners; therefore, their critical reflection of the photos was a part of the actual research analysis and became a part of the overall GT analysis. In essence, the transcriptions from the women’s analysis of the photos were included as data within the GT analysis.

Partnering in data analysis is key to the participatory nature of PV as evidenced in the initial step of the analysis process, selecting photos (Wang & Burris, 1997). Women chose the photos to be included within the study based upon which ones they believed best described their help-seeking. After deciding upon the photos to be included, the next step in the PV analysis is contextualizing or expanding on the meaning of the photos and how they represent their stories (Wang & Burris, 1997). The critical reflection used within a PV data collection process is based upon Freire’s (1970) theory for critical consciousness (Peabody, 2013; Wallerstein & Bernstein, 1988), an idea that involves creating new knowledge through critical dialogue between people from all levels of
social and political power (Freire, 1970). The critical dialogue compliments the philosophical perspective of the study, feminist ethical theory, a lens through which the context of women’s lives was critically examined.

As a collective, women’s understanding and identification with each other’s images allowed them to see that feeling controlled by an abuser and by those working within the health care system are not isolated occurrences, but rather a broader socio-political phenomenon in which they are not at fault. Women were also able to expand their inner sense of agency while analysing Millie’s artistic and abstract photos, images that evoked overcoming adversity, hope, and faith. The PV group interpreted Millie’s picture of lights on a tree (Figure 7) as hopeful. The lights represented hope that goes “Up, up, up!” the tree as they move away from abuse and wanting to end their lives. Millie thought that her photo of the green tree (Figure 8) looked like broccoli and represented nurturing her body. The group discussed the importance of finding and giving oneself things that are life sustaining; basics that help them to overcome obstacles.

Figure 7. The lights represented hope that goes “Up, up, up!” as they heal.
Figure 8. The tree represents the importance of finding things that are life-sustaining.

A guide to facilitate the critical reflection of women’s self-generated photos that is often used within PV analysis is the acronym, SHOWeD (Wang et al., 2004; Wang & Pies, 2004). This guide helps to document the participants’ responses to the following analysis prompts:

- S: What do we See that is…
- H:… Happening?
- O: How it relates to Our lives?
- W: Why is the situation is occurring?
- D: What we can Do about it?

While each photo was displayed on the screen, these questions were used as a guide in eliciting their descriptions, leading to deeper critical reflecting. The next step is to codify the data or identify “issues, themes, or theories” (Wang & Burris, 1997, p. 381) within the group dialogue.

One example of using the acronym SHOWeD was in the analysis of the images that represent reaching for a life-line, a critical reflection that identified themes vital in making contact with HCPs. The PV group could See Lilli and Jane’s images of a phone
and through a discussion they could understand what was happening. The phones signified a search for a secure connection and a first line of defense when they urgently needed help (Figure 9 and 10). The PV group was asked how the phone images relate to their lives. The phone was the communication medium they initially reached for when they were a risk for self-harm. They identified past trauma, having few resources to deal with their pain, and suicidal ideation for reasons why they needed the immediate access to help through the phone. They needed to feel connected to another human being and touching base right away with a person over the phone was the go-to solution to their distress. Feeling invalidated was often the result of reaching out over the phone; therefore, they also discussed what to do about it. The women in the study decided that they should persist in reaching out and fighting to be heard as they believed they deserved to receive help.

![Figure 9](image1.png)

*Figure 9.* The phone represented a first line of defense for Lilli during a crisis.

![Figure 10](image2.png)

*Figure 10.* Jane sought professional help through the phone during a suicidal crisis.
Mental health services were not the only crisis response they were seeking, but also another crisis-based service, the police as illustrated by Lilli’s photo (Figure 11).

*Figure 11.* Lilli relied on the police to respond right away when at risk for harm.

The SHOWeD analysis for the police car was similar to that for the phone images. Furthermore, the need for security and validation can also be just as urgent when contacting a non crisis-based service, including counsellors with whom the participant has a scheduled appointment. Millie’s images of her counsellors demonstrated wanting someone to listen without fixing things.

Using SHOWeD, the women in the PV group could see the importance of the point of contact between being in crisis and receiving the HCPs’ response while analysing the images of the counsellors. They identified what was happening by sharing their (Our) experiences and learning that they are frequently without adequate personal resources and relying on external help when in crisis. They felt vulnerable when they reached out and opened up or “put themselves out there.” The initial response of the service provider, regardless of how small of a gesture or word they provide, had significant effect on their self-concept, level of hope, and motivation to seek help in the future. For example, an invalidating or minimizing statement despite the good intentions of the counsellor created long-lasting feelings of isolation. Conversely, a prompt response by a police officer created feelings of security during subsequent crises.
Through an analysis of Why the initial response of the counsellors had such critical importance through a variety of contexts, the women realized that they were allowing themselves to be emotionally vulnerable with the service. Reaching out during a period of crisis, they were relying on the service provider to be a “life-line,” positioning themselves for a greater degree of impact from the service provider’s response.

Discussing what they were going to Do about these reflections, they decided that a poster presentation for crisis-based service providers, including police officers would be a good start in educating on the importance of providing an open and validating response at the first point of contact with women in crisis.

**GT analysis.** The primary analysis approach for this study was the GT analysis, a process that involves the generation of theory while identifying a central concern or phenomenon for the people in the study (Schreiber, 2001; Wuest, 2012). This central concern is represented by a core category that “encapsulates the substance of a pattern of behaviour seen in the data and summarizes what is happening” (Schreiber, 2001, p. 74). The core category is central to the theory that is generated; therefore, the researcher remains cognizant of and open to the core variable throughout the entire analysis process (Schreiber, 2001). In the process of discovering the basic social process, a few core categories including hunting, finding validation or humanity, and being trapped were tested out in the analysis by asking how each influenced or related to each piece of data. The result of this GT analysis is an emerging basic social process explaining participants’ actions and states of being over time (Schreiber, 2001). Hunting to Feel Human emerged as the basic social process and System Entrapment as the basic social problem.
The basic social process emerges using a constant comparative method involving “explicit coding and analytic procedures” (Glaser & Strauss, 1967, p. 102). Throughout the analysis process memos are written that reflect ideas of the researcher related to the categories (Corbin, 1986b; Wuest, 2007). Memoing the details of the different processes helped to keep track of the massive amount of data, while memoing gaps within the data led to questions that steered the inquiry into deeper understanding of the emerging theory. This process elevates the data to a higher level of conceptualization that facilitates the evolution of the theory (Glaser, 1978; Speziale & Carpenter, 2007). The GT analysis includes four phases: (1) constantly comparing the pieces of data to each category; (2) amalgamating relevant categories, their characteristics, and relationships; (3) the emergence of theory; and (4) writing the theory (Glaser & Strauss, 1967). The research analysis software NVivo11 was used during all four processes to organize the data, assist in finding relationships, and help to see patterns in the data.

**Constant comparison.** Given the premise that data collection and analysis occur simultaneously through coding or naming the events that occur in the data items (Glaser, 1992; Rennie, 2006), I began analysis began following the first interview. Included within this analysis were the transcriptions from the interviews and women’s critical reflection of their photos from the PV group discussions. Transcripts from PV discussions combined with those from interviews have been used in the analysis of other studies (Creighton, Oliffe, & Ogrodniczkuk, 2017; Kabel, Teti, & Zhang, 2016; Harper et al., 2015; Mmari et al., 2016; Sims, Huye, Landry, & Connell 2014; Skovdal, 2016; Genuis, Willows, Alexandar First Nation, & Jardine, 2014; Warne, Synder, & Gillander, 2013); but only used parts of a GT analysis without using it as the core research method.
Thematic findings derived from coding and categorizing data through constant comparison was claimed to be the work of a GT approach; however, the data was not raised to a theoretical level. Only one study was found within the literature to have used GT as the primary research approach with the addition of PV data to the analysis, rendering a level of abstraction within the findings in the form of a basic social process (Kreklewetz, 2011).

Data analysis began with open coding of the interview transcripts and PV meeting transcripts. Data is coded line by line while minimizing predetermined ideas in order to remain open to the concepts as they emerge (Glaser, 1992; Schreiber, 2001). Remaining open to the data permitted the theory’s concepts to evolve directly from the words of the participants. Questions that the researcher continually asks during coding are: “What is the common process going on here?” (Corbin, 1986a; Wuest, 2007), “What is this data a study of?” or “What is actually happening in the data?” (Glaser, 1978, p. 57). A piece of data from Michelle’s interview, “I am just a number. You go in, get your medication and leave” was initially coded as feeling invisible and feeling invalidated. This line of data was followed by, “For me, personally, I need that one on one connection” and was coded as seeking personal connection and trying to be heard.

The researcher names the data with as many conceptual codes as she can find and through constant comparison, the codes form groups and are collapsed into categories (Schreiber, 2001; Wuest, 2012). For example, the following data from a PV group was compared with interview data. Millie explained her help-seeking during a PV meeting, “I found that [the HCPs] didn’t understand what I was saying. If I would be saying white, they would be saying black.” Millie felt the HCPs were refusing to acknowledge her.
Jane related to Millie’s statement and shared, “I went to talk to the mental health supervisor… [about my problems and she said], “Everything will be OK!” Jane felt that the “supervisor” was minimizing her problems. These two lines of data from Millie and Jane were initially coded as, feeling isolated, being dismissed, and fighting to be taken seriously. An example of a photo that was used in the constant comparisons with the other data regarding not being heard is Carissa’s photo of a girl covering her ears with her eyes closed (Figure 12).

Figure 12. Carissa believed that others would not listen to her problem or see her pain.

Carissa explained that her image “symbolizes ‘I can’t hear you! I can’t hear you!’” conveying others’ refusal to listen to her. This data was initially coded as being rejected, stuck in exile, and screaming at a brick wall. Finally, memos of hunches on how the different codes related to one another were compared with the transcripts and photos. The following is an excerpt of a memo relating to not being heard or trying to be understood:

March 8, 2014: Not being believed is a new code and is similar to not being taken seriously. The latter is more about others’ minimization of the women. Whereas the former is more about just not being believed altogether (about past, trauma, suicidality, etc.). This is also close to feeling invalidated, that is, the women feel invalidated as a consequence of not being believed and not being taken seriously.
Not being believed emerged as a new code and when compared with the data on not being taken seriously, appeared to relate to the data on feeling invalidated. The initial coding from the pieces of PV data and photos, among others, were constantly compared with the interview transcripts, including Michelle’s interview above regarding the need for a connection with an HCP. Trying to be heard, fighting to be taken seriously, screaming at a brick wall, and other initial codes were collapsed into a category named fighting for validation (Figure 13).

Figure 13. Initial codes collapsed into categories.

Relationships of categories. Identifying categories or clusters that fit together based on their similarities and differences by comparing the substantive codes to one another represents the second phase of analysis (Kushner & Morrow, 2003; Stern, 1980). During the analysis of the category fighting for validation, it was observed that women were gaining a sense of agency while persisting in their search for help within the system. After testing out the idea that fighting for validation related to a sense of agency, the categories taking back control and liberating myself emerged as potential connections to the fighting process. Although fighting for validation continued to evolve through constant comparisons and later emerged in the analysis as Hunting to Feel Human, the
underlying process remained the same. The connection between having a greater sense of control and feeling more human, as a result of fighting or Hunting for what they needed, survived subsequent constant comparisons.

Some concepts that are not reoccurring within the data may be teased out and not all categories that are initially identified will survive the process of constant comparison as they are modified to fit incoming data (Wuest, 2012). Categories that began to surface while analysing fighting for validation, included defending my values and taking responsibility, a process of taking back what was owed to them or rectifying the injustice of being invalidated. The notion that fighting for validation involved a process of taking back what was owed dissolved with analysis of subsequent data and instead emerged as being a process of striving for survival by seeking to be heard.

The researcher conceptualizes the characteristics and features of the categories (Holloway & Todres, 2010; Wuest, 2000); for example, the researcher may notice that one part of the data is a conceptual indicator of the dimension of another code (Wuest, 2012). Once the characteristics of fighting for validation began to emerge, including feeling non-human and being out of control, relationships that became more apparent. Being out of control occurred simultaneously with feeling non-human, motivating an effort to take control back by fighting for validation. Avoiding help emerged as a category that was identified as being contrary to fighting for validation, but also part of the same process. When women avoided help or did not ask for needed validation, this was identified as a process moving in the opposite direction to fighting for validation or making requests of the system. However, both processes were identified as being a part
of a broader process that had been temporarily named hunting for validation. This phase is a process that raises the descriptive data to a more abstract level (Wuest, 2012).

**Emergence of the theory.** After the categories are identified, their connections are established, representing the third phase of data analysis where the researcher explores the evolution of “theoretical properties” (Glaser & Strauss, 1967, p. 106) among the categories. Theoretical properties were developed by asking what is going on when women hunt for validation in relation to other categories including wading into the water and gingerly approaching the system. Theoretical coding helps to maintain the conceptual level of the data and identify the relationships between the concepts, which are necessary steps to the emergence of a theory (Glaser, 1978). This process is different from describing a linear process. For example, the processes wading into the water and gingerly approaching the system were identified as being the first steps in the hunt, describing a temporal process. Theoretical coding revealed that the process of wading into the waters was a method of measuring distress and suicidality, yielding a judgment that determined different ways of proceeding with the hunt. Instead of describing the data two dimensionally, “Theoretical coding is the mechanism for bringing together all the data, codes, categories, and core category into a seamless, integrated theory” (Schreiber, 2001, p. 75).

As the researcher learns more about the emerging categories, they are tested out on what might be the core category or the concept that might encompass the entire process that is going on with the participants’ main concern is searched for (Giske & Artinian, 2009). The category hunting for validation was tested out continually within the transcripts, bringing to light that the ultimate goal for the hunt moved beyond being
validated toward something more abstract. Women were seeking to feel whole, to have a sense of belonging to others, or to be seen as a worthy person as Becky explained:

[It’s] really important not to be punished but to be accepted as we are and what skills we have and what skills we don't have. And it's not just skills, it's personal skills, personality on whatever makes that person a person… Not just talking to someone who is doing it to get a pay check. [HCPs] need a caring spirit... need to reach the person.

Becky indicates that the HCP must connect with her essence as a person during suicidality by conveying consideration for her inner self, allowing her to *Feel Human*.

Cassidy also explained the need to *Feel Human* during periods of suicidality:

[A couple of HCPs on the psychiatric unit] are trained and there is always empathy and sympathy and understanding and wanting to see me get better and that is probably a bigger one, wanting to see me get better. Whereas every other healthcare professional I have dealt with, I haven’t gotten that, wanting me to get better. …I felt like a number instead of a human being.

Cassidy felt better through *Feeling Human* as a result of the HCPs’ validation. Through constant comparison with the data from Becky, Cassidy, and other transcripts, the relationship between the *Feeling Human* and HCPs’ validation became clearer. Being validated was the medium through which *Feeling Human* occurred and all help-seeking or *Hunting* actions were centered on *Feeling Human*. Indeed, when the categories are constructed, the theory can be situated around a central category (Corbin, 1986a) or a basic social process that is described as a gerund (Schreiber, 2001). The basic social process for seeking help for suicidality after leaving an abusive partner emerged as *Hunting to Feel Human*.

Raising the data to a more theoretical level occurs as concepts and features of the data are amalgamated and reduced through the process of constant comparison (Glaser & Strauss, 1967; Kearney, 1998) and theoretical coding or applying analytical schemes to the data (Charmaz & Henwood, 2008; Glaser, 1978). An example of a coding strategy is
constructing typologies where distinctions of a concept are identified through dimensions, degrees, or other criteria that are external to the concept (Glaser, 1978; Sandelowski, 1998). During the initial stages of discovering the properties of being validated and Hunting, a typology was used to identify distinctions between degrees of suicidality and accessibility to HCPs’ validation (Table 1).

Table 1.

*The Typology Identified Distinctions Between Categories*

<table>
<thead>
<tr>
<th>Help accessible</th>
<th>Actively suicidal</th>
<th>Not actively suicidal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Validation inaccessible</td>
<td>End of active suicidality</td>
<td>Accepting reality. Working through problems</td>
</tr>
<tr>
<td></td>
<td>Escape from system or escape self via suicidality</td>
<td>Figuring out how to stay safe on my own</td>
</tr>
</tbody>
</table>

Typologies help the researcher to distinguish between categories and understand how they are different from one another (Glaser, 1978). Leading up to the emergence of the basic social process, *Hunting to Feel Human*, theoretical coding with the typology in Table 1 illustrated that *hunting for validation* differed depending upon degrees of suicidality and access to validation within the system. These findings propelled further investigations into how feeling invalidated and stuck within the system relates to feeling stuck while suicidal. A more extensive typology was constructed to explore the indicators for all the *Hunting* sub-processes or various ways women seek help including the desired outcome, degrees of hope, poor access to validation or *System Entrapment*, degrees of suicidality or *Trauma Entrapment*, sense of empowerment, and setting (Appendix R). This typology organized the categories and dimensions relating to help-seeking and helped to make sense of the complex processes, providing a framework for the creation
of the final *Hunting to Feel Human* diagram (Figure 6). In all, the GT analysis involves comparing coded data with new emerging codes and joining them together in categories in ways that they appear to fit together (Rennie, 2006; Wuest, 2007).

The data is theoretically coded using several coding families. One example is to find a process (Wuest, 2012) or “grouping together two sequencing parts to a phenomenon” (Glaser, 1978, p. 74) in order to discover behaviour that has occurred over time. Creating a pictorial representation of one’s emerging theory in the form of a model is also helpful in theoretically coding the data (Glaser, 1978; Wuest, 2012). Figure 14 is a pictorial representation of the emerging categories *feeling judged*, *recoiling from the system*, *feeling accepted*, and *embracing the system* and *sense of control*. Degrees of judgment and acceptance are illustrated as influencing sense of control and direction of the hunt.

![Diagram of Feeling judged > Recoil from system and Feeling accepted > Embrace system with associated sense of control](image)

*Figure 14. Feeling accepted* promoted *embracing the system*, indicating a *sense of control.*

During the phase of analysis when Figure 14 was created, *feeling judged* emerged as being synonymous with invalidation and preceded moving away or *recoiling from the system*. *Feeling accepted*, synonymous with *feeling validated*, preceded moving toward or *embracing the system*. *Feeling accepted* led to a sense of control and motivation to get help, whereas the *feeling judged* led to a decreasing sense of control, motivating women to protect themselves from the system.
Another coding family is the *six C’s*: causes, contexts, consequences, contingencies, covariance, and conditions of each major category (Sandelowski, 1998). This coding family is an analysis process that systematically raises the concepts to a higher theoretical level by identifying the relational nature of the categories in order to discover the basic socio-psychological process (Glaser, 1978; Rodgers, 2009). Within every major category, the question was asked, “What is the cause, consequence, contingency, etc. for this piece of data?” A complex coding map for each major category was created to organize the theoretical connections that emerged from the “six C’s” analysis approach. Each relationship to the major category and the connecting indicators were recorded within the coding map.

Coding maps were key in the progression and evolvement of *wading in the water*, a way of assessing degrees of validation that would eventually be named *Gauging for Validation*. The coding maps of all the core categories revealed the critical contribution of *Gauging for Validation*, that all hunting behaviours were contingent upon this process. The evolving relationships that lead to a rich understanding of *Gauging for Validation* opportunities is illustrated in the *Gauging* coding map (Appendix S). *Gauging* was initially coded as *Fore* (Appendix S) to represent actions that occur *before* interacting with the system. Levels of validation were *Gauged* in order to decide how to proceed with help-seeking. Contemplating seeking help for substance use and cutting, Jennifer *Gauged* that the system would not be helpful because she feared they would expect her to relinquish self-harming:

> It is like a constant conflict with me. Like, I think I need to go to for help or I could deal with that on my own …I didn’t have any confidence in anyone else to fix me. I just thought, well that it is, you know, hopeless and they wouldn’t
understand that I need this to not feel and I feel that I can’t function [without self-harming].

Jennifer was in “constant conflict” about seeking help because she feared the system’s judgement and coercion; therefore, the context for this piece of data is System Entrapment due to the fear of dehumanization within the system and a need for validation or to Feel Human. Jennifer Gauged for invalidation, a process that helped her to protect herself.

The coding maps and six C’s helped to tie together the help-seeking processes. All the connections relating to the major categories demonstrated a pattern of lessening the intensity of dehumanization in any given help-seeking situation, a process named Taking the Path of Least Entrapment. When every direction within the hunt appeared to lead to System Entrapment, women were drawn toward the lesser amount dehumanization within the system. Taking the Path of Least Entrapment emerged as a guiding principle for Gauging for Validation, that is, assessing for the least amount of invalidation within the system.

**Theoretical saturation.** The categories become theoretically saturated when no new information emerges after being repeatedly assessed for other pieces of data that may have led to another variation of the concept (Glaser & Strauss, 1967; Sandelowski, 1995). An example of theoretical saturation is demonstrated with the hunting sub-process Enduring System Entrapment, a way of managing the perception of HCPs’ invalidation by tolerating the feeling of dehumanization. Women kept the peace with HCPs by following the rules within the system and holding back from requesting better treatment when they felt invalidated. Enduring System Entrapment began to surface as being an antecedent and context for the major category Soaking in Validation, a process of
accepting HCPs helpful interactions, feeling greater self-worth, and subsequently not wanting to die by suicide. This relationship, however, was unclear.

When relationships are not clearly delineated and categories require more exploration, new data is theoretically sampled to seek clarity about the emerging concepts and relationship (Wuest, 2012). The relationship between Enduring System Entrapment and Soaking in Validation was initially more evident within the acute care setting and appeared to be a variation of the categories, but further theoretical coding was required to see more clearly what was happening. The researcher theoretically samples new data through the lens of what has been discovered within the findings up to that point (Wuest, 2012). In order to test if Enduring was the antecedent to Soaking in Validation only within the acute care setting, data where women sought help within non-acute settings was sampled. This relationship survived the test that Enduring was the antecedent to Soaking in Validation within both acute and non-acute settings.

Theoretical saturation was reached after sampling Enduring System Entrapment with each piece of data that was coded as Soaking in Validation. In all contexts, Enduring was found to be the antecedent to Soaking in Validation; however, this did not imply that HCPs were validating every time Enduring System Entrapment occurred. Rather, women were most likely to feel listened to and Soaked In Validation while they Endured a situation within the system that they found dehumanizing. Cross-checking the data further tested out this relationship by asking the question, “If women feel validated when they are Enduring or keeping the peace, are they still validated when they put up a fight or request to be taken seriously?”
In order to test the strength of the relationship between *Enduring* and *Soaking in Validation*, the data referring to situations where women did *not* tolerate *System Entrapment* and when they were actively seeking out help was sampled to see if they received validation. Data that was coded as having sought help while *Grasping for Help* or *urgently requesting help* and fighting back against *System Entrapment* was sampled for *Soaking in Validation*. This analysis occurred by cross checking each piece of data that was coded as each of the major categories, *Grasping for Help* and *Soaking in Validation*. Included in this search were clusters of smaller sub-categories that represented the same processes as each of these major categories. An example of a cluster of sub-categories was *communicating what I need* or *pushing back* as a part of the major category *Grasping for Help* and *feeling understood* or *gaining security* as a part of *Soaking in Validation*.

The result of the query was that *Soaking in Validation* existed in only a small fraction of the data that was also coded as *Grasping for Help* and where this relationship did exist, the level of validation was low. Specifically, women felt somewhat taken seriously by having been granted access to a service after having begged for help. To this end, validation was most often the result of having *Endured System Entrapment* and withholding requests for help. Theoretical saturation was achieved for the relationship between *Soaking in Validation* and *Enduring System Entrapment* by constantly testing out and sampling the data from different angles until no new information regarding this relationship emerged.

*Variations.* Understanding how the GT analysis accounted for variations in this study helps to explain the thoroughness of theoretical sampling and saturation. GT
involves a pattern of behaviour that illustrates the central phenomenon occurring among all the participants; however, the process is not exactly the same for all involved in the study. Rather, differences among the participants or the variations within the data are recognized and accounted for within the core category (Glaser, 1978). Theoretical saturation is a way of demonstrating rigor and consistency in the development of the core category, in spite of the differences within the data. Variations in the data force the researcher to re-conceptualize the data or to revisit past codes and categories to verify whether connections between concepts are holding up with new cases (Wuest, 2012).

Variations were found within the basic social process, *Hunting to Feel Human*, as the sub-processes did not seem to fit together initially, leading to the need for a more thorough analysis of the data. “Variation in the process is accounted for by salient conditions that emerge from the data” (Wuest, et al., 2002, p. 799) and can be found by naming these differences and the range of the concepts within the categories (Swanson, 1986). Interviews, PV transcripts, codes, and memos were revisited to get a better understanding of the variations by posing additional questions about the gaps and identifying the differences. A more in-depth understanding of the phenomenon under study helps in identifying what the variations mean and “how the degree or type of a condition or the interaction among dimensions of a condition makes a difference” (Wuest, 2012, p. 245). Digging deeper into the differences between the categories yielded hypotheses on possible reasons for the variations. These new ideas were tested out using theoretical sampling, revealing that different degrees of *Trauma* and *System Entrapment* determined the particular *Hunting* sub-process used.
*Trauma Entrapment* and dehumanization while perceiving *System Entrapment* initially appeared to result in moving away from the system due to the observation that every piece of data coded as *Distancing from Help* was also coded as having high degrees of invalidation. *Distancing from Help* was hypothesized as being the result of perceiving a high degree of *System Entrapment*. Unsure if this relationship meant that *Distancing* was the only response to *System Entrapment*, further analysis was conducted. Data coded as both: (a) high levels of *System Entrapment* and (b) methods of responding to the *Entrapment* other than *Distancing from Help*, including *fighting back* toward the system, were tested. Results indicated that data coded as being a high level of *System Entrapment* were also coded as the major category *Applying Counter-Pressure* or *fighting back* against the system. *Applying Counter-Pressure* is a help-seeking process that moves in the opposite direction to *Distancing*, creating a seemingly contradictory finding. This variation would need to be explored in order to have a comprehensive and broad range of help-seeking behaviours.

A query analysis ensued in efforts to explain the reason women responded in two opposing ways, *Distancing from Help* and *Applying Counter-Pressure*, during high degrees of *System Entrapment*. This variation could not be explained in relation to participant characteristics, help-seeking setting, or type of care received. That is, women responded with both *Distancing from Help* and *Applying Counter-Pressure* regardless of the number of past abusers, employment status, acute or community setting, and mode of therapy or other treatment. Understanding the variation occurred through constant comparison with new interviews. New participants may be interviewed “seeking further
clarification and expansion of concept properties, conditions that influence variation in process, and relationships among concepts” (Wuest, 2012, p. 243).

Sampling the data from new transcripts that were coded as having high levels of System Entrapment revealed that the ratio of suicidality or Trauma Entrapment in relation to System Entrapment determined which sub-process was used. Distancing occurred when System Entrapment was higher than Trauma Entrapment as dealing with the dehumanization of suicidality was more tolerable than the higher degree of dehumanization within the system. Alternatively, Applying Counter-Pressure was consistently found to have occurred when Trauma Entrapment was higher than System Entrapment, especially when both were at the highest levels of intensities, i.e. completely hopeless and feeling belittled respectively. Although the level of invalidation within the system had been very high when Applying Counter-Pressure, the hope to find relief in the system from the intense pain of suicidality was worth the risk of being invalidated while seeking help.

Making sense of the variations also occurred by theoretically sampling the PV data. Feeling invalidated and controlled by the system were hypothesized early on in the analysis as being the consequence of having urgently reached out and requested help from the system or Grasping for Help. A variation was revealed after having reviewed Jesse’s photos, the last photos that were analyzed within the PV group. Testing out the hypothesis that invalidation resulted from Grasping for Help, feeling invalidated and controlled by the system was sampled with Jesse’s experience within the ED. After Grasping for Help for suicidality within the ED, she was validated by the psychiatrist, a
consequence that did not fit the emerging relationship of feeling controlled while seeking help with EDs and other acute care settings.

Upon further inquiry, Jesse’s receipt of validation had only occurred after having perceived invalidation earlier on within the ED. This discovery was made with Jesse’s image of a brick wall that represented the ED nurses who did not take her seriously, a barrier Jesse felt obligated to Endure in order to access a psychiatrist. Nevertheless, being heard by the psychiatrist and receiving medications to treat her anxiety, Jesse gained a sense of control and of Feeling Human. Grasping for Help by persisting to ask for treatment eventually led to validation; however, not before Enduring invalidation and climbing a “brick wall.” Analyzing Jesse’s image helped to attain an understanding of the variation within Grasping for Help. Grasping for Help leads to the perception of being invalidated; however, validation may ensue after long periods of having felt invalidated. If women persisted enough in requesting and pressuring the system for help, they may “earn” validation from the HCPs. That is, Jesse had to put up with the brick wall in order to get help, a finding that strengthened the emerging relationship of Enduring as being an antecedent to Soaking in Validation.

Writing the theory. Writing the theory is the fourth and last phase of the constant comparative analysis. The theory is written explaining how the “core category addresses the basic problem” (Wuest, 2012, p. 244) or explaining the main outcome of the study. The main outcome of this study was a substantive theory that explains what was most problematic with women’s help-seeking during suicidality after experiencing IPV, how they dealt with this problem, and the conditions that influenced variation with this process. The theory is not presented as a descriptive story, but a conceptual one that
demonstrates the theoretical connections between the concepts and categories (Glaser, 1978). Hunting to Feel Human is explained as a dynamic journey in search of validation and influenced by differing intensities of Entrapment. The hunt is carried out using several sub-processes that encompasses the entire help-seeking journey.

Along with a discussion of a basic process, the written theory includes an explanation of the variations within the theory or how it differs depending on certain conditions and that demonstrate women’s behaviours and strategies (Sandelowski, 1998), approaches that are key in imparting the rich and complex theory of Hunting to Feel Human. Hunting to Feel Human is illustrated in a conceptual manner as evidenced in the Hunting diagram (Figure 6), a process that accounts for all the participants’ different journeys. Memos help keep track of the developing theory; therefore, are very useful in the writing of the theory (Glaser & Strauss, 1967; Wuest, 2007). Referring to the memos helped in staying true to the data while writing about the hunt to prevent the theory taking on a life of its own or so not to get lost in the abstraction of the theory. The theory of women’s help-seeking is grounded in their stories derived from the interviews and discussion regarding their self-generated photos.

Evidence of a theory that has been grounded is made visible through “conceptual indicators [that] are provided from the data” (Wuest, 2012, p. 245). Exemplars from the interviews and PV meetings demonstrated that women’s help-seeking relates to the theoretical concepts and properties. Copies of selected photographs were included within the written theory to illustrate how they influenced the development of the theory and how they relate to the different variations and dimensions of the concepts. The expected outcome of the written theory is that it is pragmatic and can be used within actual practice
In this way, Hunting to Feel Human has important applications for clinical practice, education, and policy that are discussed in the implications chapter.

Rigor

Several methods enhanced the rigor of this research. To begin, “One of the fundamental premises of feminist research has been that we locate ourselves within … the process of conducting research” (Kelly et al., 1992, p. 150). I acknowledged my ontological positioning within this study, a positioning that may influence the research process (Brine, 1994). My bias arose from the following standpoints: (a) Caucasian; (b) female; (c) born into a middle-class family; (d) personal experience of mental illness; (e) experienced IPV; (f) nurse who worked intimately with suicidal women who had experienced IPV; and (g) policy maker for psychiatric units. Self-disclosure helps to build trusting relationships with the participants and a sense of safety (Morrow, 2006), a technique I used when it was deemed appropriate. To ensure that the emergence of theory was firmly grounded in the women’s reality, I remained aware of these biases through reflexivity that included journaling and dialoguing with members of the research committee.

Rigor is detailed within two sections: (1) GT and (2) the integration of GT and PV. Considering that GT is the primary methodology for this study, criteria specific to GT is addressed first and at greater length. Highlighted throughout the GT section, are examples of how PV compliments the GT criteria for rigor. A more in-depth exploration of how the integration of GT and PV enhances the study’s rigor is presented.

Grounded Theory. For the findings of GT to have merit and to be suitable for use in life situations, the theory must meet specific criteria. Several factors help to
measure the authenticity and quality of GT and when met, solidify the rigor of the research.

**Theoretical.** Wuest’s (2012) criteria for evaluating grounded theory include first that the “theory is written at a theoretical level” and that variations of the core process are identified (p. 248). *Hunting to Feel Human* is a conceptualization of women’s help-seeking as it represents all actions in this process across settings with different HCPs and within a range of distress intensity. *System Entrapment* is a conceptualization of a wide range of invalidation, the basic problem that is managed within most *Hunting* sub-processes. The relationships between these conceptualizations are based on contextual factors that determine the choice of sub-process to use at a particular time.

Sub-processes from *Distancing* to *Letting Go* represent various ways of carrying out the core process, *Hunting*, as they share the same goal to *Feel Human*. Sub-processes are adaptations of *Hunting* tailored to suit different contexts in order to most effectively reach *Feeling Human*. *Hunting to Feel Human* is a conceptual explanation of women’s help-seeking that was created by demonstrating the dynamic relationships between categories of behaviour while accounting for variations. Not all women carry out every sub-process while managing *System Entrapment*, but all take part in a variation of *Hunting to Feel Human*. Depending upon several factors including intensity of *System Entrapment, Trauma Entrapment*, and hopefulness that help will be forthcoming women *Hunt to Feel Human* based upon women’s needs and the broader context at the time. Not all women *Applied Counter-pressure* against the system as they may not have had enough hope that their efforts would yield positive results, but rather they *Endured System Entrapment* to avoid worsening *System Entrapment*. Either way, they worked
hard to *Feel Human* using different means that best fit each situation. The integrity of the theory is measured by several criteria.

**Fit.** The theory within a GT study must *fit* (Wuest, 2000) or “correspond[s] closely to the data if it is to be applied in daily situations” (Glaser & Strauss, 1967, p. 238). Fit is demonstrated using three examples. First, *Hunting* conceptualizes women’s help-seeking by illustrating a complex process of getting what they need, a journey that goes beyond simply looking for help. Initial codes for the action of help-seeking were *taking control back, persisting, clawing, fighting,* and *battling for help.* Once Cassidy’s help-seeking metaphor of “a wolf starving in the woods” was revealed, the concept of *Hunting* surfaced, symbolizing help-seeking as a vigorous process of survival. All references to help-seeking among the other participants reflected the urgency of and the precarious environment involved in a hunt due to their high level of distress and *System Entrapment* respectively.

Second, *Feeling Human* corresponds to the data as it reflects the intended outcome for help-seeking: the need to be accepted, valued, and not judged while in crisis. These concepts point to *being validated;* however, this is not where the analysis ends as the outcome of *being validated* emerged as being more relevant. Initial exploration of validation outcomes was coded as having a sense of *familiarity, normality, understanding, identity, and connection,* terms that represent comfort, security, and belonging. It became apparent that acknowledgement of women’s dignity and recognition of being a human being helped them to feel less isolated. Seeking to be treated as a human being and to *Feel Human* is illustrated with Cassidy’s comparison of being treated like a thing verses a person, “[the HCP thinks that I am] worth this amount of money.”
That is always how I felt; like a number, instead of a human being. That is why I liked it [at the psychiatric unit]. I felt safe.” Women believe that to be human is to be worthy of basic dignity; therefore, the overarching need was to feel cared for, to feel alive, and to *Feel Human*.

Third, fit is illustrated by the way that women take part in at least one sub-process the entire time they feel suicidal or are in crisis. The sub-processes describe what women are actually doing day-to-day even when the behaviours are not obvious; for example, during periods of no access to the system, women who feel suicidal are either *Distancing the System* or *Enduring System Entrapment*.

**Grab and works.** The theory also must have *grab* or is appealing to the reader (Glaser, 1978). *Hunting to Feel Human* and *System Entrapment* create images in the mind regarding the distress and urgency of women’s help-seeking. Hunting sub-processes are described using action words in everyday language including *Grasping for Help* and *Letting Go*. The theory also *works*, which is the ability of the theory to reflect the particulars of what is occurring and to be relevant to the particular area of inquiry (Glaser, 1978). Sub-processes explain *Hunting* relationships including outcomes, informing on what to expect from women’s help-seeking. Intensity ratios between *Trauma* and *System Entrapment* determine how women will tackle this problem and intensity levels of both *Entrapments* combined further illustrates the complexity of the theory. That is, depending upon: (a) which type of *Entrapment* is higher than the other and (b) the intensity level of both *Entrapments* determine which sub-process is used.

**Grounded in data.** Evidence that concepts have been developed inductively is required for GT authenticity, demonstrating how the theory emerges directly from the
data (Wuest, 2012). Glaser (1978) wrote that the findings are relevant when the core variables emerge directly from the data, demonstrating rigor and validity. *System Entrapment* is grounded in the data with a term that emerged within the first few interviews, *disconnection*, a concept underscoring women’s separation from others while trying to get help. *Disconnection* involved not being able to attain protection from and support in managing past trauma and suicidality. The category *losing control* became apparent as urgent support was not achievable while feeling disconnected. The codes *receiving unhelpful advice* or *being told what to do* by professionals while seeking help surfaced as being one of the most significant ways that women felt *loss of control*, leading to feeling stuck or trapped. Evidence of how *losing control* was initially discovered as contributing to feeling stuck is illustrated in the following memo.

March 28’14: I can’t think of the word for what the women do when they receive unhelpful advice or when they are told what to do about the abuse or about their suicidality. It’s like they have to sit with it. This is a burden to carry…it weighs on them, it sticks to them…This may go under the code being controlled by professionals/system.

The language of being weighed down by HCPs’ intrusive comments and having a low sense of agency to change this invalidation reveals a sense of being trapped. Connections between the codes and the data are evident within the qualitative analysis computer program, NVivo, as each piece of data that was named under a particular code are stored within a folder with the code name. When the codes merge into categories, the data pieces follow and collapse into a folder with the category name. Evidence of how each code or category is grounded in the data is demonstrated within each folder, revealing all the corresponding pieces of data from interviews, PV meetings, and memos.

The concept of *being disconnected* or *losing control* merged with a *sense of being trapped*, evolving into the category *Entrapment*. The emergence of *Entrapment* as a *loss*
of control and being trapped or stuck is highlighted with Carrisa’s photo of handcuffs (Figure 15).

Figure 15. Handcuffs represent being shackled to a system that has control over her. Carrisa explains her photo of the handcuffs as being a representation that “reach[ing] out … equals having a loss of freedom.” The sense of being stuck is repeated through the data analysis including Sherry’s quicksand metaphor and study memos describing the context of seeking help as being caught in the desert or trapped in a box.

**Modifiability.** The capacity of the theory to adapt to emerging new dimensions in the data represents modifiability (Glaser, 1978). *Hunting to Feel Human* evolved throughout the data analysis as new information arose, shaping the help-seeking process by expanding and redefining the concepts. Modifiability is demonstrated in this study with the analysis for women’s search for empowerment. Self-determination and autonomy, achieved through having the option to choose treatment modalities, emerged as being foundational to the help-seeking process within the first several interviews and PV meetings. A sense of agency and empowerment or freedom from *System Entrapment* was found to be contingent on being in control and being a part of every treatment decision while receiving services. The process of *Hunting to Feel in control* began to surface and subsequently evolving into *Hunting to Feel Human.*
Variations in the need for autonomy appeared while analysing new interviews. While self-determination is an important aspect of feeling in control, some women felt supported when placed in the hospital on an involuntary status under the NB Mental Health Act (Government of New Brunswick, 1973). Feeling validated while losing the right to choose whether or how treatment is received initially seemed to contradict women’s need for self-determination. Upon further inquiry, I discovered that the women were relieved that the HCPs took control of treatment decisions during a crisis because they felt validated that their suicidality was being taken seriously. The involuntary status was not interpreted as coercion and their Trauma Entrapment actually decreased because they did not feel as isolated as when they were brought into treatment. Women were often unsure how to reach out when they felt overwhelmed and were relieved when the HCPs responded to their need for safety. Fearing HCPs’ dismissal of their suicidality, women may contact a friend without notifying an HCP, resulting in the friend contacting emergency services and the paramedics taking them to the ED. HCPs’ recognition of women’s urgent need for help gave them a sense of deservingness, worth, and human dignity.

Through further analysis, meaning was found in the contradiction that validation was the result of both losing and gaining autonomy and the evolving theory was modified to fit the variations. The common denominator in both situations was that women’s worth as human beings was upheld by being taken seriously. Hunting for autonomy was changed to Hunting to Feel Human, representing women’s help-seeking process more accurately. Care was taken during this analysis process not to seek verification of hypothesized relationships, thus avoiding partiality to “new” data that substantiates initial
connections within previous data. Variations of the theory are missed when narrowing the analysis by only picking up on aspects of the data that support previously discovered relationships. Modifiability, or the progressive ability of the theory to explain the continual changes in the data is important, as human processes are not stagnant.

**Trustworthiness.** An additional set of criteria by which qualitative research is evaluated, including grounded theory is through trustworthiness which consists of four characteristics: (1) credibility; (2) transferability; (3) confirmability; and (4) dependability (Lincoln & Guba, 1985).

**Credibility.** First, a study has credibility or validity depending upon the level of accuracy between the data and reality (Speziale & Carpenter, 2007) or the “truthful depiction of a participant’s lived experience” (Cypress, 2017, p. 257). Prolonged engagement, an example of an activity that facilitates credibility, involves spending adequate time interviewing participants in an effort to gain trust (Lincoln & Guba, 1985; Rodgers, 2009). Upon responding to the study advertisement, women were given a chance to get to know more about me and details of the research by conversing over email or phone. Touching base before meeting face-to-face for the interviews or PV meetings allowed women to share parts of their experiences in a less intrusive way.

Trust is essential in obtaining sensitive information about women’s traumatic experiences; therefore, using empathy, genuineness, and warmth conveyed a sense of safety and comfort during prolonged engagement. My extensive experience as a clinician working with people who feel suicidal contributed to creating a safe environment. Becky explains how I gained her trust during our first meeting on the phone:

I guess I am allowing myself not only to be honest, [but] by my allowing myself to be free to talk to you, if like... all I had before that was your voice and you
know I felt in my head my thinking was I feel she sounds like she has got her shit together… But you stood firm on what you were trying to do and that made me want to trust what you were saying but the next part is would have been when I would see you and how you come across when I met you.

The initial interaction with Becky and the other participants enabled them to get a sense of my character and intentions and to begin building trust.

Further, in keeping with feminist ideals of research validity, a method that increases the level of accuracy of women’s realities is to be conscious of listening to the woman’s being by hearing the implicit meaning behind the words that she is speaking (DeVault, 2006). A researcher’s openness, awareness, and insight enhance the credibility and trustworthiness within a qualitative study (Stewart, Gapp, & Hardwood, 2017). I was effective in hearing the message behind the message by focusing on what participants were saying and observing their body language instead of thinking about my response to them or my next question. Paraphrasing and empathizing conveyed to participants that I was listening and provided an opportunity to clarify the accuracy of their message. Using these skills during Jane’s interview helped in the understanding of how she felt controlled by her HCPs.

Jane: One lady came to me and wasn’t a good nurse. She just said, “Forget about it!” [re: distressing thoughts].
Researcher: Easy!
Jane: [Ya], easy to say, “Forget about it!”
Researcher: That is really minimizing what you went through and again telling you what to do.
Jane: ...What to do! Exactly! Telling me what to do. She said, “You know, I wouldn’t even think about it.” I said, “It’s is easier said than done! I don’t want you as a nurse anymore,” I told her.

Listening intently to Jane recounting the interaction with the HCP allowed for a greater understanding of her frustration with not being taken seriously. Reflecting this understanding back to Jane allowed her to expand on her help-seeking.
Generous amounts of time with participants also contributed to prolonged engagement. Time was allotted for social interaction for women who needed to warm up to the topic of help-seeking through light conversation and making tea. Approximately two to three hours were blocked for each interview and PV meeting to prevent feeling rushed and having enough time to take breaks if needed or to answer questions. Remaining time at the end of the interviews and meetings provided space for women to share important information that may not have been disclosed while answering interview questions.

Another example that demonstrates credibility is persistent observation, in which the researcher continuously focuses on the important elements of the data and explores these in detail (Charmaz & Henwood, 2008; Lincoln & Guba, 1985). Persistent observation helped to identify which initial codes found during the beginning of the data gathering process remained during subsequent interviews and PV meetings. Being judged or not accepted that contributed to being controlled were found at the very beginning of data gathering during the PV meetings. This sense of being trapped and isolated continued to emerge during subsequent interviews, evolving into Entrapment. Not being taken seriously and HCPs’ dismissive attitudes were a constant thread through all the data and then captured with the code invalidation. The final codes that emerge are stronger or more relevant to the phenomenon being studied because the initial labels or codes survive the persistent confirmation of the data (Lincoln & Guba, 1985; Wuest, 2000).

When all that emerges from the data are the same surviving codes, categories, and relationships related to *Hunting* or when no new information emerged from the data, theoretical saturation occurred. Constant comparison of the data revealed variations of
these processes but no new information evolved that changed the basic relationships and properties of the theory. Credibility is also demonstrated through member checking during the follow up interviews and PV meetings. Member checking involves the modification of the emerging theory with the study participants in an effort to clarify the findings and to validate the researcher’s interpretations with those of the participants (Keddy et al, 1996; Wuest, 2007). Member checking occurred throughout the PV meetings and interviews. After several PV meetings, I compiled help-seeking categories from the group’s analyses of their photos, organized the photos in accordance to themes, and attached the photos to posters using Velcro with their corresponding quote or explanation about the image on the back of each photo. Women were invited to review the posters, discuss how the themes and pictures within the categories related to their help-seeking, and provide feedback.

The posters provided a slightly different angle from which to reflect on their shared experiences, a mode of analysis that deepened the understanding of their help-seeking. The women discussed the accuracy of the interpretation of the photos by how they were presented on the posters:

Jane: It was very inspiring to see that, like, our pictures … seem to be at the right like it was at the right place and what was said behind was exactly what we did say. And it was really like I saw a few of mine and I read behind and I thought, “Yeah, that is really good”… Millie: It is so real. …even the other ones that I did read that wasn’t mine... I felt from the picture what they had said, like, and it’s nice to know that other people feel the same way as I do because I don’t feel so alone.

My understanding of the women’s photo analysis was validated when the women identified with how I presented the images on the posters. Their acknowledgment of an accurate portrayal of their images and how they closely identified with the images of the other participants demonstrates credibility of the study findings.
Although the posters of the images portrayed accuracy, the member checking session shifted the focus of the basic problem. Prior to receiving feedback about the posters, help-seeking problems were described broadly as *blocked services*. Women’s emphasis on judgement and acceptance during the member checking sessions heightened my awareness of these factors during the analysis of subsequent interviews. This awareness allowed me to be more sensitive to the relational properties of the help-seeking problems within the data. The significance of invalidation and the lack of human connection with the HCPs emerged more clearly, properties that helped to shape the basic social problem, System Entrapment. Member checking also occurred by testing out hunches about the theory through individual follow up conversations. After reading a draft of the findings chapter for this study, Cassidy provided feedback on the theory accuracy, “On exactly the right track!”

Moreover, credibility is obtained within the PV data as the participants’ perspective and authentic voice are derived directly through their self-generated photos and analysis of these images (Findholt, Michael, & Davis, 2011; Janzen, Perry, & Edwards, 2011). Stefanie’s picture of the bottom of what used to be a lake reveals the extent of the harmful consequences from seeking help within an invalidating system (Figure 16).
Figure 16. The exposed lakebed illustrates feeling drained from managing suicidality on her own.

Stefanie wrote in her photo journal, “Dried up lake: represents how drained I was, how exhausted I was from dealing with things on my own.” The images offered an intimate look at help-seeking while providing a different angle to view the problems. For example, Figure 16 enriched my understanding of the participants’ losses. The dried-up lake illustrates the extent to which the invalidating system leaves women feeling depleted. Not only does the system fall short of providing support, but also this lack of help worsens their conditions, further stripping them of agency.

Transferability. The second criterion that demonstrates trustworthiness, transferability, “refers to the probability that the study findings have meaning to others in similar situations” (Speziale & Carpenter, 2007, p. 49). Dense descriptions of the data and the many variations of the theory must be provided to enable the reader to apply the findings elsewhere (Lincoln and Guba, 1985). Hunting to Feel Human is very contextual, informing where, when, and in which circumstances women Feel Human, how they get there, and the dynamic variables that influence the management of their help-seeking. These thick descriptions allow the reader to apply Hunting to Feel Human elsewhere by comparing the theory’s properties and relationships to those of others.
seeking help in crisis. *Hunting to Feel Human* may provide better understanding of women seeking help for trauma related conditions apart from suicidality, as similar processes occurred for participants when seeking help for anxiety, depression, and addiction during periods of time when they did not feel suicidal.

**Confirmability and dependability.** The third and fourth criteria of Lincoln and Guba (1985), confirmability and dependability are addressed with the use of coded interviews and group discussions, memos, and an audit trail (Streubert & Carpenter, 2007). Memos are pieces of writing by the researcher that “preserve emerging hypotheses, analytical schemes, hunches, and abstractions” (Streubert & Carpenter, 2007, p. 148). “Memoing” began at the very beginning of data collection with the PV meetings and interviews with detailed descriptions of what was going on with women’s help-seeking and continued through the line-by-line open coding. As concepts formed and relationships began to emerge, memos were organized into separate categories and processes. Color-coding subject matter within the memos also helped to organize the analysis. Writing with a free flow style helped to organize the plethora of information that was coming from the complexity of women’s experiences and to make sense of what was happening. Important ideas and connections about the data that spontaneously came to mind throughout the day were recorded into a dictation app on my phone. Memoing regularly and diligently allowed me to notice patterns that would eventually emerge into processes.

Recording all observations and hunches indiscriminately allowed me to decipher between the data that survived the constant comparison analysis and those that would not. Even when I was not sure about an idea, I recorded my observations and
questions to make sure that I was capturing the depth and breadth of women’s help-seeking. Below is an example of using memos to explore, test out, and make sense of the data by examining relationships and following hunches with further questions about the potential relationships. Not quite understanding the process of conforming, I wrote a memo on preliminary thoughts about the context preceding HCPs’ validation by exploring the role of women’s persistence in help-seeking.

February 9, 2016: I am seeing that HCPs are more validating when women are experiencing lower levels of suicidality or crisis… Is this because they have a bit more stamina when they are in a lower crisis and they had the energy to persist for help until they finally get it from the HCPs? I.e. the ‘squeaky wheel gets the grease’?

February 11, 2016: Seeing also that when women are in the highest levels of crisis, they are getting the least amount of validation. Does this mean that they are in such a state of crisis that they don’t have the energy to communicate their needs?... Thereby, substantiating the idea that they need more energy to do the begging for help?

This memo explores the newly emerging relationship between lower levels of suicidality and validation. I initially thought that validation during lower levels of suicidality related to having more energy to persist for help. Throughout ongoing analysis and testing this hypothesis against incoming data, the process of greater levels of validation occurring with lower levels of suicidality became clearer. That is, the women conform to the system rules and gain HCPs’ approval when they are in a lower degree of crisis, an action that may require a calmer state of mind.

An audit trail is a record of research activities that confirms how the research process unfolded over time (Munhall, 2007; Streubert & Carpenter, 2007). The entire data analysis was organized and recorded within NVivo 11. All data including codes, categories, memos, diagrams, and relationships between categories were recorded in the software program with the date they were entered or created. Within the body of each
memo, I also recorded the date with each separate note I added. Sequencing the notes in this way helped me to understand how I had made connections between categories and arrived at conclusions within the data, enabling me to go back and check my work if I had questions about the relationships forming. Keeping track of my hunches strengthened the findings as I was able to see patterns and consistencies in the data. Organizing the data through a structured and consistent method of documenting emerging findings enhances the dependability of the research (White, Oelke, & Friesen, 2012).

As a result of memoing and an audit trail, evidence of the participants’ perspective and accuracy of how the findings evolve is demonstrated (Lincoln & Guba, 1985). As categories become evident from the initial codes within this study, they were compared to and confirmed with the data that came from subsequent interviews. As relationships emerged, I tested out these findings with new pieces of data and recorded the similarities and differences. Analysing the part of the data that did not fit previous findings yielded questions on where to further sample the data or to make sense of the variations. Memoing and audit trails also provide the context for the theory, which helps explain the findings through its history (Corbin & Strauss, 2008). In other words, another researcher should be able to follow the audit trail, from substantive codes to theoretical codes, and understand the conceptual process used in the study. In all, the progression of analysis from open coding to the development of abstract relationships is evident using the analytic and organizational tools within NVivo11.

**Integration of GT and PV.** Validity within PV is evaluated on the bases of utility within practice (Carlson et al., 2006), a parallel ideology to GT because this approach involves the belief that the theory created by GT ought to be useful (Glaser,
PV researchers and participants are concerned with discovering realities or knowledge that will make a difference in people’s lives and will lead to their empowerment (Wang & Burris, 1994; Wang & Redwood-Jones, 2001). Creating, displaying, and analyzing their self-generated images within the PV group setting provided women an opportunity to acknowledge ways of protecting themselves against coercion. For example, Carissa, Gabrielle, and Jane each had photos of Stop signs, images that provided space for the women to proclaim, “STOP!” to others’ maltreatment (Figure 17).

Figure 17. One of the STOP sign images representing setting boundaries.

The process of standing up for themselves, derived from the PV analysis of STOP sign images, merged into subsequent data about pressing the system for help, a process that would eventually develop into Applying Counter-pressure during the GT analysis.

Similar to PV, GT is also centred on women’s actual experiences, a focus that is then analysed for what works or is not working regarding the main concern in the study (Stern, 1980). Discovering what helped or hindered while seeking help did not only occur during data collection by asking women directly, but also during the data analysis. With each piece of data including their actions, the kind of treatment they received from the system, and contextual factors, I posed the question, “How does this influence women’s capacity to attain help?” Remaining sensitive to the influence of “real-life” factors and
situations on women’s agency strengthens the link between what was discovered and how this information has utility for their everyday lives. The GT process safeguards against removing concepts and relationships from women’s realities, thus creating a theory that only makes sense on paper.

As the findings emerge, the GT researcher maintains focus on pragmatism by continuously reflecting on how incoming data makes sense in relation to what is already known and the meaning it has for potential change in the person’s life (Wuest, 2012). This might include revisiting participants and past analyzed data order to assess how the findings have applicability in their lives. I continually referred to past interviews and examined how the Hunt and problem of Entrapment applied to women’s individual experiences. For example, vigorous attempts at seeking help were initially named fighting for help with Grasping for Help as a method of fighting. After analyzing subsequent transcripts, Applying Counter-Pressure emerged from fighting for help, separate from Grasping for Help. Since I did not discover the sub-process, Applying Counter-Pressure until quite far into the data analysis, I tested out the real-life applicability of this sub-process by revisiting earlier transcripts. I recognized the separate processes between Grasping for Help and Applying Counter-Pressure in the earlier transcripts, an important distinction in women’s help-seeking. Revisiting previously analyzed data allowed for a deepening understanding of the theory and helped to keep it grounded in everyday realities of help-seeking. Women’s participatory engagement in the data collection and analysis within the PV research process further strengthened the development of relevant findings that have meaning in real-life help-seeking situations.
In addition, variety within data collection methods or triangulation increases this study’s rigor (Mays & Pope, 2006). Combining interviews and women’s analysis of their images in data collection helps to enhance the validity of the research as it decreases the risk of “misinterpretation” (Duffy, 2010, p. 795). The images that depicted women’s healing from suicidality through a connection with loved ones highlighted the significance of connecting with HCPs on a human level. The images of Lilli’s granddaughter, Jesse’s mother, Jane’s friend, and Millie’s cat, factors that increased their self-worth and made their lives worth living, represent the acceptance, compassion, and caring that women seek within the system. The images helped me to understand that a key part of the HCP relationship that decreases suicidality is having a human or personal connection. Women do not expect the HCP to behave like a loved one, but look for the HCP’s humanity or vulnerability and will seek HCP who care. Validity is also enhanced by combining interviews and images as the researcher is able to compare findings between both data collection methods (Cannuscio et al., 2009).
Chapter Four: Ethical Considerations

This study adhered to the Tri-Council Policy Statement on Ethical Conduct for Research Involving Humans (TCPS-2; CIHR et al., 2010), meeting approval of the University of New Brunswick Research Ethics Board, file #2013-071 and the Horizon Health Network Research Ethics Board, file # 2013-1900. Feminist ideals of respecting women’s dignity and challenging power imbalances that impose on well-being were of utmost importance during this study. The focus of feminist research on the relationship between the researcher and participant, the nature of the in-depth interviews, and the duration of time that the participants were engaged in the interviews, made ethical considerations especially important (Gergen, 2008). Ethical principles inherently shape the PV research process, including non-maleficence, social justice (Wang & Redwood-Jones, 2001), and participant empowerment (Abma, Voskes, & Widdershoven, 2017; Fals Borda, 2001; Foster-Fishman et al., 2005; Liegghio, 2010), promoting acute attention to ethical considerations within the GT approach.

Effective use of ethical considerations in this study is most evident from women’s perception of their participation. Researchers conducing PV believe that taking knowledge from participants and giving nothing in return is immoral (Wang, Yi, Tao, & Carovano, 1998; Wang & Redwood-Jones, 2001); therefore, attention was paid to help the women obtain personal rewards from being involved in the research process. Sara expressed the benefits of participating in the study in an email by writing simply, “Thanks for being a part of my healing journey. 😊” Most participants expressed similar comments. Nonetheless, due to the sensitive nature of women’ experiences, extra vigilance was taken to maximize their safety, including obtaining information on the ex-
partners’ continued role in their lives (Appendix J). Care was taken to promote women’s sense of safety, including inviting them to choose the location and time of the interviews or meetings. All women felt secure that their involvement in the study would not place them at increased risk of harm from their past abuser or future relationships with the health care system.

**Power Considerations**

Identifying and exploring the ethical approach of the research is also important in the mitigation of harm (Mishara & Weisstub, 2005). True to feminist ethics, this study involved social justice considerations through valuing the women’s perspectives and acknowledging potential power imbalances between researchers and other persons who are marginalized with society (Eckenwiler, 1997). Feminist research acknowledges that power differentials naturally exist within the research process (DeMarco et al., 1993; Sprague & Kobrynowicz, 2004). Differences in knowledge level, education, social class, gender, or culture can give the researcher or other decision makers more power, leaving participants in a vulnerable position (Wang & Burris, 1997; Wang Yi, Tao, & Carovano, 1998). Promoting a collaborative relationship between the researcher and the participant is critical (Locke, Spirduso, & Silverman, 2007; Munhall, 2007). I was able to develop collaborative relationships with the participants by having a non-judgmental attitude, creating space for all women to speak during the groups, avoiding steering the direction of the interviews or group discussions, and requesting feedback about the study’s findings.

Another factor that impacts power imbalances is the stigma of mental illness. A common assumption is that the seeking help for or responding to a research
advertisement about mental illness is an indication of deficiency and the HCP, the “expert,” is free from such problems. Self-disclosure of the HCP helps to dispel these myths and stigma. Disclosing my own experiences with IPV, depression, and other mental illnesses helped to neutralize the power imbalances within the researcher-participant relationship. I tried to ensure that women did not feel they were under the microscope of a scientist examining their short-comings, but rather tried to give them a sense of being a research partner seeking to improve health services. The fact that in a PV study participants are invited as research partners is an important step in reducing power differentials.

**Recruitment and Meeting**

Recruitment in this study was non-coercive. Women were not directly approached to take part in this study, but rather voluntarily responded to an advertisement. Respect for the women’s autonomy was upheld which “means giving due deference to a person’s judgment and ensuring that the person is free to choose without interference” (CIHR et al., 2010, p. 8). Women were not hospital clients under my care as a clinician at the time of their participation, a condition that decreased the risk of thinking that their health care would be affected by the choice to participate.

Confidentiality was respected by inviting the participants to choose the meeting location, enhancing their sense of security. Some of the women had “bad” experiences at the psychiatric unit near my office; therefore, I found alternate meeting locations away from the hospital. The interviews occurred at various locations throughout the community, the most common location being women’s homes. The women who participated in the PV meetings were comfortable to meet in a private room at the
Moncton Hospital. The participants either travelled by bus to the hospital or I picked them up at their residence. A meal was provided at each meeting, allowing for time together not directly focused on the serious study topic, therefore, helping to establish a relaxing and inviting setting.

**Consent**

Consent, or an understanding of what is involved when participating in a research study, is an important ethical issue. Open communication with the participants about the potential for harm when taking pictures, disseminating research findings by sharing their images within the community (Wang & Burris, 1997), and engaging in other risk taking activities, including political action (Duffy, 2010, 2011) is important. Obtaining informed consent is a key method of communicating risk and engaging participants in a collaborative manner within the research process (Wiles, Prosser, Mason, Coffey, Crow, & Heath, 2009); however, this does not imply merely obtaining the participants’ signature.

Respect is maintained for the participants’ right of choice by providing adequate information regarding the research process in the consent form, which aids in the decision of whether to participate or not (Goodwin, 2006; Locke et al., 2007). Nearly all the questions women had about this study were answered in the consent form. Consent requirements are different for every group and are most ethical when it is a process of reflection, negotiation, and ongoing adaptation to the participants’ unique needs (Clark et al., 2010); therefore, adequate time was given to discuss the consent form and answer questions. Separate consent forms were used for the interviews, for the photovoice groups, and for public use of their photos, a practice supported in the literature (Castleden
et al., 2008; Clark et al., 2010; Wang et al., 2000; Wang & Redwood-Jones, 2001). I provided my contact information and phone numbers for use in case the women had concerns regarding the research process and provided information on supportive resources within the community. Further, consent should be ongoing and dynamic (Lakeman & Fitzgerald, 2009; Munhall, 2007); therefore, women were given opportunities to decline participation throughout the entire process. Participants were ensured that withdrawal from the study at any time would not result in prejudice in any way.

Other methods used to reduce risk within the PV group are as follows: (a) we discussed the power one has in using a camera and possible risks to participants; (b) the participants choose the photos to be used in the study; (c) I facilitated group discussions on managing difficulties related to taking pictures; and (d) I returned any copies of the printed photos to the participants. Moreover, in the spirit of community collaboration and respect, the participants were encouraged to obtain written permission from anyone included in their photos, or they would not be able to be used publically (Appendix Q), a caution noted in the PV literature (Castleden et al., 2008; Clark et al., 2010; Wang et al., 2000; Wang & Redwood-Jones, 2001).

Confidentiality was respected by keeping identifiable data separate from the transcripts and other written material from the study so that participants’ names could not be connected with the data. Signed informed consents were placed in a separate locked drawer and a pseudonym name was assigned to each woman for use in writing the theory in order protect her identity. The participants were given the option of having the electronic interview files sent to them and the opportunity to receive a summary of the
research findings. They retained ownership of the photos; therefore, I obtained their permission to use them in presentations or publications and they retained electronic and hard copies of the photos. All raw data, including electronic copies of the transcripts and photos, are stored on a password protected USB memory stick and kept in a locked drawer for seven years, at which point they will be erased.

**Minimizing Risk**

Some people believe that talking about suicide causes suicidal behaviours; however, Eynan et al. (2014) found that assessing for suicidal thoughts among 120 research participants with suicidality did not increase their risk for self-harm. Discussing IPV experiences with an empathetic researcher sensitive to power inequities can be empowering for women (Burgess-Proctor, 2015; Jansen, Watts, Elsberg, Heise, & Garcia-Moreno, 2004). Sharing stressful life experiences may allow women to make sense of their experiences with the opportunity to obtain help if deemed necessary (Lakeman & Fitzgerald, 2009). Nevertheless, talking about stressful and traumatic events can cause emotional distress; therefore, providing safeguards was a priority. I heeded Fisher and Goodman’s (2009) suggestion to assess the participants for suicide risk before the interviews began. Interviews and PV meetings were conducted only if the women were a low suicide risk as determined using an established screening protocol (Appendix F). In addition to the screening protocol, suicide protective factors are important to assess as more evidence of the participant’s safety and security and these include: (a) close relationships (Skopp, Luxton, Bush, & Sirotin, 2011); (b) sense of purpose (Pietrzak et al., 2010); (c) spirituality (Brenner, Homaifar, Adler, Wolfman, & Kemp, 2009); (d) positive thinking skills (Kleiman, Miller, & Riskind, 2012); (e) self-esteem (Walsh &
Eggert, 2007; Wang, Lai, Hsu, & Hsu, 2011); and (f) problem solving skills (Donald, Dower, Correa-Velez, & Jones, 2006; Marty, Segal, & Coolidge, 2010). These assessments helped me to determine that all women were at a low risk of suicide during the time of their participation.

Although only women with a low-risk were eligible to move on to the PV group, I remained vigilant to signs of suicide risk; for example, verbalizations of wanting to end their lives, appearing withdrawn, or increased agitation. I also encouraged women to notify me if they were having strong suicidal feelings during the meetings. These precautions were in line with the WHO’s (2016b) recommendation to assess suicide risk at different intervals when doing research with women who have experienced IPV.

During the last PV meeting, one of the participants indicated that she wanted to give up on life; however, was not thinking about killing herself. At this the group stopped discussing the PV content and provided her with support. The other participants and I helped her access the resources that she needed at that time and attended her initial assessment appointment at Addictions and Mental Health upon her request.

I had been prepared to assist participants who were at high risk for self-harm by remaining with them until another appropriate support person became available and if required, I would have accompanied them to the local emergency department (ED) or call the Mobile Mental Health Crisis team. In any case, I encouraged participants to use external resources when feeling distress including, contacting people they trusted, making an appointment with a health care provider, using prescribed as-needed medication, and accessing help with children if required. I also encouraged women to tap into their internal resources by using distraction techniques, focusing on reasons for living, and
making a list of optimistic future goals (Appendix K). In addition, opportunities for
debriefing were offered through a follow up phone call after an interview or PV meeting.

Another safety challenge was that despite having left the abusive relationship,
women might continue to be abused or harassed. While only one woman reported
continued harassment, safeguards were implemented as indicated within the IPV Safety
Protocol (Appendix J). The Stress Reaction Handout (Appendix K) was also provided to
help them anticipate and recognize possible responses to talking about past abuse.
Permission was obtained to contact the participants and I encouraged them to consider
whether having research related materials in their possession would place them at risk.
Most importantly, I valued their personal perception of safety by conveying to them that
any interviews would be cancelled if they did not feel secure.

Once the women were assessed to be low risk and felt comfortable with
continuing participation, methods aimed at minimizing risk were implemented on an
ongoing basis. Strategies for reducing distress included developing a trusting relationship,
frequently assessing for signs of distress (Lakeman & Fitzgerald, 2009), encouraging the
use relaxation strategies if needed, and facilitating interviews at the women’s pace
(Wuest, 2007). My experience in building trusting relationships with marginalized
populations and people who have experienced trauma was key to promoting a sense of
safety during the study. Active listening and validation are the most important skills I
used in building trust. Validating women’s trauma helped them to feel comfortable
sharing their experiences and allowed them to go more in depth in their sharing.

An ethics of care (Prosser, 2011) approach, where compassion for the participants
and their well-being directly influences ethical decisions, can help decrease risk within a
participatory study that uses visual methods (p. 493). I was able to minimize risk by focusing on the women as human beings first and research participants second. When women presented an image within the PV meetings, my first concern was for their emotional well-being and once I was confident that they felt comfortable, the discussion about the image’s meaning continued. I invited the women to notify me if they experienced distress during the sessions so that we could take a break or end participation whenever they wished; however, none of this was required. Ultimately, genuine compassion for participants translates into ethical actions and decisions during research activities.

Stressful life circumstances can negatively influence sharing distressing experiences; therefore, I helped the women in the study overcome barriers to participation. Lilli was unexpectedly the caregiver for her sick infant granddaughter and did not have access to basic necessities the day that I met her. Sheri asked me to take the money that she received for her participation in the study and go to the store for juice and medication before the interview began. I also held the baby as Lilli shared her experiences so that she could express herself freely. Although caretaking is not the role of a researcher, helping out in small ways enables a more comfortable interview. Otherwise, placing my needs as a researcher to obtain information over participants’ need to meet basic needs would not be ethical.

My ability to create trusting relationships was evident in their comfort sharing trauma experiences and their gratitude for being in the study. Evidence of creating trusting relationships was also demonstrated through participants’ ability to assert their needs, that is, to end participation in any part of the study when needed. Stefanie and
Cassidy began the PV group, but once they began collecting images of their experiences they felt overwhelmed and declined to continue. I validated their decision and encouraged them to keep the camera. They leaned on their support network and appreciated our ongoing relationship to help manage their distress and emotions soon abated. They both voluntarily allowed their images to remain in the study and they stayed engaged by providing feedback on the development of the theory. Finally risk was minimized by using pseudonyms, chosen by the researcher, in the writing of the theory to uphold women’s privacy.

**Benefits**

Women benefitted in various ways by being involved in this study. Providing an environment of empowerment through having their voices heard is an important ethical consideration (Morrow, 2006). In this light, the most common response about their participation was a sense of comfort from being heard. Sherry writes, “Petrea, I found our meeting very cathartic and wanted to thank you for taking the time to really ‘listen’… If you would like to talk again or have other questions, please contact me.” Other participants expressed their gratitude for being validated during the interview and felt relief and support after sharing their help-seeking experiences. They also gained a sense of empowerment through recognizing the injustices of their trauma and health care treatment.

Considering a feminist approach is foundational to this study and community empowerment within a group setting is encouraged within feminist research (Paradis, 2000), a safe and supportive atmosphere during the PV group discussions was another priority. The group indicated they felt accepted, valued, and secure. The group setting
provided women with a sense of connection, reminding them they were not alone, thereby increasing their sense of safety and support. Millie explains the impact of participating in the PV group while answering the question of how the women give each other hope:

I just listen to what the others are saying and sometimes I relate to it. It really helps me. It really helps that we all have something in common…The first time I came here I really liked it. I thought this is what I have been looking for. I need someone. I feel that we all seem to know why we are here and we are reaching out. It’s very powerful for me.

The women in the PV group maintained supportive relationships with each other outside of the study. Another illustration of the sense of belonging and support PV participants experienced is seen in a photo of Gabrielle, Jane, and I (Figure 18).

Figure 18. Gabrielle and Jane had a picture taken of us as a memento.

Jane showed this photo to the PV group and explained that it is an example of support and friendship that aids in help-seeking. Gabrielle and Jane wanted a picture of us as a remembrance of the meaning they gained and the enjoyment they experienced in the process.

Conveying my gratitude to the women in the study for their time and sharing was essential in gaining their trust and elevating their self-worth. Knowing that their
generosity and wisdom will help others was exciting, but gratitude for having connected with me was most important to the women in the study. After thanking the PV group participants for their part in helping me help other women in similar situations, Ann, Millie, and Lilli reciprocated their gratitude:

Ann: You think that you are the … we are helping you, but like I am doing this personally for me, like I can’t thank you enough for listening and being here and taking it seriously (began to cry).
Millie: This is the first time that I think I can voice my opinion without being shot down.
Lilli: Well when somebody (researcher) stops and then you see that they care and they are your voice… they are going to do something … then your life comes back and you want to live and it gives you that splurge of life.

Their expressions of gratitude directly counteract the idea that talking about their problems could be harmful. In reality, the women within the PV group experienced more distress outside of the study, as they often did not have anyone to confide in.

Benefits of this study were felt beyond the time spent in the research sessions. Jennifer became motivated to see a counsellor to work on her problems after discussing her trauma during an interview. Sharing their experiences helped to increase their insight about themselves and learn about ways of managing their ongoing mental health problems. Becky reported feeling very good about the interview because she could tell that I was a “good person” and she trusted me. She was also proud that she contributed to helping others by sharing her experiences. The next time Becky had thoughts of self-harm, she used the positive experience from the interview to pull herself out of the crisis. Stenius and Veysey (2005) also found that women with a history of abuse felt a greater sense of safety and level of confidence after sharing their struggles with other women who had similar experiences.
Ethical principles are used to guide policy development within PV research (Wang & Burris, 1994). Women found hope in the belief that their experiences will influence changes within the system. I emphasized how their sharing helps other women and gave examples of how my new understanding of their help-seeking was improving the way that I help clients in similar circumstances in my clinical practice. This gave them a sense of being valued. I will continue to follow up with the women on how the findings are distributed and applied to service delivery.

While beneficence or doing good (O’Neill, 2002) for a participant within a feminist research study is important, avoiding paternalism or the misuse of beneficence by assuming that I knew what was best for the women was important (DeRenzo, 1998). I remained open to the women’s wisdom and learned about their help-seeking from a non-judgmental standpoint. I set aside any stigma of suicidality and rejected the belief that is common among some HCPs that women who make non-lethal suicide attempts are manipulative and weak. This allowed me to see more clearly what is going on in the women’s help-seeking journey. My open standpoint helped me to see the extent to which IPV and the system traumatize women; thereby, understanding their help-seeking behaviours as evidence of strength. In this way, I avoided paternalism by not judging their self-harm as being attention seeking or something that they ought not to do. I allowed findings related to self-harm to naturally emerge from the data, revealing that communicating their pain by harming themselves does not mean that they are weak, but that it is oftentimes their only perceived option. Attempting suicide and other forms of self-harm sometimes lead to health care access; therefore, it is a sign of strength while experiencing unbearable pain and isolation. I conveyed that HCPs are not the experts on
women’s lives, but rather the wisdom and strength they need to survive resides with women themselves, a gesture aimed at promoting empowerment and self-efficacy.

The women in this study were also offered opportunities to participate in advocacy by joining community groups who seek social justice within the system. Jane and Gabrielle participated in education sessions that I facilitated aimed at improving client involvement within Addictions and Mental Health services. Cassidy joined an advocacy group with past mental health clients and clinicians on making positive changes with a local adult psychiatric unit. She was instrumental in many improvements on the unit through meeting with the nurse manager, creating awareness about the health needs of clients within psychiatric units, and helping to educate clinicians about the importance of the therapeutic relationship. Collaborating with community groups was invigorating and increased the sense of agency for Jane, Gabrielle, and Cassidy. I will continue to invite the women to participate in research dissemination and in policy decision making sessions, checking in to ensure that they find their involvement personally rewarding.

In summary, the women in this study were treated with respect and dignity. Munhall (2007) wrote that the priority is always toward the participants’ safety rather than the research itself, an ethical consideration that I upheld. I respected the women’s right to self-determination by following their lead and minimized harm by being cognizant of emotional discomfort. This study promoted the discovery of how suicidal women who have been abused seek help from the health care system while upholding their well-being.
Dissemination of Findings

Findings from this study will be disseminated throughout Addictions/Mental Health within Horizon Health Network, including the Moncton, Miramichi, Saint John, and Fredericton areas. The aim will be to engage administrators in policy changes and to educate clinicians on ways to improve services for women. Another goal is to reach clinicians through dissemination of the findings so that they may have a better sense of women’s help-seeking, an understanding that may facilitate their role as critical helpers within this process. In order to enhance knowledge translation on the front lines, I will continue to seek administrators’ support and endorsement of educational sessions for clinicians.

Findings will also be shared through presentations at local, national, and international conferences in areas of violence against women, mental health, nursing, and other health-related forums. Depending upon the wishes of the PV group, the women may choose to participate in photo displays within the community as opportunities are made available; for example, in the lobby of the Moncton Hospital or local community health fairs. Considering my leadership position within Horizon Health Network, Addictions and Mental Health, I will offer opportunities for the women to share their findings with various program committees. Finally, I will submit articles for publication within research and professional journals.
Chapter Five: The Findings

Hunting to Feel Human: Women’s Help-seeking for Suicidality after IPV

Women who have experienced IPV encounter burdensome obstacles while seeking help within the health care system. Hunting to Feel Human is the basic psychosocial process used to manage the basic psychosocial problem, System Entrapment or feeling trapped, dehumanized, and worthless while seeking help for suicidality within the health care system. Hunting to Feel Human exists within a context of Trauma Entrapment or feeling suicidal due to a sense of being stuck, disempowered, and hopeless. The aim of the Hunting process is to Feel Human, a sense of value and belongingness obtained through health care providers’ (HCPs) validation, an acknowledgment that is critical to survival. Sharing mutual humanity by recognizing HCPs’ fallibility and relatability to women equalizes power imbalances and lessens Trauma and System Entrapment, which then increases self-worth, belongingness, and Feeling Human. Attaining Feeling Human is the result of considerable work through several complex Hunting processes.

Gauging for Validation guides the hunt through a continuous judgement of the level of System Entrapment risk and opportunities for validation, yielding a measure of hope in the system’s potential to be helpful. Gauging for Validation opportunities increases the chance of finding validation, but does not guarantee it. Validation is maximized using the following Hunting sub-processes through trial-and-error: Distancing from Help, Enduring System Entrapment, Applying Counter-Pressure, Grasping for Help, Soaking in Validation, and Letting Go. The Hunting to Feel Human diagram (Figure 6) illustrates these processes. Feeling Human, represented in pink within the
diagram, is a covariant with *System Entrapment*, represented in blue. Where the pink part covers more area, the blue covers less as *Feeling Human* is barely present with the existence of *System Entrapment*. Validation is illuminated with the yellow dotted arrow brightening as it nears the largest pink section, indicating the consequence of validation is to *Feel Human*.

![Diagram](image)

*Figure 6. The Hunting to Feel Human diagram.*

**Entrapment**

*Entrapment* represents a sense of being controlled and living with the pain of having low self-worth, a lack of belonging with others, and little hope. *Entrapment* encapsulates all aspects of women’s lives, including their thoughts, emotions, and behaviours *Entrapment* includes being literally trapped within the grasp of an abuser and being placed in a locked room on a psychiatric unit or figuratively trapped by seeing no end to depression. The crux of *Entrapment* is dehumanization, a deteriorating a sense of personhood, identity, and reason for existing.

**Dehumanization: The core property of Entrapment.** Dehumanization is the sense of not being fully alive or lacking identity as a person of value in the world. On the
most basic level, dehumanization leads to thoughts of ending one’s life and no longer being alive. Three main indicators of dehumanization are a low sense of: (1) self-worth; (2) belongingness; and (3) agency. First, dehumanization moves beyond the concept of survival or the lack thereof, representing a feeling of being unworthy of living. Feeling unworthy of living means to feel deep shame and undeserving of self-determination, protection from harm, and connections with others, basic needs that had been withheld or missing during trauma experiences.

The second indicator of dehumanization is a low sense of belongingness. Isolated and feeling unworthy of a quality life contributes to existential angst that one does not belong in the world. Having been betrayed by an abusive intimate partner leads to deterioration of trust in others and a move away from relationships and feeling overwhelming distress prevents the cognitive capacity needed to maintain relationships. Others’ lack of understanding of suicidality and trauma contributes to further disconnection. The third indicator of dehumanization is low agency or the belief that one’s actions have little influence on outcomes, including escaping the effects of violence, managing suicidality, and seeking help. Without self-determination, harm from oneself or from others is extremely difficult to avoid, contributing to the inability to fully participate in life or realize one’s personhood. Cognitive disruption related to suicidality impedes self-expression, freedom of thought, and the ability to act in accordance with one’s values. Ann felt trapped during periods of depression; for example, she described staring at the dishes intent on cleaning them, but unable to move. Ann also described feeling disconnected from her family; her self-concept was disrupted when she was unable to fulfill her role as a mother, resulting in a sense of deep shame.
Dehumanization also occurs from others’ mistreatment. Living under the abuser’s control, women felt stripped of the ability to make decisions and fulfill their needs, factors that lead to loss of self. Sherry explained being controlled by her partner and basing all her decisions on his bidding:

“It was almost like after 4-5 years, I lost complete sense of who I was. It was more like I was a puppet. I had to sort of go along with …he made his ideas seem like they were my ideas so that I would feel that I was contributing to the relationship even though I so obviously wasn’t.”

Controlled like a puppet, Sherry lost self-determination and sense of identity. The loss of agency meant that women no longer identified as human beings who are deserving of basic physical and emotional needs. Once help was sought within the health care system, dehumanization continued through the invalidation of having poor access to urgent care, feeling misunderstood, and being told what to do by HCPs. Lack of validation leads to self-doubt about the legitimacy of these needs and their self-value.

Dehumanization occurs within all forms of Entrapment: (a) Abuser Entrapment; (b) Trauma Entrapment; and (c) System Entrapment. Abuser Entrapment occurs while experiencing IPV, Trauma Entrapment occurs during suicidality, and System Entrapment occurs while seeking appropriate help within the health care system. Each form of Entrapment is a separate entity; however, they share core elements, overlap, and influence one another (Figure 19).
Figure 19. Abuser, Trauma, and System Entrapment are separate entities, yet overlap.

**Abuser Entrapment.** Abuser Entrapment represents feeling out of control within IPV and hopeless about escaping the violence. Women longed for freedom from abuse, but felt stuck within the relationship fearing that their safety would be jeopardized if they left. IPV erodes women’s sense of safety and humanity through coercion, an exertion of power controlling what they do, where they go, and with whom they have contact. Abuse in the form of physical, emotional, sexual, financial, and controlled access to loved ones disrupts self-concept, safety, and connection to the world. Jane demonstrates the level of fear and violence related to her Abuser Entrapment in her photo of a knife, the weapon her abuser used to control her (Figure 20). Jane explained the significance of the knife:

That's a picture of a knife and that was the same knife that my ex-husband had and threw it at me the last day that I was at our house and it just… I just have a feeling of wind right beside my head … he could have killed me.

Figure 20. The knife that Jane’s abuser threw at her.
Violence erodes a sense of personhood as one’s safety and basic needs are ignored. Many forms of IPV are pervasive including physical, sexual, emotional, spiritual, financial, among others; however, women indicated that name-calling, isolation from loved ones, and other coercive emotional abuse were the most harmful. Maxine shared part of her IPV with emphasis on the emotional impact:

I am like crying and crying and [the abuser said] "You are an effing bitch, you are making me lose my hard-on! Stop your crying!"…I tell myself what a dumb stupid bitch I am, how ugly I am and well, I have been told that for so long you know, you start to believe it.

Verbal abuse was pervasive for Maxine, eroding her sense of self. Identifying as less of a person is exacerbated by mental health conditions that disrupt emotional regulation and cause feeling of emotional numbness or extreme psychological pain. Despite the pain and hopelessness of Abuser Entrapment, various concerns about leaving the relationship make escaping IPV very difficult, including fear of worsening violence, financial insecurity, and negative impacts of the violence on children. Freeing from Abuser Entrapment is contingent on others’ support, the kind of help that is difficult to attain due to segregation from others. Even when the abuse ends, the health consequences of IPV continue to control one’s life. In combination with IPV, other forms of abuse contribute to feeling stuck and suicidal.

Non-IPV violence. Abuser Entrapment and suicidality exist within the context of a history of past trauma, particularly violence that took place during childhood. Cumulative trauma from childhood, including witnessing violence within the home, sexual abuse, and neglect, increases vulnerability or the intensity of negative outcomes from IPV. Lilli recounts the influence childhood abuse had on her experience with IPV:

I was 9 and I was raped. …A man came through that used to do work for my father …and so he molested me…he raped me…My grandfather…every
chance…I was scared to be around him. He was all the time grabbing for me… I believed they thought they could do with me what they wanted. Who could I tell? They wouldn’t listen to me… Every man it seemed to be that I was involved with was abusive, physically, verbally… that is the way it was supposed to be because my dad was abusive to my mom.

Lilli felt unworthy of safety and respect and believed that abusive relationships were unavoidable due to the violence she experienced in her past. She felt compelled to put up with it and instead supressed psychological pain with alcohol. Memories of childhood abuse are triggered during Abuser Entrapment, causing a re-experiencing of the past trauma. The result is higher levels of suicidality and loss of control or Trauma Entrapment.

**Trauma Entrapment.** Trauma Entrapment represents feeling hopeless or stuck while suicidal and is the context for the basic psychosocial process, Hunting to Feel Human. The common denominators for Trauma Entrapment are personal devaluation and disconnection from life. Mental health problems, including post-traumatic stress disorder (PTSD), depression, and anxiety, most of which results from Abuser Entrapment, contribute to and worsen Trauma Entrapment. While Trauma Entrapment, represented in green within the Hunting diagram (Figure 6), continues long after the violence has ended, Abuser Entrapment is implied as being a part of the green section as it is the biggest contributor of Trauma Entrapment.

**Managing Abuser and Trauma Entrapment.** Abuser and Trauma Entrapment are managed alone by: (a) bearing the burden; (b) escaping the pain of feeling stuck and hopeless, and (c) finding meaning. While bearing the burden and escaping the pain are helpful temporarily, finding meaning is a more constructive way of managing that has longer lasting effects. Despite the strength, ingenuity, and effectiveness of fighting Abuser and Trauma Entrapment, the impacts of IPV and its health consequences are
overpowering. Help from the health care system is sought once personal methods of managing are exhausted.

**Bearing the burden.** Recognizing that fighting back against the abuser may worsen the violence, women gain a sense of control by *keeping the peace* and bearing the burden and pain of *Abuser Entrapment*. Agency within *Abuser Entrapment* is extremely limited; therefore, women hold on to what they can control when they see an opportunity to affect change in their situation. Between two painful options: (1) to push back against the violence or (2) to put up with it, the latter is the safest option. *Trauma Entrapment* is also tolerated in order to manage the pain when other attempts to abate the pain are not effective. The despair and hopelessness of suicidality is all consuming, leaving little energy to rally internal or external resources to escape from this psychological pain. Latoya describes being stuck with suicidal thoughts:

> It is hard to change your thoughts. I mean I say it's hard, but there are ways of doing it, but when you're suicidal it just stays there with you. It is always in the back your mind. You don't get rid of it.

Despite knowledge of strategies on combatting the thoughts, Latoya did not have the capacity to free herself from the *Entrapment*, but rather had to bear the suicidal thoughts. *Trauma Entrapment* is endured by feeling the despair, noticing that they are stuck in this feeling, and lingering in the *Entrapment*. Bearing the burden of *Trauma Entrapment* also occurs by purposefully resisting the urge to cut or to engage in other self-harm that help to escape the pain and instead, bearing the pain becomes the focus in order to avoid suicidal behaviours. These approaches provide only temporary relief and since the underlying causes of the *Entrapment* are unchanged, the pain gets worse. Suicidal thoughts are inevitable when the burden becomes exhausting and unbearable.
**Escaping pain.** When enduring *Abuser* and *Trauma Entrapment* becomes unbearable attempts to escape the pain are made. Escaping an abusive relationship occurs over months or years while safety nets are built to assist in leaving, for example, developing more self-confidence, obtaining access to finances, using a shelter, and obtaining legal documents for child custody. Escaping the relationship is not synonymous with escaping *Abuser* or *Trauma Entrapment* as life beyond IPV continues to be extremely difficult or worse due to the abuser’s ongoing harassment, withholding of finances, and other forms.

Escaping *Trauma Entrapment* occurs through planning, attempting, and fantasizing about suicide, representing a way out a life controlled by despair, fear, and hopelessness. Suicide is a way of gaining control by being the authors of one’s future in achieving relief or peace. Managing *Trauma Entrapment* requires endurance and strength, skills that aid in the help-seeking process. Escaping pain through self-harm provides *Entrapment* relief in the short run; however, ends in feelings of worthlessness and self-destruction. Escaping through the use of self-protective measures provides relief in the long run, a process demonstrated in Cassidy’s photo of her T-shirts with the collars cut out around the neckline (Figure 21).

*Figure 21.* Cassidy’s T-shirts with the necklines cut out makes her feel safer.
Clothing that touches her neck area triggered feelings of being stuck and out of control, an automatic response to having been abused. Cassidy described escaping from *Trauma Entrapment* with a creative strategy she adopted long after having left her abuser, “I can't wear shirts that have collars as I feel like I'm being choked the way he used to choke me. Cutting the collars off gives me control.” Ongoing fear of being strangled is managed by adapting how she dresses, providing some freedom from *Abuser and Trauma Entrapment*.

**Finding meaning.** Finding meaning helps to free from *Abuser and Trauma Entrapment* by having a purpose to continue with life. Identifying something that is worth living for loosens the grip of *Entrapment* and provides hope of a life without feeling trapped. Veronica had her children’s names tattooed on her arms, the place where she has urges to cut: “I got my tattoo so I won't cut anymore. I thought, ‘I don't want to cut myself anymore’ so …every time I have an urge to [cut], I just see it. It says my kid’s names.” Dedication to motherhood gave Veronica meaning in her life, decreasing her self-harm behaviour. Women may also find meaning by identifying how their past trauma affected their lives and how they came to be suicidal, thereby allowing for understanding and self-compassion. Self-awareness and insight into their trauma motivates them to turn their pain into something positive by helping others with similar experiences.

**Abuser and Trauma Entrapment conclusion.** *Trauma and Abuser Entrapment* lay the framework for the difficulties in seeking help within the system. Carissa explains:

I actually had a full-blown anxiety attack when they sent me to an occupational therapist and my psychologist, God love her, was very quick to let [the occupational therapist] know, “You are pushing her and she's actually having suicidal thoughts again. Because you were pushing her and you were taking away her control and with her history of being abused and raped and so on…” So control is a huge thing. “You take control away from her, she is going to become
suicidal again.” So I've found that instead of being controlled by a boyfriend or an ex-husband, I’m being controlled by my provider so that's a really significant one for me.

Carrisa’s Abuser and Trauma Entrapment intensified the difficulties in seeking help, a process that leads to System Entrapment.

**System Entrapment.** System Entrapment is the devaluation of human worth or dehumanization through the invalidation of suicidality while seeking help. System Entrapment refers to HCPs’ minimization of suicidality and psychological pain and its role in eroding a sense of security, decreasing self-worth, and fuelling the desire to end life. When their humanity is not respected, women feel stuck, unable to free from the situation because they feel worthless and have a low sense of agency. Dehumanization caused by invalidation separates women from others, creating alienation, rejection, and feelings of abandonment. System Entrapment is represented by the blue part within the Hunting diagram (Figure 6) and overlaps with the green Trauma Entrapment part, illustrating that they may occur simultaneously.

The system refers to health care services and includes HCPs, treatment, programs, and the environment within governmental health care or the private sector. The system includes acute or tertiary health care services designed to help people with urgent health problems, such as, psychiatric units, EDs, and crisis hotlines. The system also includes non-acute services designed for people with less urgent and ongoing health problems, such as, counselling centers and family physician offices. System Entrapment occurs at any time; during all levels of urgency from contemplating help before reaching out, to requesting help for depression, to seeking help after a suicide attempt. The common denominator for System Entrapment is the perception that HCPs’ behaviour is often
invalidating, contributing to the feeling of non-existence or low self-worth. *System Entrapment* exists in different forms and occurs within different phases.

**Relation to Abuser and Trauma Entrapment.** *Trauma Entrapment* increases the sensitivity to *System Entrapment*. *Trauma Entrapment* is the lens through which women viewed the world, influencing the way they perceived barriers in the help-seeking process. Because of the influence of *Abuser Entrapment* on *Trauma Entrapment* women compared HCPs and events within the system to their past abusive relationship. Violence from an intimate partner alters every aspect of women’s lives by shattering their view of the world and affecting how they relate to themselves and others. For example, Jane acknowledged that she was vulnerable to feeling invalidated and controlled by her male HCP due to having been dehumanized by her male partner. Dehumanization skews the self-concept through a disconnection from others and the rest of the world. Violation by a romantic partner of the basic human right to safety leads to a deep-seated need for self-protection, including guarding oneself from others and distrusting self.

Simultaneously seeking out others and guarding from others is a balancing act. Although drawn to the system for safety, the *Trauma Entrapment* lens maintains a sense of distrust of HCPs. Beth’s past IPV and mental health problems contributed to fearing the nurses when she sought help in the ED.

That’s how [ED nurses] would control me. They were talking about me and all the paranoia would come and all the fear of everything…going through the stuff with my husband… [Believing] they are belittling me and that belittling me is what made me stay quiet and do what they wanted.

Without the opportunity to express her problems, Beth was not able to ascertain the support she needed as she perceived the nurses’ treatment as invalidating and abusive.
The consequences of invalidation within the health care system are particularly harmful due to pre-existing trauma experiences.

The psychological pain and dehumanization of System Entrapment exacerbates Trauma Entrapment. Stephanie recounts the influence of feeling invalidated by the HCPs, “You can come out of [the ED] feeling three times worse than when you go in with a crisis… because [the HCPs] are too judgmental.” Women in this study were ambivalent about suicide while seeking help because, although they thought about ending their pain through suicide, they were also curious to see if an HCP could help. Presenting at the emergency department (ED) hoping for help, Stephanie’s sense of worthlessness increased in the face of feeling invalidated, leading to decreasing ambivalence and thinking more seriously about suicide.

Role of power. System Entrapment exists within a context of power imbalances, intensifying all instances of invalidation. The invalidation of being placed in seclusion without women’s consent during a suicidal crisis intensifies with the knowledge that the HCP literally holds the keys to freedom. Pre-existing power imbalances create a vulnerability to System Entrapment as the invalidation and dehumanization while seeking help are similar to Trauma Entrapment or occurrences that led to the need for help-seeking in the first place. Another pre-existing power imbalance exists within the system itself, an institution built upon a hierarchical framework where the HCPs have authority over the environment and functioning of services. While the system is the entryway for treatment, it is believed to be the only avenue for help, making the system seem all-powerful. Hope for pain relief or a sense of agency is dashed when met with invalidation, solidifying women’s belief that finding help is nearly impossible. Wrought with multiple
entry points, medical jargon, different roles for various clinicians, and complicated policies for each health care service, the system is confusing to navigate. The system is complex and not easily understood with its own language and set of rules, creating a culture that is not easily accessible or comfortable.

Being gatekeepers of treatment, controlling how the services are run, and enforcing the rules that women were obligated to follow automatically places HCPs in a position of authority. While some aspects of the HCP’s powerful position are helpful, including the authority to administer emergency medication in a crisis and the ability to make referrals to other treatment programs, other aspects of HCPs’ power is perceived as disempowering. Most service provision knowledge is held by HCPs as much of their work occurs behind desks or glass enclosures and personal health records are concealed, further granting HCPs power and alienating the women. Power imbalances also existed due to women’s lower socio-economic status as a result of financial abuse or poor health status that prevented them working. Carissa’s photo (Figure 22) of having her picture taken from high above illustrates her low sense of value and agency when seeking help.

*Figure 22.* Carissa feels HCPs’ look down on her while seeking help.
Carissa described the photo: “When you reach out and you say I'm suicidal. I have anxiety I have whatever, people look down on you and you don't want [that]!” The power imbalance decreases a sense of security and the capacity to obtain relief from distress.

**Forms of System Entrapment.** *System Entrapment* occurs primarily through three different forms: (1) physical coercion; (2) limited access; and (3) judgement. All forms of *System Entrapment* include different forms of invalidation and dehumanization.

**Physical coercion.** *System Entrapment* generally refers to a metaphorical sense of being trapped; however, literal forms exist as well. Firstly, physical coercion used as treatment within psychiatric units includes seclusion rooms, physical restraints, and sedative medication. Involuntary treatment through the New Brunswick Mental Health Act (1973) awards great power to the system as clients are forced to remain locked within an institution for at least 72 hours and possibly up to several months at a time. Such coercive treatments almost always occur within the hospital environment and often leads to isolation and loss of dignity. Reminiscent of being physically or sexually abused, physical restraint can be especially disturbing and harmful. Alexa described this experience when she was put in a locked seclusion area while feeling suicidal in a psychiatric unit:

[The HPCs] put you in a place called the [Acute Observation Unit] and you feel like you are in a cage and there are two nurses that sit behind glass and watch you steady... it was very scary...that doesn’t help me. It makes me worse…It brings back a lot of stuff. You go there for help and they give you more of that stuff... I felt like some of the abuse that happened in the past was happening all over again.

Alexa relived her past “stuff” or IPV trauma while receiving treatment, placed in a situation that mimicked her partner’s abuse. Being watched behind an enclosure amplified Alexa’s alienation and sense of dehumanization.
Physical coercion ultimately leaves women feeling out of control. In response to a question about being controlled by the abusive partner and the influence on help-seeking, Jane responded with an example of the seclusion room: “That is right. You don’t want that same control. It’s like when they put you in that room, it’s like they control you. It’s like, ‘I am a person!’” Jane did not interpret being put in the seclusion room as a place to remain safe, but rather to be dehumanized, similar to the way she felt during IPV. Although women were sometimes told that restraint and other modes of physical-orientated treatment are for safety reasons, psychological security was often ignored with little regard for self-determination and emotional validation.

Limited access. A second form of System Entrapment is limited access or not being admitted to a service that has the potential to provide security. Blocked access is interpreted as not being taken seriously and being unimportant or a low priority. Health care policies about how people in crisis are received into care and how care is delivered influences System Entrapment through long wait times. Effective provision of care is delayed based upon convenience instead of the system adapting to the care needs. Women in the study had to manage their distress on their own while waiting for services, tolerating their anxiety in a crowded waiting room, and conveying their needs repeatedly to HCPs. Waiting leads to System Entrapment and decreases opportunities to Feel Human. System Entrapment is also the result of blocked access through ineligibility for a program, unaffordable transportation to appointments, and expensive private counsellors.

Rejection and discouragement are so powerful that it takes only one incident of blocked access to create System Entrapment. Being turned away from a service before even having a chance to explain the crisis and make a plea for help leads to exasperation,
anger, and hopelessness. Blocked services left women in exile, rejected from the system with nowhere to turn. Another challenge is a lack of service coordination and continuity of care. Maxine explained that acceptance into a housing-first program meant that she had to end counselling with a trusted HCP for her drug addiction and suicidality after the devastating loss of visiting rights to her children: “[The housing-first program] was good, but… I had to give my psychologist away… I called Mental Health. I begged them to get me on the list or something for a counsellor.” Although stable housing provided Maxine with some security, she was prevented from getting the help that she needed most urgently, that is relief for her overwhelming despair.

**Judgment.** The third and last form of *System Entrapment* involves perceiving judgement by the HCPs as being worthless based upon thoughts, feelings, and behaviours that are beyond women’s control. *System Entrapment* exists within the context of a society that stigmatizes mental health, including judging women for having been in an IPV relationship and for wanting to kill themselves. Judgment is described in Carissa’s photo of a gavel (Figure 23) that demonstrates how she believed others treated her by minimizing IPV and shaming suicidality, causing isolation and dehumanization.

*Figure 23. Carissa’s photo of a gavel represents being judged.*

Carissa also described being judged with a metaphor of a magnifying glass: “I felt like [the HCPs] are going to look at me through a magnifying glass which would just make
me look more broken and they find my faults and I couldn't face that.” This metaphor symbolizes fear of being shamed by being analyzed and criticized while seeking help.

Judgment is most harmful due to feeling rejected as a person, a shaming of one’s humanity. Women anticipated that HCPs as caregivers would understand the difficulty of suicidality more than anyone else. Therefore, when the HCPs were perceived as not being accepting, women in this study felt worthless. Furthermore, the stigma of suicidality contributes to feelings of being weak for being incapable of managing life more effectively. Shamed for staying in an abusive relationship, for not being able to “snap out of it,” and judged as being selfish for considering suicide, there is no escaping the disapproval of others. The follow up to being judged is the expectation to change. Even when believed and taken seriously, women perceived HCPs’ intent to make improvements in their lives as threatening because the implication is that women must be different than who they currently are. Although women sought change by aiming to Feel more Human, HCPs’ expectations about ending suicidality by telling women what to do, how to think, or how to fix their problems resulted in dehumanization. Due to the loss of control while suicidal, pressure to change suicidality is coercive and seems impossible.

**Phases of System Entrapment.** System Entrapment occurs during different periods of time, including while approaching the system and interacting with the system. Although the key properties of System Entrapment are consistent, different factors of each time period during the hunt determine how System Entrapment is perceived and managed.

Approaching the system. Before interacting or receiving treatment from the system, System Entrapment begins while approaching the system, including working
one’s way up to approaching. Fearing or anticipating HCPs’ invalidation, women spent a lot of time contemplating whether they should approach the system for help. Loss of control is felt merely at the thought of seeking help due to fears of judgment within the system and society. Seeking help is seen as a weakness, a belief that creates barriers in accessing help because of the expectation that emotional problems ought to be dealt with privately and without professional help. Requiring mental health assistance is perceived to be an indication of having done something wrong. System Entrapment is also influenced by IPV stigma that invalidates women by not believing the trauma they have experienced and blaming them for staying with the abusive partner.

Women felt lost and overwhelmed while contemplating approaching the system due to a lack of knowledge on how to approach the system. Alanna described:

I was like what do you do? Who do you see?... It is just hard. Again, it's the stigma... it's not knowing how to access mental health. Like who do I call? Like I said I didn't know that there was a mobile mental health crisis unit.

Alanna continued to feel lost when, despite her computer savvy skills and determination to locate answers, she was unable to find guidance on the internet. Discouragement from the lack of guidance may result in ending the Hunt and not receiving help at all. Contemplating seeking help involves being caught between managing suicidality without help and risking further loss of control by approaching the system.

System Entrapment continues as contact is made with a service. The unwelcoming environment with locked entryways and unwelcoming waiting rooms is intimidating, triggering feelings of powerlessness and low self-importance. Angie explains the difficulty waiting in the ED while seeking help in crisis:

I have a lot of anxiety so when I do go to the hospital, they have TVs blaring and it’s all bad stuff. I can’t watch all that. I really get freaked out. If I am in the waiting room, I will go outside or somewhere else. I find it very disturbing.
The ED waiting room was not a safe environment for Angie when she was feeling suicidal in part due to the noisy TV that was distracting, contributing to her unease. System processes and policies do not reflect the needs of someone who is feeling suicidal. Verbalizing suicidal thoughts in the ED, for example, often results in being assessed as a low risk and sent to the waiting room without receiving any kind of support. Other examples of *System Entrapment* while approaching the system include getting an answering machine on a crisis line and being placed on a long wait list for services at a community mental health clinic.

*Interacting with HCPs.* Feeling invalidated while interacting with an HCP is the most significant source of *System Entrapment*. Intake assessments, crisis interventions, therapy sessions, casual conversations, quick exchanges of information, and body language are examples of interactions with HCPs where invalidation was perceived to have occurred. Interaction with the HCP is intimate and personal, a form of contact that has the potential to create a sense of humaneness and hopefulness by being present with another person. However, invalidating interactions were seen as a reflection of the women’s low value. If women felt that they were judged or not accepted, they believed that they were unacceptable; when felt that they were not taken seriously, they believed that they were not worth being taken seriously. These forms of invalidation are the greatest contributors of dehumanization and immediately kicked *System Entrapment* into high gear.

HCPs may have made service provision decisions without first understanding the suicidality and distress or the crisis situation. Women were frustrated when the prescribed interventions did not match their needs. HCPs’ words and body language conveyed
judgement, creating feelings of low self-worth and weakness for needing help.
Interpreted as impatience and hostility, HCPs’ eye-rolling, sighing, and avoidance of women when they were crying or expressing anger, contributed to a sense that they were being accused of exaggerating their distress. The perception that HCPs were criticizing their decision to seek help, insinuating that women were to blame for their problems and that they ought to fix them. Suicidality was interpreted as having been minimized by HCPs’ with clichés and advice, leading to greater intensities of System Entrapment. The feeling of being trapped is solidified by the cyclical nature of invalidation. Not being taken seriously increases psychological pain, which then may increase expressions of this pain toward the HCPs, who in turn become defensive and continue to invalidate. The vicious cycle creates a feeling of being at the mercy of the system.

Settings and System Entrapment. System Entrapment occurs throughout the health care system regardless of the setting. System Entrapment occurred most frequently within the in-patient and acute care setting as compared with the non-acute or community-based services possibly because the acute care settings are usually accessed during the most urgent suicidality. Higher intensities of Trauma Entrapment led to higher intensities of System Entrapment due to feeling worse to begin with and having greater urgency to Feel Human. Even subtle forms of invalidation are extremely dehumanizing during the highest levels of suicidality. After crisis line workers’ lack of support in response to Maxine’s urgent requests for help, she became hopeless about ever finding help.

I called [the crisis hotline] and the girl was like, "Yeah…yeah… Okay." And then another time she didn't even say anything … She offered no help, no support, no words, nothing… I hung up. I had called all of the crisis lines. That's all there is.
Maxine’s perception was that she was stuck with having to deal with her problems alone. Even slight intonations of voice that are perceived as invalidating immediately impact System Entrapment.

The most prominent reason System Entrapment occurred more frequently within the acute care setting is that the HCPs’ behaviour was more likely to be interpreted as being unresponsive to women’s needs related to past trauma. All levels of distress intensities and suicide risk were more often and more harshly judged within the acute care setting. Feeling judged within the acute care environment is partly related to how these services are not designed to be sensitive to mental health needs. Emergency departments, a common entry point for treatment of the most intense mental health crises, including high-risk suicide attempts, lead to dehumanization because they are designed to treat physical ailments not mental health problems. Women believed that if their health problem was not manifested as a physical ailment, they were not taken seriously. Stefanie explained:

[If] I come in [to the ED] looking half decent … I am told [by the HCPs], “Why are you coming here? You look resilient. You look fine.” They do not take into consideration the symptoms or what I'm going through.

HCPs did not believe that Stephanie needed help because she did not look sick. Likewise, Veronica compared HCPs’ responses to her help-seeking for cancer to when she sought help for mental health problems:

[HCPs] are very short with people who are there for problems with depression and stuff like that. They don't treat you nearly the same as if you had a physical problem. If you go [into the hospital with cancer] and you say “Oh, I don't feel good,” you get seen immediately… Like you can end your life faster [through suicide] than cancer is going to end your life.

Veronica’s perception of the HCPs’ invalidating attitudes about her psychological problems was interpreted as a stark confirmation that she was alone in managing
suicidality. Attention to emotional distress, disturbing thoughts, and other psychological health consequences of trauma are regarded as unimportant.

Getting help for suicidality requires immediate and ongoing contact with a HCP who interacts in a validating manner, a level of service that is not always available within acute care settings; however, hospital services are designed to treat relatively short-term health problems. Instead, women were pushed through and out of the system based upon the HCPs’ first impressions, while other less obvious aspects of the problem were not taken into account. For example, medications were often perceived to have been pushed on women for treatment of sleep problems, anxiety, and irritability without addressing ongoing harassment from an abusive partner and other contributors to their suicidality.

Help for everyday problems, including transportation to therapy appointments and money to feed their children, were difficult to access. Women were treated for their crisis symptoms only, dismissing more important concerns dismissed. Valerie explained:

I have had psychiatrists and psychologists and medical doctors and friends and nurses say to me, “Are you sure you aren’t bipolar?” And I say, “No, it’s not bipolar. It’s fucking ...it’s my life! My life is really hard!” …I need help with the practicalities. I have no support network. I didn’t need psychological help. Well I did, but my urgent matters were practical; getting a lawyer, getting [my abusive partner] out of the house, getting us separated.

Despite having mood problems and thoughts of suicide, identifying a label for her mental health problems was not Valerie’s priority. Critical factors that contributed to symptoms of anxiety, depression, and suicidality were ignored.

System Entrapment within acute settings involves feeling trapped within a huge machine run on rules that ignore the client’s need to be heard and validated. Direct invalidation from an HCP during an interaction, for example, perceiving that one’s emotions are being minimized, is less personal and more dehumanizing than the indirect
invalidation derived from feeling restricted by the rules in a psychiatric unit. Direct invalidation is more harmful than invalidation that is directed at clients in general. For example, waiting in a sterile ED while thinking of suicide is less dehumanizing than being told by an HCP that mental health problems are not a priority.

**Entrapment summary.** *Entrapment* represents feeling stuck and controlled within three different contexts. *Abuser Entrapment* occurs as long as IPV exists and is the greatest contributor to *Trauma Entrapment*. *Trauma Entrapment* represents living with suicidality and is the result of having experienced dehumanization from experiencing abuse and other trauma events. *Trauma Entrapment* intensifies *System Entrapment*, the sense of being controlled while help-seeking due to the perception of HCPs’ invalidating behaviour. Despite feeling controlled by an abusive partner, the state of suicidality, and the invalidating system, women find ways to manage *Entrapment*. The core characteristics of all forms of *Entrapment* are a low sense of agency, worthlessness, hopelessness, and overall feeling of being stuck within a coercive situation. The management of all forms of *Entrapment* are also similar; however, the management of only *Abuser* and *Trauma Entrapment* have been described. *System Entrapment* is managed by *Hunting to Feel Human*, a process of overcoming the difficulties in accessing help for suicidality after leaving an abusive partner.

**Managing System Entrapment: Hunting to Feel Human**

*Hunting to Feel Human* is a process of searching and fighting for validation and a justification for human existence within the health care system that is critical for continuing with life in women who are suicidal following IPV. *Feeling Human* is achieved through *Hunting*, a process fuelled by the hope that the system is validating and
helpful. Once validated, women gain self-determination and agency. Figure 6 illustrates the entire *Hunting to Feel Human* process.

**Feeling Human**

Actions within the *Hunt* have one purpose, to *Feel Human*, a sense of having personal value and a connection to the world that reinforces continuing to live. The basis of *Feeling Human* is a justification for one’s existence, counteracting the property of dehumanization that leads away from living. *Feeling Human* is sought within every interaction with an HCP by sharing past traumas, distressing emotions, and suicidal thoughts. *Feeling Human* signifies a movement toward freedom from *System Entrapment* by being validated. When taken seriously and accepted, a feeling of relief and hopefulness about the future arises. Feeling Human is not an endpoint and it does not imply recovery from depression, PTSD, or other health problems related to past trauma, but rather a fluid sense of being deserving of recovery that is ever changing based upon the opportunities for validation within each context. Corresponding to the indicators of dehumanization, the three indicators of *Feeling Human* are: (1) being worthy of living; (2) belongingness; and (3) agency.

The first indicator of *Feeling Human* is consistent with dehumanization in that it moves beyond the concept of survival. *Feeling Human* is not synonymous with ending suicidality, but rather a sense that living is deserved. Worthiness is sought by asking a family physician for a referral to a psychiatrist or medication to treat insomnia, signs of feeling more deserving. Seeking help occurs by conveying emotions through crying, yelling, and presenting oneself to a health care service in hopes of being noticed. Accustomed to feeling invisible, acknowledgment of their existence gave women self-
value. Belongingness is the second indicator of *Feeling Human*, a sense of connection with others that is sought from HCPs throughout the system. Belongingness is implicated when calling a crisis line to relieve loneliness or requesting increased frequency of group therapy sessions. Being validated by having access to a service or recognized for being in distress are indicators of being taken seriously. Validation conveyed that women deserved relationships with others, including therapeutic relationships with HCPs.

The third indicator for *Feeling Human* is a sense of agency as a result of increased self-value and belongingness. This recognition enabled women to feel more empathy for themselves and strengthened their identity as a person with capacity for self-determination. Ultimately, *Feeling Human* is being validated for one’s personhood. Sarah described the essence of *Feeling Human* that is sought within mental health services:

> Psychiatry is about the heart of the person… that is the real deal, what you are seeing. The absolute utter worst of the person and that is where all your emotions and feelings and everything. That is probably where you are going to deal with people as a nurse and that is where you are seeing… the real part of the human spirit.

Sarah recognized that women seek help from HCPs for problems related to the essence of being human.

**Validation.** The path to *Feeling Human* is through HCPs’ validation, an acknowledgement of unbearable pain and one’s value as a human being. Validation is associated with a combination of factors. First, as indicated previously, invalidation occurs more often within the acute care settings. Second, encountering a validating HCP occurs fortuitously as HCPs have varying attitudes and skill on helping people with mental health problems. For example, which nurse is working in a psychiatric unit on any particular day or whether the ED physician is exhausted from working the past 16 hours will influence the level of validation received. Third, receiving validation is contingent
upon how women seek help and manage *System Entrapment*. Validation is more apt to occur while meeting oppressive expectations and rules and less apt to occur when reaching out for help, processes that are explored more in depth in later sections.

Risks to physical safety are taken seriously, especially if the risk is obvious including a highly lethal suicide attempt. Recognized as being at risk of physical danger is a form of *Feeling Human* because access to services are granted, an event that is interpreted as having measured up to the criteria for professional assistance. HCPs’ confirmation that the need for help is high is a sign of self-worth and deservingness. Access to a hospital stay is validation of basic physical needs, including food, shelter, and medication for disturbing thoughts. Access to services that meet immediate physical needs contributes to feeling more in control and lays the groundwork for meeting higher level needs including emotional regulation. Access to services or programs without validating interactions with HCPs, however, has limited results for *Feeling Human*.

**Compassionate interactions.** Compassionate interactions with the HCP are by far the most validating way to help women *Feel Human*. Compassionate interactions move *Feeling Human* beyond the physical security aspect, increasing self-worth and sense of belonging. In fact, compassionate interactions nullify invalidating experiences that occur simultaneously, such as when other HCPs are unhelpful or services are inaccessible. Although Yolande’s HCP was unsuccessful at accessing additional community crisis support for her, she felt valued and empowered with their interactions. Yolande cried while she recounted what she told her HCP:

[I told her] “If it wasn't for you I would've never made it through because when I need somebody to talk to, you didn't refuse to talk to me. You were there to listen.” Even if it was good or bad she was there... If it wasn't for [her] I wouldn't
be where I'm at now. [HCPs] give you the courage. They give you the strength to keep pushing, to keep going.

Having someone to listen was the most important resource for Yolande as it gave her strength. Validation within interactions led to lowered suicidality. Women felt like they mattered and were worthy to remain alive. The power of compassionate interactions derives from being accepted or not judged and receiving empathy.

**Being accepted.** To *Feel Human* is contingent on being accepted and begins when suicidality is believed, the framework upon which HCPs’ validating interactions are built because it demonstrates their understanding of the problem. Acceptance through being believed is impactful as it offsets the feelings of being invisible or ignored and lessens the shame of having difficulty functioning and requiring urgent help. Jesse describes her HCP’s acknowledgment of her distress, freeing her from *Entrapment*, “It was so relieving once I was being listened to. It was like a breath of fresh air. It was like, ‘Oh my God! Someone is finally going to help me after all this time, argument, and struggle!’” Suicidal experiences are so pervasive and all-consuming that *Feeling Human* is attained simply by being believed and taken seriously.

Acceptance also embodies HCPs’ non-judgemental attitudes towards choices and behaviours related to suicidality, past abuse, and level of functioning. Being accepted and given a safe space to feel a range of emotions provides agency and some freedom from *System and Trauma Entrapment*. Whereas pressure to end suicidality is associated with a loss of control, acceptance of expressed emotions and disturbing thoughts contributes to agency by moving at a self-directed pace. Without the expectation for women to stop thinking about suicide, the pressure to fix their problems is lessened and women are free to explore the problems that led to the suicidal crisis. Acceptance from HCPs encouraged
women to accept their difficult life circumstances, resulting in struggling less with the pain, recognizing the reasons for being in crisis, and figuring out what is needed to gain a sense of control. Alanna had been feeling shame about loving her abusive partner after they had separated, feelings that got in the way of her healing process. Her counsellor supported her in these feelings and helped her to understand the reasons behind them. Alanna learned to accept her emotional experiences and to let go of self-blame.

HCPs’ acceptance of behaviours that are stigmatized, including having attempted suicide multiple times helped the women manage suicidality. Stefanie found a safe environment with her psychiatrist to discuss her chronic suicide attempts, behaviours that other HCPs grew tired of and minimized. Stefanie described how her psychiatrist understood her irritation after perceiving invalidation from the psychiatric unit HCPs and provided an opportunity for her to freely express this anger:

My doctor understands how it works here [psychiatric unit]… He understands me. He understands my needs and if I am having a hard time because of the stuff, he lets me vent without being judgemental or anything. So that really helps because if I truly need something, then he can kind of sort out what I need and what I don’t need. So that really helps.

Stefanie was able to focus on the problems she needed to work on to feel better.

Achieving greater insight into how to manage suicidality occurs within a safe and non-judgemental environment. While in the psychiatric unit after a suicide attempt, Carissa found that given space to be in her difficult situation without having to change helped her to get through it. She described the quality of interactions she needed from the HCPs:

I was at the point where I wanted and needed some [homework from the HCPs]… as long as it wasn’t any pressure behind it or expectation. Just a, I don’t want to say recommendation. Just a “If you feel like it, here you go.” I was ready for it.
Carrisa had capacity to work on her problems when she was not pressured and given space to do it on her own terms. In the end, suicidality has a chance to subside when it is accepted. In other words, *Feeling Human* is achieved without pressure to feel better.

*Receiving empathy.* Empathy is a powerful medium for validation and involves conveying understanding of women’s experiences. Empathy is communicated through the HCPs’ observable responses reflecting women’s expressed thoughts and emotions, contributing to feeling understood and valued. Acknowledging suicidal thoughts and painful emotions by demonstrating an appreciation of trauma experiences and other problems is a powerful way of empathizing that provides immediate relief. Having connected with HCPs through perceiving their empathy is the woman’s indication that she has the power to emotionally influence another human being. Although it was Alanna’s first appointment with her psychiatrist, he apologized for the psychological distress that she had been experiencing for years without proper help. Alanna described her gratitude: “he pretty much just read [my history report] sand said ‘I'm sorry I haven't seen you before’. He was just so, so empathetic. He is phenomenal. And just so great.”

Furthermore, empathy is especially powerful when feeling shame or undeserving of care when HCPs are occupied with other clients.

*Validation summary.* *Feeling Human* is about being validated, resulting in self-worth and a sense of belongingness. Validation is to be accepted and to receive empathy, providing relief from distress and shame. The components of validation are described by the PV group’s reflection on Millie’s photo that represents her reason for living, her pet cat (Figure 24).
Figure 24. Millie’s cat provides her with love and acceptance.

The validation received from a beloved pet describes *Feeling Human*, a sense of understanding and acceptance that is also sought from HCPs. Millie’s plea for HCPs “to teach [women] how important they are” and Ann’s wish for women “not [to be] clumped altogether into one category” are indications of the need for acceptance as individuals. Lilli explained the need to be believed by detailing how HCPs help by “listening to you and taking it seriously what you're saying, that this is going on inside you, and you are looking for help.” The need for empathy and belongingness is indicated when Millie emphasized the importance of HCPs conveying that they are on the “same level as women” and that they “understand what we are going through.”

Validation is partly dependent upon luck of encountering a compassionate HCP; however, women also have a significant role to play in achieving *Feeling Human*. Several processes are involved in the search for validation, a journey that, for much of the time, seems impossible as *System Entrapment* continually disrupts the search for humanity. Finding a sense of *Feeling Human* is a fierce journey requiring vigour and persistence, a process achieved through *Hunting*.
Hunting

*Hunting* represents how women seek help for suicidality after having experienced IPV and encompasses all behaviours in the quest to *Feel Human*. The meaning of the word hunt demonstrates the depth and intensity of this journey as the definition implies a vigorous search for a sense of security and confidence about remaining alive. *Hunting* comprises various ways of searching for validation, battling the system, and protecting against dehumanization. The breadth of *Hunting* is that it is not merely sought, but also fought for while searching for validation. Fighting and battling do not imply attack, but rather an unrelenting expenditure of energy and skill in finding relief from their distress so that they can continue with living instead of killing themselves. Finally, protecting from dehumanization is about lessening exposure to invalidation by amending help-seeking behaviours based upon the particulars of the *Entrapment* within each context.

*Feeling Human* is required to avoid death during periods of suicidality, a crucial outcome that is not actually the primary focus of the hunt. In fact, the act of killing oneself is almost a second thought when requesting help. The focus rather is attaining self-worth and belonging by having their voice heard and being taken seriously.

Miranda felt like she was in a battle with her HCP to be an active participant in the treatment planning as she believed that the HCP was imposing complicated coping strategies and other unhelpful interventions. Miranda’s hunt included opening up to her HCP in hopes of being accepted, attempting to convince her HCP of her urgent needs by “show [ing] the feelings inside of me.” Exposing her vulnerabilities to an HCP with whom she perceived to be invalidating was an indication of the extent to which women battle for help. Battling requires an expenditure of substantial effort, depleting energy
levels and inner resources, and contributing to a sense of being out of control. *Hunting to Feel Human* is a journey toward regaining control. Taking power back by persisting to hunt is carried out in isolation until a compassionate HCP is found. Women did the work themselves by searching for what they needed and going after it. After being blamed within therapy her for problems in her IPV relationship and unable to access services for her suicide attempts, Cassidy defended her right for services when she encountered an HCP:

I had finally gotten an appointment and they had screwed it up and I went in and I was angry and I sat down with a social worker who just kept telling me to calm down. Unfortunately I was probably being too aggressive with her … That is too bad but she was being very, very, very mean and I obviously didn’t deserve that because I am mentally ill and I don’t want to be treated like shit. That was more out of desperation, just like a wolf starving in the woods, just like I’m so desperate for somebody to see [my need for help].

With little agency over access to helpful health care services, Cassidy attempted to take back control by urging the social worker to take her seriously or like a “starving wolf” she was hunting for what she desperately needed. The power of the hunt is reflected in Cassidy’s behaviour toward the HCP, an aggressive response that was not intended, but rather a survival reflex. Feeling a low sense of value, Cassidy was fighting to feel worthy of help and trying her best to convey her urgent need for validation.

*Hunting* is not a passive process of finding validation, but rather, an active one of using validation to build self-worth and to connect with others. When validated, the urgent need to *Feel Human* abates. The break from *System Entrapment* is temporary; however, because periods of validation are intermittent. Feeling validated often does not last due to the frequency of encountering invalidating circumstances within the system. Furthermore, moving through the system entails brief interactions with different HCPs,
followed by being forced to move on to another part of the system and new HCPs. After losing a validating HCP, the hunt continues with the help of hope.

**Hope.** Despite hopelessness related to suicidality or fear that psychological pain will never end, some degree of hope to *Feel Human* is required to hunt. Hope fuels the hunt and is a necessary motivator when there is a limited amount of energy, agency, and other personal resources available. Degrees of hopefulness range from feeling very hopeful or confident that HCPs can be trusted, to feeling hopeless or not having faith in the system. *Hunting* processes that move toward the system are influenced by higher levels of hope, while processes that move away are influenced by lower levels. Hope is represented in the *Hunting* diagram (Figure 6) with the dark line that travels in a gradual upward direction from left to right. This line is at a lower point during times of greater *System Entrapment* and at a higher point during periods of *Feeling Human*.

Believing that the system is the gateway to health care, the *Hunt to Feel Human* begins with the hope that HCPs will be helpful. In fact, attaining help is often expected because HCPs are believed to have a caring role. Hopefulness takes a hit, however, when confronted with an uncaring response. Hopelessness includes the fear that suicidality will become worse when feeling judged, isolated, and restrained in the system. The hunt toward the system decelerates without hope as women protect themselves against *Entrapment* by withdrawing; yet, only a very small amount of hope to be taken seriously is needed to persist in *Hunting*. The hope for validation is more potent than the fear of *System Entrapment*; therefore, the hope to *Feel Human* is worth the gruelling hunt.

Hope is particularly relevant in *Hunting to Feel Human* because it is critical to managing suicidality. Hope includes the cognitive ability to perceive a future with a sense
of agency and self-worth. Without hope, women do not perceive that they have the power to fulfill their own needs and are, thereby, left with a life dominated by psychological pain. With the perception that HCPs, who are supposed to be the most helpful, are not validating, there is no hope of ever feeling better. The persistence and fortitude used in the hunt loses momentum and instead, the focus is on ending the pain through suicide. Alternatively, with more hope in the system’s ability to be helpful, suicidality decreases as motivation and the ability to engage with others is higher, factors that are useful when reaching out for help. Less intense suicidality is also an indicator of an increased sense of being deserving of help.

**Deservingness.** The degree to which women feel deserving of help influences the level of intensity of fighting to *Feel Human*. Deservingness fuels motivation to reach out for help and the lack of deservingness contributes to withdrawal. Perceptions of deservingness increase agency that energizes the hunt in the face of invalidation, a boost that provides confidence to fight for just treatment, make requests with greater conviction, and persist for validation. Alternatively, feeling undeserving or burdensome and self-blame contribute to hopelessness and an intense fear of rejection. Feeling undeserving hinders capacity to access help, including seeking information on how to access help, requesting services less often, and having more difficulty pushing for help when up against barriers. Awareness of what is needed to feel better justifies the desire to seek help. Knowing what is needed to relieve the pain of suicidality guides the direction of the hunt and aids in making requests of the HCPs. While not always sure how *Feeling Human* will be achieved, women figure it out through the *Hunting* process. The greater awareness of health risk, the greater the sense of deservingness and motivation to fight
for what they deserve. Women’s awareness of their needs and how they meet their needs in relation to each context within the system involves a careful analysis, *Gauging for Validation.*

**Gauging for Validation.** *Hunting to Feel Human* is informed by constant *Gauging for Validation. Gauging* precedes all actions in the hunt and no help-seeking behaviour occurs without it. Represented in purple across the entire base of the *Hunting* diagram (Figure 6), *Gauging for Validation* provides a plan on how to seek help by measuring and comparing levels of *Entrapment* and validation in any given situation. The outcome is a map or an inner guide on how to maximize *Feeling Human.* *Gauging for Validation* points women in the right direction by feeling out for compassion and being on the alert for judgment. This preparatory process comprises scoping out the landscape before advancing and generating clues on how to proceed with help-seeking. Gingerly wading into the system by remaining alert for judgment and open to validation provides a sense of agency.

Approaching the system with distrust, women vigilantly assess the environment for power imbalances, helping to protect against further distress or loss of control. In every direction and with each opportunity, intricate details of the system and the services provided are observed and processed. Beth explained the process of *Gauging for Validation* by measuring power levels through a comparison of how she responds differently to HCPs’ commands within the ED. First Beth gave an example of not feeling obligated to obey a command simply because she did not like being told what to do. In her second example, she explained how she felt obligated to follow orders because the HCP who had given her the command had been simultaneously belittling her.
See like if [ED HCPs] had of said, "OK you have to go in there and sit in that room for 20 minutes," I would've said, "Pfft! In your dreams! I am not going to sit in that room for 20 minutes for you!" I wouldn't have done it, but where they did [give a command] by belittling me and laughing at me and poking fun… If they had of said [after belittling me], "OK, we want you to go in that room and sit there and be quiet for 20 minutes," I would have done it because the control of being belittled was greater than the control of being demanded that you do this or that. So by belittling me it was more control.

Beth Gauged that System Entrapment was worse when her personhood was attacked as compared with receiving commands without being personally attacked. Having lost trust in others as a result of IPV intensifies the Gauging for Validation process. Beth later related the Gauging process with HCPs as being the same process as figuring out how to minimize Entrapment from her abusive partner.

The crux of Gauging for Validation opportunities is to generate a judgement on the level of hope in the system’s ability to be helpful, a process achieved by weighing potentiality for validation and risk levels for invalidation. The degree of hopefulness in the system’s potential to be validating is compared to the degree of hopelessness in the system, yielding a judgment that determines how the hunt unfolds. Gaining experience with Gauging, leads to greater proficiency at determining which situations are hopeful and which are risky. Past experience with hypervigilance and continually assessing for danger risk with their abuser helps with staying safe within the system, as these past experiences contribute to the skill and accuracy involved in Gauging for Validation. Likewise, taking notice of mood and suicidal ideation helps in managing daily functioning, an awareness critical to the success of Hunting. Therefore, along with measuring System Entrapment by evaluating the ratio of validation versus invalidation, Gauging also measures the ratio of System Entrapment in comparison to Trauma Entrapment.
One purpose of *Gauging for Validation* is to figure out which is worse: experiencing *System Entrapment* in hopes of getting help from HCPs for the *Trauma Entrapment* or dealing with *Trauma Entrapment* without help. When the prospect of validation is hopeless within the system, dealing with *Trauma Entrapment* alone is determined to be the least dehumanizing option because the dehumanization within the system feels worse. Conversely, when the degree of dehumanization and validation related to the system is *Gauged* to be lower than the dehumanization and pain related to *Trauma Entrapment*, seeking help becomes the better option. In this case, there is enough hope fuelling the hunt within the system that they are willing to face *System Entrapment* for a chance to *Feel Human*. In all, *Gauging for Validation* opportunities is a continuous complex process of measuring a variety of factors and weighing risks and opportunities. This complex process occurs in both strategic and non-strategic ways.

**Means of Gauging.** *Gauging for Validation* opportunities occurs reactively or strategically. First, observing HCPs’ interactions provides a snapshot of the way that they respond to women in crisis and their attitudes toward suicidality. In this way, *Gauging for Validation* opportunities is achieved quickly and visually without even talking to the HCP. Women can spot negative attitudes by the way HCPs interact with each other or other clients, discouraging the disclosure of suicidality and expression of needs. A depreciating tone is easily noticed, for example, an HCP telling a woman who is sobbing and expressing hopelessness to “Cheer up!” Women believed that some of the HCPs’ language was a reflection of the HCPs’ underlying biases related to suicidality and distress. HCPs’ use of the terms “attention seeking” or “repeat-patient” contributed to
women’s belief that HCPs did not take their suicidality seriously or that they were being criticised for taking advantage of the system.

Secondly, *Gauging for Validation* occurs strategically with a pre-planned analysis over longer periods of time through contemplation and detailed observation. *Gauging* begins before ever approaching the system through careful consideration of whether help will be found. Before ever observing the behaviours of HCPs, fears of countless possible invalidation outcomes are imagined. Women cautiously *Gauge Entrapment* risk levels against validation opportunities for as long as possible to get closer to an informed decision on whether or how to navigate the hunt. With both kinds of *Gauging*, the aspects of the hunt that can be controlled are identified, making the movement toward *Feeling Human* clearer. Most times, however, a judgement is made that all signs point to dehumanization in which case a harm reduction approach is used by taking the path that leads to the least amount of *Entrapment*.

**Path of Least Entrapment.** The decision on how to seek help when all options appear hopeless is based upon minimizing the dehumanization from *System Entrapment*. *Taking the Path of Least Entrapment* is a guide that helps minimize exposure to invalidation despite being surrounded. This *Path* is also considered in managing *System Entrapment* in relation to *Trauma Entrapment*. That is, if *Trauma Entrapment* is higher than *System Entrapment*, taking any path within the system is better than the anguish of managing pain alone. The need to *Feel Human* and hope in the HCPs’ ability to be validating propels the hunt in the direction of the system. While the risk of *System Entrapment* still exists, the chance of finding relief while seeking help is worth the risk.
Taking the Path of Least Entrapment is identified in the Hunting diagram (Figure 6) with black lettering along the bottom of the diagram.

While Taking the Path of Least Entrapment is not a ticket to Feeling Human, it is a way of gaining a sense of control by guiding the hunt and providing some hope in getting closer to this goal. Beth took the Path of Least Entrapment by persisting to wait in the ED for the doctor despite hearing the ED nurses talk negatively about her. She decided that this was better than going home without medical treatment. Beth explained her decision by recounting her stance toward the ED nurses:

[In reference to the ED nurses], “So if you are not going to listen to me anyway and I'm going to sit here and wait for the goddamn doctor to see me, I don't give a rat’s ass if you don't believe me or if you were judging me as long as I end up getting [the psychiatrist] to help me.” So I think my will to live and my will to survive is craziness and that's what it was; craziness. … the will to get better was stronger than… having to put up with people judge me in the hospital.

The least dehumanizing choice was Gauged to be waiting for the psychiatrist in the ED while feeling invalidated by the ED nurses, treatment that was less dehumanizing than managing suicidality alone. Beth was willing to sacrifice feeling disrespected for a chance to Feel Human. The emptiness of low self-worth and isolation causes a deep sense of hopelessness, but the desire to feel differently maintains a slight sense of hope that dehumanization will be reduced. Gauging for Validation is the prefix for the Hunting sub-processes, providing the basis of how the hunt unfolds.

**Hunting Sub-processes**

*Hunting to Feel Human* moves beyond searching for validation to a variety of complex sub-processes of managing exposure to System Entrapment and attaining a sense of Feeling Human. Each sub-process is a different way of Hunting. During periods of lower level crises when cognitive abilities are less impaired, the sub-processes are more
strategic based upon risk assessments for *Entrapment* and opportunities to *Feel Human*. During periods of higher crises, the sub-processes occur without planning, but rather by making gut decisions in concert with how the hunt draws toward the least dehumanizing situations. The resources and opportunities for validation that exist within each context determine how the sub-processes are used.

The *Hunting* sub-processes are *Distancing from Help, Enduring System Entrapment, Grasping for Help, Applying Counter-pressure, Soaking in Validation*, and *Letting Go*. The sub-processes are listed in this order in black letters from left to right within the body of the *Hunting* diagram (Figure 6) and are separated into sections by black dotted vertical lines. Two continuums that run parallel to the sub-processes: (1) hopeless to hopefulness and (2) moving away from the system to moving toward the system. Hopelessness lines up with moving away from the system whereas when hope increases, so does moving toward the system. Gaining or losing hope is not a linear process; therefore, the sub-processes are fluid and run along a dynamic trajectory, possibly jumping from one section to another depending on the context.

*Figure 6.* Basic psychosocial process: Hunting to Feel Human.
The sub-processes in the diagram are listed in a sequence that fits the theoretical relationships within the hunt; however, the hunt does not unfold in this order. The ordering of the sub-processes differs among women, is always changing for each one, and not all use every one of the Hunting sub-processes. Nonetheless, the sub-processes illustrate a pattern of help-seeking that encompass a full range of variations for Hunting to Feel Human. The way that the sub-processes are used and unfold is outlined below in an order that best represents the pattern of Hunting and explains the journey in the most comprehensive manner. Where variations exist in the ordering of the sub-processes, theoretical explanations and how they expand the understanding of the basic psychosocial process are provided.

**Distancing.** Distancing from Help or from the system is a Hunting sub-process encompassing a movement away from health care services and HCPs as a way of evading invalidation and protecting against System Entrapment and is located in the first section from the left in Figure 6. Distancing from Help is the most common occurring sub-process, highlighting the significance of harm of System Entrapment. Gauging yields the judgment that System Entrapment will occur if help is sought; therefore, Distancing from Help is the best way to Take the Path of Least Entrapment. Distancing occurs within two conditions. First, Trauma Entrapment is at a lower level in comparison to System Entrapment. This ratio is represented in Figure 6 with the blue part, System Entrapment, reaching higher than the green part, Trauma Entrapment. Secondly, there is no hope in the system’s ability to be validating, a condition illustrated in Figure 6 with the dark hope line positioned at the very bottom in the Distancing section. Steering clear of the system is Gauged to be the best strategy as the need for help is not so high as to be worth risking.
encountering an HCP whose behaviour is perceived as invalidating. The consequences of Distancing are relief, a slight sense of agency, and a boost in Feeling Human. This outcome, however, is temporary, as Trauma Entrapment still needs to be managed during periods without health care services.

Distancing from Help has similarities to the management of Abuser and Trauma Entrapment. Distracting and escaping from the psychological pain related to past trauma and suicidality is akin to Distancing from Help as all the approaches seek relief from distress by avoiding the factors that lead to the pain. Whereas drinking alcohol distracts from or escapes the pain of suicidal thoughts, Distancing from Help avoids facing HCPs’ invalidating behaviour. Avoiding the intensity of the distress is a skill that is transferred from the suicidality and trauma experience to System Entrapment. This skill transfer, however, is not intentional. Women did not purposefully apply their method of avoiding suicidal thoughts to avoid HCPs’ invalidation, but rather, instinctively withdrew from System Entrapment after Gauging the situation to be dehumanizing. Distancing from Help can occur at any time before or after help is sought.

Distancing before ever approaching the system involves wanting help while remaining apart from the system for protection against System Entrapment. Distancing from Help at this time does not imply aversion to ever seeking assistance; however, the fear of dehumanization is motivation to Distance. The consequence of Distancing before approaching the system is that suicidality is managed in isolation for a long time before seeking professional help. Self-taught methods of soothing distressing emotions, escaping disturbing thoughts, and distracting from the urge to self-harm help to maintain safety without risking System Entrapment. Most Distancing before seeking help leads to
eventually seeking help; however, a variation of Distancing is that contemplation to seek help is as far as it goes. Women who experience a lesser intensity of Abuser and Trauma Entrapment may never reach out for help and are better able to manage suicidality with the help of personal supports, legal services, and greater financial stability.

Distancing from the system also occurs intermittently after having sought professional help. Eventually, the methods used to manage suicidality without professional help are no longer effective and Trauma Entrapment increases, at which point Hunting moves toward the system where invalidation inevitably occurs. If System Entrapment is Gauged to be more intense than Trauma Entrapment, then Distancing from Help is once again activated. The threshold for the degree of System Entrapment that is required to activate Distancing from Help depends upon the level of Trauma Entrapment within any given context. Jennifer knew that she needed help for her self-harm; however, after being unable to access a trusted past counsellor, she Distanced from Help due to fears of being “locked up.” She instead managed without professional help, “My therapy was just my mom pushing me to be human in a sense.” Whether Jennifer had been able to receive support from a trusted counsellor or managed without this help after Distancing, the goal either way was to Feel Human. Distancing from Help is enacted by responding to the system in the following ways: (a) removing oneself; (b) withdrawing; and (c) staying away.

Removal. Removal from the system involves leaving the system after having received services when System Entrapment exceeds Trauma Entrapment. Removal is swift when the opportunity for escape exists; for example, after growing tired and agitated while waiting for services in the ED, some women left the hospital. Depending
upon the involvement with the health care service, removal from the system varies between requesting to end participation in the service and escaping the service without the HCPs’ knowledge or permission. Removal is enabled through self-determination in making the choice to leave and a belief that removal will lead to self-protection. In some situations, strategic manoeuvring is required to escape the system. Maxine’s admission to the ED was on an involuntary status and she Gauged that the lack of proper treatment in the ED overpowered the need for professional help and did not justify taking the chance in waiting to see if help would become available. She described freeing herself from the HCP who was assigned to her for suicide watch by edging toward the entrance of the ED, pretending that she was trying to get better reception on her cell phone:

I wanted help but at the same time I don't see how it's going to help me lying in bed. You know if I had a proper doctor or counsellor… [The ED HCPs] had somebody babysitting me and I pretended that I was on the cell phone saying, “Can you hear me? Can you hear me now?” And as soon as I could, I ran out the [ED] door.

Being kept in a bed while an HCP observed Maxine without engaging her was objectifying and dehumanizing; therefore, Distancing from Help became the safest path to take.

Withdrawal. Withdrawal from the system is to remain emotionally distant from HCPs’ behaviour that is perceived to be invalidating by withholding private information, holding emotions inside, and keeping suicidal thoughts secret. Hiding vulnerabilities decreases the risk of being invalidated without having to Distance from the System altogether; therefore, treatment access remains. For example, when Gabrielle sought anxiety medication from her psychiatrist, she felt that he had minimized her trauma experiences. As a result, she withdrew from the relationship with the psychiatrist by
withholding IPV information. Gabrielle was able to limit further dehumanization while continuing to receive anti-anxiety medication prescriptions from him.

**Staying away.** The final method of *Distancing* is staying away from the system, involving the choice not to return for help after having withdrawn from the system. Similar to *Distancing* before ever seeking help, staying away is a form of self-protection that is used outside of the system altogether. Past *System Entrapment* was much higher than *Trauma Entrapment*; thereby, the dehumanization was at such an intense level that accessing help within the system was emphatically deemed not to be an option. After perceiving repeated invalidating responses when seeking help for multiple suicide attempts, Cassidy measured the risks and benefits of returning to the ED at her next suicide attempt. *Gauging for Validation* opportunities resulted in the judgement to stay away from the system:

>[After] trying to commit suicide… it made no sense for me to come [to the hospital] because I would feel shamed, so why come in? What’s the use? If ... I down a bunch of bottles of pills and wake up, well then almost the same thing would happen at the hospital so what’s the use. If I don’t wake up, well who cares. Or it’s just I achieved what I was looking to do… If I didn’t call them or nobody else called them, or I didn’t give anybody a reason to think I was in that situation [having attempted suicide], or that mind frame, meant I was either going to die or I was going to wake up, and for either thing, I wasn’t going to feel ashamed, or shamed by other people.

Cassidy figured that seeking help at the hospital for her suicide attempt would result in further invalidation; therefore, staying home, or risking death was less dehumanizing. *Distancing* is only effective until *Trauma Entrapment* becomes unbearable, at which point the tolerance threshold for system invalidation increases. In this case, hope that relief from suicidality can be achieved within the system increases and the *Hunt to Feel Human* refocuses on health care services.
**Grasping for Help.** *Grasping for Help* entails reaching out to the system during a suicidal crisis and occurs only when women feel their needs are urgent; therefore, it is like reaching for a lifeline. *Grasping for Help* is a desperate plea to *Feel Human* without explicitly communicating one’s needs. Overwhelmed with distress, women presented themselves within reach of HCPs in hopes that they would know how to help. Women called hotlines and presented at the EDs with limited cognitive capacity to articulate their needs, anticipating relief upon initial contact. Counting on HCPs’ validation does not mean that *Grasping* is a passive process, but rather, *Grasping* is an active process requiring energy to attain help swiftly.

Due to the time-sensitive nature of the need for help, *Grasping* most frequently occurs within a setting that provides 24-hour crisis or acute care services, including a suicide hotline, the ED, or a psychiatric unit. *Grasping for Help* within an acute care service is frightening as it involves exposing vulnerabilities to an HCP who is likely a stranger. *Grasping* occurs primarily with HCPs who work on rotational shifts in an environment that functions according to the staffing schedule or the system’s requirements instead of the women’s needs. For example, the nurses who gained women’s trust during the night shift were not available to support them in a crisis during the day shift. *Grasping* for help from an unfamiliar HCP is frightening, only to be forced to encounter another unfamiliar HCP a short time later due to changing shifts or HCPs’ transfer between service programs.

**Grasping for Help contingencies.** *Grasping* occurs when all the following exist: (a) a belief that their risk for harm is high; (b) a high level of hope that HCPs will be validating; and (c) a belief that their distress is deserving of professional help. These
conditions indicate that \textit{Trauma Entrapment} is greater than the \textit{System Entrapment}, a ratio reflected in the \textit{Hunting} diagram (Figure 6) with the green part slightly higher than the blue. Not all women fit the three requirements for \textit{Grasping for Help}, including not believing that the system can meet their needs and continue to \textit{Distance} without reaching out to the system.

\textit{High risk}. The first contingency to \textit{Grasping} is when the safety risk of intentional self-harm is high. \textit{Gauging for Validation} yields a prompt judgment that help is required. \textit{Distancing} from the system is no longer effective in protecting against \textit{Trauma Entrapment}; therefore, not seeking help becomes less of an option and motivation to seek help increases. Figure 6 reflects this context where the green \textit{Trauma Entrapment} part is higher within the \textit{Grasping} section in comparison to the height of the green in the \textit{Distancing} section. Anticipating relief through validation, \textit{Grasping} feels like a battle when met with \textit{System Entrapment}. Merely making a request for help does not match the urgency of the situation at a time when suicidality is very high; therefore, \textit{Grasping for Help} by eagerly and demonstratively pressing to be heard is needed to best meet the need.

Exasperated from being prescribed ineffective anxiety medications, Jane attempts to convey the urgency of her situation by showing the HCP an image of a poster that describes anxiety that has reached excessive limits (see Figure 25):

\begin{center}
\includegraphics{poster.png}
\end{center}

\textit{Figure 25}. Jane used the “Excessive Anxiety” poster to alert her HCP of her needs.
I went to my psychiatrist and… there was something wrong with my pills. My pills were not working and I was having a lot of anxiety, a lot of crying, and everything was not right and I thought I will take a picture of that [poster] and then I brought it to him and I said like, “Things are not working out.” I said, “You have to change my pills!”

Jane felt compelled to alert the psychiatrist about how bad her anxiety had become by showing him the photo, a mode of communication that amplified her verbal requests. The need for relief is high; therefore, the intensity level of reaching out is high. *Grasping for Help* is akin to gasping for air and just as air is required for survival, so is validation during suicidality.

*High level of hope.* The second contingency for *Grasping* is having a fairly high level of hope in the system’s ability to help, illustrated with the dark hope line approximately at the mid-point of Figure 6. The perception is that any intervention will be helpful because nothing is worse than the high level of *Trauma Entrapment* at the time. Ridden with anxiety and intense suicidal thoughts while riding her bike one day, Jesse spontaneously approached a police officer in hopes that he or she would bring her to safety:

Things were so bad then … I had my grandmother’s rosary with me and I was pretty much like, “I’m going to go find a police officer.” … I locked up my bike and went for a walk and I was just like in such a state of mind, like a really bad state of mind, but as soon as I saw an officer I was like, “Can you help me? I am a danger to myself and others.” … “Can you take me to the hospital?”

Jesse needed immediate assistance to keep herself safe. She placed herself in a vulnerable position by *Grasping for Help* from the police officer, an undertaking that was made easier with hope that she would find assistance.

*Deserving of basic needs.* The third and final contingency for *Grasping* is a feeling of being at least somewhat deserving of help or that their distressing situation warrants having their basic needs met. Feeling somewhat deserving is indicative of
Feeling Human and is reflected in the steep climb of the pink area within the Grasping section of the Hunting diagram (Figure 6). When distress is very high, women feel they deserve respect for basic human rights, including the right to live; therefore, they are more motivated to communicate their needs. Valerie clearly and confidently repeated to her psychiatrist that her priority was her personal safety: “[I told him], ‘I’ve gotta be safe.’ For years, everything I would say would have safe in it. I have to get to where I am safe.” Knowing that HCPs take physical safety more seriously, women feel more deserving of help and have greater confidence to Grasp for Help when they are at risk of harming themselves. Believing that ending suicidality will not occur without HCPs’ help also contributes to feeling deserving.

**Grasping consequences.** Grasping consequences are illustrated with a blue arrow pointing out of the Grasping section toward the left-hand side of the Hunting diagram (Figure 6), away from the direction of the pink part that represents Feeling Human. Movement away from Feeling Human at this point is the result of HCPs most common response to Grasping, invalidation; thereby, urgent needs are minimized and unmet. In fact, Grasping for Help is the strategy that leads to the highest levels of System Entrapment throughout the entire Hunting to Feel Human journey. The anticipation of Feeling Human is shattered when women are not able to connect with an HCP, as illustrated by Ann’s photo of a phone that appears broken on the floor, "To me this represents helplessness because the phone is not working so I can't call for help so I feel alone and cut off" (Figure 26).
Figure 26. Ann’s image represented being without the means to connect to others for help.

Blocked attempts at meeting urgent needs contribute to dehumanization and a sense of being undeserving. Jane explained her belief that the crisis hotline HCP invalidated her:

I called twice and [the HCP] told me to deal with it...[the HCP said], “You can't [attempt suicide]! Go to the hospital...Ok bye! I hope you don't do it!”... [I] get off the phone, I slammed the receiver, and then I walked off.”

Being told what to do was dismissive of Jane’s agency and minimized her suicidality, worsening her distress. Feeling defeated, dehumanized, and hopeless that HCPs will be helpful after Grasping for Help, Distancing from Help occurs as was the case when Jane “walked off.”

An exception to invalidation as a consequence of Grasping for Help is when women reach out to an HCP with whom they have already established a trusting relationship. In contrast to fleeting relationships with various HCPs, trusting relationships are usually those with HCPs who work on a regular schedule, for example, a counsellor or physician within the community. Receiving services from a consistent HCP provides continuity and the opportunity for trust to develop. Considering the immediacy and danger risk while Grasping, a successful outcome depends upon the HCP’s accessibility. Flexibility with the HCP’s schedule and willingness to respond to women’s crises outside of appointment times is imperative to validation.
Before the initial *Grasp for Help*, the hunt is focused inward on the distress and health needs. Ways of communicating the distress is not a significant concern as the belief is that the crisis will speak for itself. The assumption is that the HCPs will see the distress and take it seriously; however, once they feel invalidated and still have a high risk level, have hope of finding help, and still feel deserving of help, they discover that *Grasping* must turn more outward. *Grasping* in this way is a more obvious display of distress symptoms so that the HCPs might see the full extent of the problem and take it seriously. Women must raise-the-stakes and use a stronger version of *Grasping* to offset the invalidation. The pressure and intensity of *Grasping* is turned up by *Applying Counter-Pressure*, a transition illustrated with the blue arrow emanating from the bottom part of the *Grasping* section toward the left symbolizing having just encountered *System Entrapment*.

**Applying Counter-Pressure.** *Applying Counter-Pressure* involves women standing up for themselves in the face of repeated rejection, an indication of *Feeling* a bit more *Human* and deserving of help. *Applying Counter-Pressure* is used in self-defence to counteract being trapped and to fight for their lives. This is reflected in slight increases of the pink area or *Feeling Human* within the *Applying Counter-Pressure* section located on the left-hand side of the *Grasping* section, in the middle of the *Hunting* diagram (Figure 6). *System Entrapment* is at the highest level outweighing *Trauma Entrapment*, demonstrated in Figure 6 with the blue section rising above the green. *Trauma Entrapment* is at a mid-level with decreasing cognitive function and goal-directed behaviour making it difficult to remain calm; however, energy needed to fight back is not completely depleted as when *Trauma Entrapment* is at the highest level. Nonetheless, the
intent of Applying Counter-Pressure is to convince HCPs of the critical nature of suicidality and the need for help. Applying Counter-Pressure occurs when a particular service is perceived to be the last chance for help. Women believed that the HCPs had the power to provide security within their services; therefore, feeling like they had nothing to lose, they made a last effort to Feel Human by pushing back on System Entrapment.

Applying Counter-Pressure is a response to power imbalances that occur most frequently within the hospital, a setting where clients’ movements, behaviours, and interactions are restricted. Lauren was restrained on a bed by her arms and legs when brought to the ED for overdosing on pills, placing her in a physically and mentally vulnerable position. Grasping for Help by trying to get the psychiatrist to listen to her, Lauren fought back:

I just said to [psychiatrist], “You aren’t listening to me!” [Psychiatrist responded] “Well nothing is wrong with you, [Lauren]” [I responded] “OK, why am I here? Why am I doing this all to myself?” Then they had to… restrain me… I tried to get away. The nurse said, “No, we aren’t letting you go.” I said, “Well, take these off of me!”… I was so like out of it that I just… [said] “Let me go! Let me go!”... I was mad and I was trying to get them off.

Applying Counter-Pressure was the only way to defend herself against not being heard and placed in restraints, treatment that dehumanized Lauren and resulted in feelings of being completely out of control.

Despite feeling overwhelmed, Applying Counter-Pressure requires great strength to emphasize reasons for being in crisis, the urgency of the need for help, and the risk of self-harm. More energy is available to Apply Counter-Pressure as Trauma Entrapment is not at its highest level at this point and since System Entrapment is higher than Trauma Entrapment, women have more energy motivation to push against the coercion they are receiving from the system. This is illustrated in the Hunting diagram (Figure 6) where the
blue part, *System Entrapment*, is higher than the green part, *Trauma Entrapment*. The following properties contribute to *Applying Counter-Pressure*: (a) knowing what works to increase access; (b) proving that the suicidality is urgent; and (c) having a willingness to risk death in order to be taken seriously.

**Knowing what works.** Knowing how the system functions helps guide the *Application of Counter-Pressure* by providing a boost of confidence and sense of deservingness. Knowledge acquired over time by *Hunting to Feel Human* in different contexts and settings provides information on the kind of health conditions, situations, and symptoms that limit access and treatment. Women learned that the best return on *Applying Counter-Pressure* is to have access to a service; for example, seeing a psychiatrist in the ED, being admitted to the hospital, or being assigned a counsellor. Knowledge gained regarding available services and client rights informs how to *Apply Counter-Pressure* more effectively to maximize access. Multiple help-seeking interactions for suicidality give women greater knowledge of how the system functions and how to gain access. Knowing the right things to say and do in order to trigger HCPs’ obligation to provide access to services expedites *Applying Counter-Pressure*. The discovery is made that access is not granted on the basis of suicidal thoughts nor pointing out to the HCPs the injustices of *System Entrapment*. Rather, communicating suicide plans or the desire to attempt suicide increases the chance of being taken seriously, a technique that some women used in order to gain access to services and to get closer to *Feeling Human*.

**Proving their case.** *Applying Counter-Pressure* is a way of proving their case to the HCPs, hoping to earn their way into the system. Women had very limited time to
make their case with the HCP; therefore, they Applied Counter-Pressure skilfully by expressing their emotions and details of the suicidality clearly. Communicating anger is a way of Applying Counter-Pressure with intent to correct the injustice of not receiving help, including repeating in detail the extent of health problems, questioning HCPs’ treatment decisions, calling the HCP out for being disrespectful, and making requests about other treatment methods besides medication. Applying Counter-Pressure also entails expressing the extent of how bad the suicidality can be while not actually feeling that way at the time of the interaction with the HCP.

Due to suicidality not being at the highest level during Applying Counter-Pressure, the HCP may not directly observe the extent of the problems when providing care. Further, suicide crises are temporary and the levels of intensity oscillate, sometimes within a short period of time; therefore, during the wait to see a HCP, the intensity of the crisis may diminish by the time they see someone. Demonstrating the extent of their distress during the time that they are with the HCP was thought to be the best way of relaying the urgency of their needs. Women believed that it was the only chance of getting help and the time needed to be used wisely; therefore, they presented with the most distressing emotions and suicidality even if they were not feeling that way at the time. Communicating the reality of suicidality occurred by crying, withdrawing from answering questions, self-harming while close to HCPs, or relaying to HCPs that self-harm potential will increase if help is not received.

**Risking death.** Although women amplified the distress to convince the HCP to help them, the increased demonstration of suicidality was genuine. They were willing to risk their lives to get help. Verbalizing a suicide plan or attempting suicide communicates
high danger risk of dying by suicide. Further, the chance of receiving help increases with higher lethal attempts. The outcome is usually receiving treatment in the ED or a hospital admission where the physical symptoms are addressed, but not necessarily the emotional problems. When Gabrielle’s pleas to have her depression medication adjusted were ignored, her suicidality increased along with her motivation to communicate her need for help. Either way, ending her life or persisting for help had the same goal, to end her psychological pain. Gabrielle described communicating the intensity of her need for distress relief through a suicide attempt:

It took me a long time to get my doctor to listen. To make my doctor listen, it took for me to take an overdose… And once I took the overdose, that the next couple of days after I was in the hospital, my doctor came to see me and he said, “What is wrong? You look like you're mad!” [I replied], “Yes I am! I am very mad! I'm tired of being drugged! I'm tired of crying! I'm tired of everything! Do something for it!” And I was crying and I was screaming and he said, “You're very emotional!” and I said, “Yes I am! So I think that's all I have to say.”

Risking her life for the chance to be validated was somewhat accomplished by being admitted for a medication change; however, Feeling Human was limited as a result of her perception that her physician’s behaviour was invalidating.

Elevated risk for death is further demonstrated by Veronica who had been feeling invalidated for weeks in the psychiatric unit. She fought to be validated by telling an HCP about her suicide attempt soon after she overdosed on pills. Aware that HCPs’ discovery of her overdose would activate their emergency response to treat the overdose, she attempted suicide and communicated this in hopes of being relieved of dehumanization. Veronica knew that the overdose would not kill her immediately; however, she was willing to risk her life to have her distress validated. The intention was to die slowly from the overdose, providing a window of time before her death for others to recognize the degree of her suicidality and demonstrate compassion. The genuineness of suicidality or
risking death is also evident in the willingness to give up autonomy and face the most coercive interventions, including the loss of consent to treatment through the New Brunswick Mental Health Act (1973). While losing autonomy is otherwise avoided to prevent System Entrapment, it is welcomed when the need for help is great enough.

Eventually, the need to Feel Human goes beyond receiving validation for being at risk for bodily harm, to being validated as a person in pain. Grasping for Help and Applying Counter-Pressure do nothing to increase HCPs’ compassion and validation for living a dehumanizing existence. Added to this is being judged for being angry and out of control when Applying Counter-Pressure. Women were left feeling exasperated afterwards, prompting a break from this fight and hope that Enduring the Entrapment will avoid further invalidation.

**Enduring System Entrapment.** Enduring System Entrapment is a Hunting subprocess of tolerating invalidation and conforming or meeting the expectations of the system. Instead of trying to convince the HCPs that they are in urgent need of help, women put up with the invalidation. Accepting the fact that validation is limited helps to Endure the dehumanization, an acknowledgment that releases the urge to demand better treatment. Acceptance does not mean agreeing with the invalidating treatment, but rather acknowledging their limitations in changing the system and controlling HCPs’ responses and interactions. Enduring provides a sense of stability because it is the only thing women believe that they have control over at that time. Enduring is visible within the second section from the left in the Hunting diagram (Figure 6).

**Enduring** is a way of Taking the Path of Least Entrapment in hopes of preventing dehumanization from worsening by continuing to request help. Feeling undeserving,
women blamed themselves for the poor access, aiding their willingness to put up with System Entrapment. Enduring is also enabled by little expectation or hope for the system to be helpful. Women also believed that invalidation was an indication that requesting help bothered the HCPs; therefore, Enduring aims to prevent irritating the HCPs by keeping the peace. Help-seeking behaviours are adapted by making allowances for the system’s limitations, resulting in a less dehumanizing outcome.

Stefanie Endured HCPs’ invalidation and adapted her help-seeking to prevent worsening System Entrapment. When Stefanie presented to the ED or called the crisis line, she perceived that the HCPs either did not believe her suicidality or they blamed her for being in crisis. The HCPs would say that they could not do anything to help and that she ought to manage the suicidality with the distress tolerance skills she had learned:

They really want to get rid of you if you have called more than once. … So if you are in a crisis you don’t want to hear "Use your skills" …It is like, hello? I am calling you… like I am calling you for help! I am calling you to talk with.

Stefanie believed that the HCPs had unrealistic expectations. Her photo of a rock (Figure 27) explains how she felt pressured to cope on her own: “[This picture represents] people telling me I had to be strong, solid like a rock, to be able to stand by myself.”

Figure 27. Stephanie felt pressured to be as strong as a rock.
The pressure to be completely independent was overwhelming. Stefanie *Endured* the expectation to be strong like a rock by pushing herself to manage her chronic suicidal thoughts without assistance.

It is only by myself trying to figure out what was going on and reading and learning... It has helped… not has always helped the suicidal feelings or ideations or attempts, but it does help to make sense of certain things that lessen the suicidal ideation so I don't have to go to the hospital. So it has lessened it so [the ED HCPs] don't see me as often.

Stefanie tried to accept that the HCPs were invalidating by managing the suicidality for as long as she could on her own in hopes that she would not have to return to the ED.

*Enduring System Entrapment* is a similar approach to bearing the burden of *Abuser* and *Trauma Entrapment*. Suicidality, IPV, and HCPs’ invalidation are *Endured* for periods of time due to the belief that efforts to free from *Entrapment* are futile or a sense of being stuck in unbearable distress and hopelessness. Whereas women keep the peace by following the abuser’s demand to never leave the house, women keep the peace by following the system’s rules to remain seated in a crowded ED waiting room during a panic attack. The belief is that isolating within the house decreases the abuser’s anger outbursts and choosing not to talk to the HCPs in the ED waiting area decreases the number of invalidating interactions. In both situations, upsetting the person enforcing the rules is avoided. *Enduring System Entrapment* prevents dehumanization from worsening at the very least, but the best outcome is *Feeling Human*.

The most striking consequence of *Enduring* is that validation most frequently occurs in response to this *Hunting* sub-process. Validation in response to *Enduring* is illuminated in the *Hunting* diagram (Figure 6) with the yellow arrow jutting out from the top of this section, leading to *Feeling Human*, the largest section of the pink area. Jesse describes earning validation in the ED waiting room:
[I told the ED HCP], “I have been here for 12 hours, like I am pulling my hair out. Help me!”… I feel like the doctors are like, “You’ve waited 12 hours. We are ready to take you seriously.”

Despite the *Entrapment* of the waiting area, Jesse reaped the benefits of conforming to the long wait because she was able to obtain the medication she needed for her anxiety.

*Enduring System Entrapment* occurs within two different contexts: (a) when access is blocked and (b) while receiving services within the system. Within both contexts, being without access or feeling invalidated while receiving services, *Enduring* is neither passive nor a sign of giving up, but rather a skill of courage and stamina in feeling the dehumanization without running from it.

**Blocked access.** Blocked access to the system is *Endured* because the urgency of suicidality is not high enough to warrant fighting for access. In other words, *System Entrapment* is higher than *Trauma Entrapment*. Fighting for access is overwhelming; therefore, the blocked access is *Endured* to avoid increasing their distress levels. *Enduring* blocked access is evident on the left side of the *Enduring* section of the *Hunting* diagram (Figure 6) where the blue part, *System Entrapment*, is a bit higher than the green part, *Trauma Entrapment*.

Being rejected by the system leads to a feeling of living in exile and feeling more dehumanization than before help was sought. The bit of hope for validation that exists upon entry to the system diminishes when access is blocked. This low level of hope is illustrated with the dark line in the lower left side of the *Enduring* section. Carrisa’s image of a Take-a-Number-Dispenser helps to explain *Enduring* poor system access as she and the other women in the study had to wait for services at every turn (Figure 28).
Carissa felt forgotten while waiting for services and powerless to obtain more timely help. Believing they had no other options, the women in the study Endured the wait time by acknowledging the lack of options and going through the motions of waiting in isolation.

*Endurance of System Entrapment* also occurs when blocked access is anticipated before ever approaching the system. While contemplating seeking help for suicidality, System Entrapment occurs when it is discovered that options are limited or they are afraid of being judged when approaching the system create a feeling of being locked out and having nowhere to turn. When the urgency for help is lower while *Enduring* the blocked access, it overlaps with *Distancing from Help* because it involves staying away from the system. This process is positioned at the border or the dotted line between the *Distancing* and *Enduring* sections in the *Hunting* diagram (Figure 6).

*Entrapment within the system.* Enduring also occurs after gaining access while directly interacting with HCPs. *Trauma Entrapment* is slightly higher than System Entrapment as illustrated in the right side of the *Enduring* section in Figure 6 where the green part is a bit higher than the blue part. Both *Entrapments* are also at their highest
peak within the entire help-seeking journey because the invalidation perceived during interactions with the HCP is perceived to be the worst *System Entrapment* and yields the greatest levels of dehumanization and *Trauma Entrapment*. The hope is that *Enduring* invalidation will avoid: (a) *Distancing from Help* and losing access altogether; and (b) irritating the HCPs by *Grasping for Help*. Trapped between these *Hunting* sub-processes, women managed by conforming to or following along with the system’s coercion. Despite losing power from following the some of the HCPs’ rules, conforming helps to maintain access to the service while simultaneously preventing irritating the HCPs with requests.

*Distancing from Help* is avoided while *Enduring* in hope that more help will become available. The slight increase of hope is illustrated with the slight elevation of the dark line at the bottom of the *Enduring* section in Figure 6. Access to a community health clinic meant that Alanna had to wait long hours for help with high anxiety and suicidality causing her distress to worsen. Despite the urge to escape the situation, she felt compelled to stay since she had already invested hours in waiting for her turn to see the physician:

I had been seeing this doctor several times in the walk-in-clinic and every time I quite literally want to leave, but [decided to stay because] I have been waiting a couple of hours. Horrible.

Alanna maintained access to the physician by conforming to the wait time. *Distancing* is even less of an option in the case of being treated under involuntary status under the law and attempts at leaving or fighting the system results in stricter system restraint. The police were called to find women in this study who fled the psychiatric unit, forcing them back to the hospital. Upon return to the psychiatric unit they experienced greater degrees of *System Entrapment*, including being locked in seclusion or having to *Endure* the HCPs anger regarding their attempts to flee.
Tempering requests of HCPs is a way of adapting to the system’s demands. Despite wanting help when having suicidal thoughts in the psychiatric unit, Latoya conformed to what she believed were the psychiatric unit HCPs’ expectations to not bother them when they were doing other things including talking to each other in the nurses’ station:

I look at the nurses, they have other stuff to do than just to see the clients. So… they are getting meds ready… I don't know… and they are doing whatever they are supposed to be doing, so they are not available at all times. There should be someone who is available at all times… They just wouldn't bother with me. And some nurses made you feel like you were bothering [them] …This didn't help my depression because you feel like you have nobody to go to. I shouldn't have to wait to see someone… I felt more like I would be disturbing somebody …maybe they would not listen as much because they had other stuff to do.

Taking cues from the HCPs, Latoya conformed to what she perceived to be the routine of the psychiatric unit; that HCPs are too busy to help the clients and they will respond with invalidation if approached. Careful to let the HCPs be, Latoya adapted to the isolation of the psychiatric unit and often managed her suicidal thoughts alone. Ann explained why she put up with HCPs’ lack of engagement on a psychiatric unit: “I hate to bother people.” Her sense of burdensomeness led her to suppress her emotions:

Like in the hospital, it’s awesome that they will keep you with the camera, but nobody talks to you… Well like, the doctor only goes in once a day and it’s only like two minutes and he asks you how you are doing. I don’t know. There… is staff that can talk to you… If you are depressed or something, they will sit down and watch movies and you try not to cry.

While Ann talks about the possibility of talking with the HCPs, she did not feel safe to share and felt the need to hold back tears.

Women may still make their needs known despite the fear of invalidation without Grasping for Help or Applying Counter-Pressure. Downplaying the distress, gingerly conveying the need to talk, being careful not to convey criticism toward the HCPs, or not
soliciting the HCPs’ help at all increase the chance of being validated. Ann was unable to receive validation as a result of directly seeking help from the psychiatric nurses as she felt intimidated approaching the closed doors of the nursing station. She was eventually validated by an HCP while she was keeping to herself in her room:

There was one [nurse] that came in my room and she sat there and she talked to me for a little bit, probably 20 minutes and I thought, “Geez! I really appreciate that.” 20 minutes really made a difference.

Other examples of receiving validation while Enduring include receiving a follow up phone call from an incoming crisis hotline or receiving a hug from an HCP during an encounter in the community.

*Enduring System Entrapment* is a way of Taking the Path of Least Entrapment or preventing invalidation from worsening; however, *Trauma Entrapment* is not necessarily prevented from worsening. When validation is received, regardless of it being in response to *Enduring* invalidation, *Feeling Human* increases. The transition from being validated toward *Feeling Human* occurs through *Soaking in Validation*.

**Soaking in Validation.** *Soaking in Validation* involves absorbing HCPs’ empathy and integrating it as a part of the self-concept, elevating the degree of *Feeling Human*. *Soaking In* occurs at any point within the system depending upon whether the HCP is perceived to be validating at that time. Though not always a conscious process, HCPs’ efforts to understand and believe suicidality and past trauma are quickly identified through HCPs’ validating verbal communication, attentive facial expressions, and open body language. Women had a sense of what they needed to *Feel Human* and when it was recognized, it was *Soaked In. Soaking in Validation* is positioned in the second section from the right side of the *Hunting* diagram (Figure 6) where the pink section is nearly at
the highest point. *Trauma* and *System Entrapment* are significantly lower, as evidenced by the green and blue parts sloping downward.

Validation more often occurs after *Enduring* but is also dependent upon the chance of getting an empathetic HCP. *Soaking in Validation* is not a passive receipt of HCPs’ care, but rather an active integration of validation through recognizing it, accepting it, and finding meaning through it. Shelby became more self-aware and insightful about her problems within a safe and open relationship with her HCP:

Like, [my HCP] is amazing. I don’t know what I would do without her… I just know there is more meaning to life… You don’t need to go and end your life just because you are having problems in life… Everybody has problems… I am grateful that… like I don’t know if I would [have made it if I] hadn’t met her… it’s really great. I got a little bit more confidence talking to her. Every day I talk to her when I leave I feel better about myself, just getting everything off my chest.

Shelby *Soaked In* the security when her HCP offered to explore her suicidal thoughts, changing the way that she thought about her life and how she managed her problems.

Accepting validation involves believing that HCPs are authentic. Validation is genuine when HCPs convey concern on an emotional or personal level rather than as only a part of their job. Trust is gained when the HCPs consistently convey acceptance with their words, body language, and actions. Women were given choices and were made to feel that they were not weak or to blame. Accepting validation is transformative as it is integrated within the self-concept, elevating the sense of personal value, belongingness, hopefulness, and freedom. *Soaking in Validation* alters the lens through which problems are viewed, shifting the sense of being trapped and allowing in a bit of light to see possibilities beyond suicide.

*Validation from other clients.* *Soaking in* high levels of *Validation* also occur with other clients who understand what it is like to have a history of trauma including
IPV and suicidality. Interactions with other people who are going through similar experiences occur naturally between clients within a psychiatric unit or members of an educational group at a community mental health clinic. Other clients who understand suicidality are almost always validating, particularly within the context of validating HCPs who foster peer relationships. Gina describes the benefits of meeting other clients in a psychiatric unit:

We all hung together. There was a group of us. … We had fun. We laughed. … We were able to share. … We were helping each other … That’s why a lot of us in there grew. We grew together. I used to go in the groups. … Each time I went, something different would be in my life and I was able to share that. Many people helped me in my life and I was able to give back in their life. … I was able to sit down and really share it all with them… open up and let them know what we can get out of life if we work hard and, you know, get to where we are today.

Not only was Gina able to obtain support from the other clients, but also helped them within their recovery journey, giving Gina meaning and a higher self-concept.

Jesse also explained the benefit of having met other clients within the psychiatric unit with her photo of candles (Figure 29).

![Figure 29. Candles represent Jesse’s recovery among her peers.](image)

Lit candles represented the collective of other clients with whom she received a sense of belongingness:

Once you do get admitted to the hospital, you meet other people in there that are going through the same stuff so you’re not alone. But it’s like you are alone when you’re not in the hospital; when you’re on the outside [of the hospital].
Jesse was grateful to have sought help and to have accessed peer support, something that she had not been able to find outside of the system.

**Reciprocation.** The consequence of *Soaking in Validation* is reciprocation with the HCP, a relationship where a personal connection is made by relating to the HCP as a fellow human being. That is, HCPs reciprocate their human vulnerability by acknowledging their human fallibility; an understanding that reduces women’s feelings of inferiority and increases a sense of belongingness. Jocelyn’s HCP’s willingness to interact with her outside the context of formal therapy by helping her paint a prayer statue that provided hope and meaning contributed to their reciprocation. This simple action decreased the power that a therapist can have over the client and instead helped to nurture meaning. Likewise, Carissa identified that she needed, “someone to listen, someone to talk to, non-judgmental, there’s to be no therapy, no professional intervention.” Lee described reciprocation from the HCPs “talking to me like they were non-professionals.” Reciprocation acts as a safety net by providing a sense of *Feeling Human* for longer periods of time beyond the short periods of contact with the HCP.

Reciprocation from an HCP leads to women’s sense of responsibility and accountability toward the provider. After learning to trust her HCP, Yolande resisted self-harming knowing that her HCP was counting on her to stay safe.

And [my HCP] told me "I am not leaving this house until you tell me that you are not going to [attempt suicide]." She stayed for the longest time and I had promised her that day that I would not do something to myself. And when she started coming every week… there were sometimes that I did not want to answer the door and then when I started to realize… something [positive] is going to happen for me and then when she started [to help me], we started to talk… because when you get that bond with them…it doesn't hurt because you have a special bond with these people and they trust you and we trust them… because if we need [to ask]… “Am I doing this right? You think I should do this? You think
I should do that?” And like I feel like they have a good say with me and I really really appreciate their opinion.

Reciprocation occurred over time as the relationship became mutual and they learned to trust each other, an important factor that transcends the confines of the HCPs assigned role. Reciprocation helped to decrease Gabrielle’s suicidality in addition to helping her with other personal problems. She also believed that being understood and shown patience helped in getting through problems even after overcoming suicidality. Using her image of the “Understanding” title in a book (Figure 30), Gabrielle explained:

“With understanding and patience, you can find a way through any difficulty,” and if you do have that from the [therapeutic] groups or you have that from your counselling… if they understand you and they have the patience to listen to you, you might find a way through anything that you can conquer.

Figure 30. Gabrielle believes that understanding is the key to Feeling Human.

Reliance and self-determination. Reliance on HCPs is a property of connecting with validating HCPs and is a medium toward gaining more independence and agency. Reliance does not imply loss of autonomy. Believing the system was the only option for distress relief during suicidality, women relied on the HCPs for a sense of belonging and validation. The perception that relying on others for help infers weakness is dispelled during reciprocation from an HCP as women became stronger by defying feelings of insecurity. Giving HCPs a chance while working hard to maintain a sense of agency within the relationship, illustrates self-determination. Mobile crisis HCPs were prepared to place Lee on an involuntary status and bring her to the ED during a suicide crisis. Lee
quickly learned to trust the HCPs because they welcomed her to partake in the decision-making, motivating her to work with the HCPs in maintain her safety. Lee recounts, “[The intervention] wasn’t controlling because I made the decision in the end… they kept making it seem that they cared about me.”

Acknowledged for their pain and feelings of powerlessness, women got a breather from the chaos of suicidality when received reciprocation from an HCP, a break that provided space to take stock of their emotions and gather their thoughts. The capacity to gain control and reduce suicidality increases once heard, believed, and understood, decreasing the reliance on others. Validation from HCPs, however, is always Soaked In regardless of having moved past suicidality and with a growing sense of agency. Soaking in the highest level of Validation allowed women to let their guard down with HCPs by Letting Go.

**Letting Go.** Letting Go is the last section in the Hunting diagram (Figure 6) with the highest levels of Feeling Human and lowest levels of Entrapment evident with the predominance of the pink area and considerably smaller green and blue areas. Once feelings of security develop from reciprocation, the power dynamics shift and the focus drifts away from the need to take back control; allowing for Letting Go. Less fearful of being invalidated and more confident in being taken seriously lessens the urge to protect from System Entrapment and increases the capacity to share vulnerabilities with HCPs. Letting Go is evidence of trusting one of more HCPs. Letting Go involves handing over some of the control to the HCP, as described by Sherri:

> It was my family doctor that I trust the most, so I usually go to him for everything… I kind of have these nice talks about who he thinks would be a good person to refer to or …I kind of let him guide…he made all the referrals to Mental Health and Family Enrichment.
The key factor in the ability for Sherri to Let Go is trust.

Different intensity levels of Letting Go are based upon a sense of safety with each HCP. Initially, Letting Go might only mean not having to constantly Gauge the environment for Entrapment risk, including being on guard for HCPs’ judgmental body language, freeing up energy to delve into difficult emotions. As comfort with HCPs grows, the tolerance level for the system’s restraint is increased, for example, interpreting rules as less dehumanizing. Women in the study were relieved to Let Go of some of the pressure related to managing suicide and allow HCPs to guide the care even if it meant temporarily not having as many treatment decisions. Women Let Go of the need to control the situation while admitted to the hospital on an involuntary basis when a trusted HCP was present. Letting Go of the need to control and protect against invalidation is evidence of having a greater sense of agency and self-worth that is required to decrease suicidality.

Letting Go involves releasing some of the fear of being judged and feeling safe enough to divulge vulnerabilities. Gabrielle’s Believe photo (Figure 31) illustrates how she Let Go after feeling accepted within a therapeutic group for women who have experienced IPV:

![Believe Photo](image)

*Figure 31. Gabrielle learned to believe in herself.*

I went to [abuse shelter] and they said, “Look at yourself in the mirror” and I said, “I can’t.” I couldn’t. But now I can look myself in the mirror and I can say, “You
know what? I may not see a pretty woman, but I see a person with a smile on her face. Not with tears in her eyes that wants to go sit in the corner and cry, go down and take her life just because somebody else wants control…45 weeks in the abuse center helped…I would tell anybody to go to support group and learn all these things.

Gabrielle felt secure in the therapeutic group, allowing her to explore her insecurities, believe in herself, and to Let Go of how the past trauma controlled her life. With the help of the group, Gabrielle came to terms with her past trauma and learned to accept herself. Letting Go is an indication that Feeling Human is elevated and suicidal risk has greatly decreased, freeing up space and energy to explore how to manage living.

**Interconnections of Hunting Processes**

The Hunting to Feel Human process is a dynamic journey comprised of interconnected sub-processes and relationships between major concepts within the theory. Variations within different contexts and how opportunities for validation are Gauged will determine how the hunt unfolds; however, general patterns of Hunting exist throughout the journey of seeking help. The Hunting to Feel Human sub-processes not only occur separately, but also overlap according to changing circumstances. When validation levels oscillate or the ratio between System and Trauma Entrapment changes, the sub-process is replaced by another. This transition does not occur abruptly, but rather there is overlap and change may happen gradually. For example, Distancing may begin while Enduring is ending. Similar processes thread throughout the management of Abuser, Trauma, and System Entrapment, increasing the understanding of how women go about Hunting to Feel Human. When feeling out of control, Entrapment is either Endured, fought, or averted.

**Entrapment intensity.** Two formulas of Entrapment intensity influence the Hunt. First, the ratio of intensity levels between Trauma and System Entrapment determines
which sub-process is used. System Entrapment is higher than Trauma Entrapment in both Distancing and Applying Counter-Pressure. Second, the total intensity level of Trauma and System Entrapment combined determines whether Distancing or Applying Counter-Pressure is used. Distancing is used when System Entrapment is greater than Trauma Entrapment, but also when both levels of System and Trauma Entrapment are lower. Women avoid the system when they do not feel high levels of suicidality and believe that managing the pain using personal resources is better than seeking help. System Entrapment is also at a lower level while Distancing. At this point, treatment has not been forced through the NB Mental Health Act (1973) or injustice has not reached a point where fighting back is required. Applying Counter-Pressure occurs when System and Trauma Entrapment are at the highest levels. Along with a sense of being deserving and hope that the system will be validating, the need for help with suicidality is urgent and despite high levels of System Entrapment, pushing back occurs. Higher intensities of both types of Entrapment indicate that dehumanization is greater; thereby, increasing the will to Feel Human.

Entrapment Patterns. Abuser, Trauma, and System Entrapment share common patterns. Abuser and Trauma Entrapment are intertwined within System Entrapment and are contexts through which the theory is situated. First, the sense of being controlled within Abuser and Trauma Entrapment is similar to the sense of being controlled within System Entrapment. Second, Abuser and Trauma Entrapment are managed through Distancing and Enduring.

Feeling controlled. Women in the study drew parallels between Abuser and Trauma Entrapment and System Entrapment as they felt controlled and dehumanized by
the abusive partner, suicidality, and some HCPs’ invalidating interactions. Stefanie perceived that the HCPs grew tired of seeing her in the ED with repeated suicide crises and she would often feel worse having sought help. She compared the HCPs’ treatment with the abuse from an intimate partner.

You can go [to the ED] and suffer worse than if you were being abused by your partner because you leave there feeling like you are worthless even if you tell them you were suicidal, it is not taken seriously. They almost refuse to treat you. They refuse to talk to you. You are just worthless.

Stefanie believed that the pain experienced from having been invalidated by an HCP is akin to being abused. Past IPV and suicidality amplified the dehumanization of feeling invalidated by HCPs. When she perceived the HCPs within the ED to be uncompassionate, she believed this was confirmation that she was undeserving of compassion.

Jane also describes how having been controlled within Abuser and Trauma Entrapment created a vulnerability to dehumanization. Jane felt intimidated and pressured by an HCP to open up about her distressing feelings while in the hospital:

[The HCP] said, “But Jane, we have to know. You know, the thing is, we can only help you if you tell us.” So I said, “Well I will tell you a little bit. That is how I will start, with a little bit but I won’t tell you everything.” [I wouldn’t open up] because he was superior than I was. …He needed to earn my trust, yeah…. He was older than I was and he made me feel like “You have to tell me!”… I said [to the HCP], “I have been told what to do my whole life; my mom, my [abusive] ex-husband. I don’t need this!” Then I went out.

Jane’s perception of the HCP’s demand was experienced through the lens of her past.

Being told that she had to talk about her problems led to a sense of being trapped because she did not feel safe talking about her pain and felt overpowered by his authority.
System Entrapment related to the feeling of being controlled by medication also parallels Abuser Entrapment. Michelle described the intersection of Abuser, Trauma, and System Entrapment when she was admitted to a psychiatric unit:

Michelle: [The psychiatric unit HCPs] are in control every day. They are in control of when you take your medications. They control how you feel. Sometimes I take my medications when I am upset. I can’t cry because [the medications] are controlling my emotions. It’s like you are trapped inside your body most of the time…

Petrea: And how is that different from being trapped in an abusive relationship?
Michelle: Um, it’s not really, is it? …It definitely is pretty much the same if you think about it.

Michelle describes System Entrapment as being controlled by medication, through HCPs’ authority over the medication administration and the side effects that blunted her emotions. This System Entrapment experience was further heightened in intensity by the memories of feeling coerced during IPV.

Distancing and Enduring. Managing the different forms of Entrapment also share similarities. Distracting from Trauma Entrapment is similar to Distancing from Help. In both processes, the Entrapment is overwhelming and relief is sought by escaping the distress. Managing suicidality by numbing the pain with substances or cutting and managing the feeling of being invalidated by HCPs by fleeing the system are ways of evading dehumanization. Women have an unconscious back-up plan to manage distress when unable to attain help during suicidality. They hope to find relief through help-seeking, but when they do not, they are able to regulate some of the pain.

Bearing the burden of Abuser or Trauma Entrapment is similar to Enduring System Entrapment. Women bore the burden of their abuser’s and some HPC’s demands as not to upset them further. Women tolerated suicidality and mental health conditions by simply experiencing the symptoms, for example, accepting that the consequence of
depression is extreme fatigue and sleeping most of the time. Acknowledging the feeling of being controlled, women tolerated it by remaining silent, isolating, and doing what was expected of them. Ann explained how she Endured the belief that the HCP’s were disinterested in her problems by holding back from explaining her needs to the HCP. She compares this sense of worthlessness and lack of deservingness to bearing the burden of a past abusive partner who ignored her needs. Within both relationships, Ann put up with the mistreatment and did not fight for her needs:

Sometimes you feel like you're not worth explaining [to the HCPs] because when you are in an abusive relationship they make you feel like you were this big [gesturing a tiny measurement with her fingers]. You don't count. You don't matter. [My abuser would say], “Oh you are lucky that you have me. You should consider yourself fortunate for what you have.”

Ann attributed her difficulty seeking help to having been abused. Feeling undeserving of HCPs’ validation, women Endured or put up with being misunderstood. In all, System Entrapment prolongs the pain and dehumanization of Abuser Entrapment and worsens Trauma entrapment; however, some level of freedom from Entrapment occur while Hunting to Feel Human.

**Hunting to Feel Human Summary**

*Hunting to Feel Human*, the basic psychosocial process of women’s help-seeking for suicidality after IPV is used to manage System Entrapment, the basic psychosocial problem. System Entrapment is the result of invalidation, causing dehumanization and loss of control. Hunting to Feel Human seeks to increase a sense of value as a human being through HCPs’ validation. Feeling Human is sought by Gauging Validation opportunities that inform which Hunting sub-processes to use in order to Take the Path of Least Entrapment and maximize freedom from dehumanization within the system.

Validation is Soaked In and integrated as part of women’s self-concept. High levels of
validation through sharing mutual humanity or reciprocation from HCPs allowed for

_Letting Go_ of the need to protect against judgment and dehumanization. Trust in HCPs

creates a secure environment in which to work on moving beyond suicidality and toward

living. Validating women in the study did not require grand gestures from the HCPs, but

when women are taken seriously, the effect on _Feeling Human_ is palpable and has a
direct impact on continuing to live.
Chapter Six: Discussion

_Hunting to Feel Human_ is a vital addition to the literature as no other studies on patterns of women’s help-seeking for suicidality after leaving an abusive partner exist in the literature. A modest level of knowledge on suicide help-seeking and a confident level of knowledge on IPV help-seeking and health outcomes exist; however, these two topics are usually studied separately. _Hunting to Feel Human_ is understood through a critical lens, feminist ethical theory, a philosophical underpinning that challenges the status quo bio-physiological paradigm in which the large majority of suicide research is conducted. Knowledge of women’s mental health is strongly influenced by the medical model that focuses on biology or internal factors while socio-political forces and women’s perspectives of trauma are devalued (Remer & Oh, 2013; Tseris, 2013). Psychology, traditionally an area of study grounded in absolutism and the attribution of expert knowledge to professionals, has branched out into more critical paradigms that acknowledge multiple ways of knowing and dimensions of health (Alvelo, Maquire, & Knauss, 2016; Grabe, 2016; Krischner & Martin, 2010). _Hunting to Feel Human_ is in line with the latter worldviews, focusing on women’s standpoint in getting help.

Most of what is known about suicide, epidemiological data, risk factors, and treatment outcomes, derives from the medical model, while help-seeking behaviours, contextual factors, and evaluation of suicide interventions from the clients’ perspective is secondary. The suicide literature is limited due to correlational studies about risk factors, limiting the understanding of a complex and multifaceted human behaviour. Although some studies illustrate perceptions of health access barriers, particularly in youth, the bulk of suicide help-seeking research measures the prevalence of visits to HCPs. _Hunting
to *Feel Human* expands the knowledge of help-seeking by illustrating a variation of contextualized behaviour over time. This theory also zeroes in on and expounds women’s perspectives, experience with IPV, and patterns of behaviours related to suicidality. Complexity of the theory is illustrated through a description of continually changing relationships between life sustaining and life impeding factors. The relentless battle for acceptance is also demonstrated with rich descriptions of women’s needs during a time when their safety was most at risk. Dynamic processes are added to the literature including how past trauma influences motivation to seek help, what happens when help is not received, and in which circumstances help is received.

Humanity, a concept that has been studied since ancient times, is a new addition to the understanding of suicide prevention and recovery. While highly abstract and laden with varying connotations, the concept of humanity is explored specifically in relation to women’s help-seeking and provides clarity and pragmatism to a complex topic. Relational aspects of the *Hunt to Feel Human* are echoed in the body of knowledge on suicidality and treatment, including feeling hopeless and the need for interpersonal support. Being blamed or not taken seriously for being suicidal and having experienced IPV also parallel what is known about seeking help after having experienced IPV. In all, the traditional medical model has shaped the current state of knowledge though a focus on symptomology (May, 2010) and attempts to find ways of changing or controlling suicide behaviours. *Hunting to Feel Human* disrupts the assumptions that frame dominant knowledge on suicide and highlights the power differentials within: (a) an abusive intimate relationship; (b) a culture that stigmatizes mental illness and suicide; and (c) the health care system.
**Entrapment**

*Entrapment* is not a new concept within the literature. IPV is widely understood as coercive control and entrapment is a term used to explain reasons for suicide; however, *System Entrapment* is a new term. Isolation and loss of control while seeking help for suicidality is consistently found; however, characterizing this process as feeling trapped has not been documented. While the sense of being trapped is not foreign to the suicide or IPV literature, *Hunting to Feel Human* illustrates the continuity of *Entrapment* that threads throughout the entire journey.

**Abuser Entrapment.** *Abuser Entrapment* underscores the influence of IPV on suicidality, a finding that is well established within research (Lamis et al., 2017; Shamu et al., 2016). *Abuser Entrapment* directly coincides with the finding that “being trapped” (Hicks, 2003, p. 457) within an abusive relationship and being dominated by men (Niehaus, 2012) contributed to women’s suicide attempts. The impact of IPV, however, is overlooked in the psychiatric literature and clinical standards. Service provision that aims to address the health consequences of IPV have been explored using a feminist lens (Brown, 2017; Wuest; Ford-Gilboe, Merritt-Gray, & Berman, 2003), a paradigm that allows for the identification of the socio-political impact of violent trauma. *Abuser Entrapment* is also supported by the language and meaning of the Partner Violence Entrapment Scale, a tool that assists in recognizing that women remain in IPV relationships due to worrying about the well-being of her children, herself, and the abusive partner if they were to leave (Torres et al., 2016). The cycle of violence is a well-known model describing patterns of partner abuse through a vicious cycle of tension build up, violence, and reconciliation that feels nearly impossible to escape (Walker,
The cycle of violence relates to *Abuser Entrapment* by feeling stuck in the tension build up stage where women devote considerable time and energy averting violent outbursts.

The key characteristic of *Abuser Entrapment*, a sense of being controlled, is well established within the literature; however, the findings of this study extend our knowledge of women’s resistance. The theory of learned helplessness (Walker, 2005) has influenced mainstream understanding of IPV, depicting abused women as being powerless victims. Learned helplessness has linked IPV with PTSD and depression (Bargai, Ben-Shakhar, & Shalev, 2007), removing focus from the violence and attributing mental health problems to women’s deficits. The implication of the term learned helplessness is that women have the choice to end the abuse; however, they believe that they are incapable (Walker, 2009). To assume that the inability to leave is attributed to women’s faulty beliefs implies that women’s perceptions are not valid. Onlookers who do not understand the complexities of IPV believe that a woman should and can leave her abusive partner, and when she stays in the relationship, they judge her as being foolish for putting herself in harm’s way. Fixating on women’s deficits in the learned helplessness theory imparts a victim-blaming connotation (Kelly et al., 2011; Magnusson & Marecek, 2017), an assumption that is individualist and that contradicts how external factors are acknowledged within *Abuser Entrapment*. *Abuser Entrapment* is supported by Wuest et al.’s (2003) study of how single mothers promoted their family’s health while limiting ongoing intrusion after leaving an abusive partner. *Abuser Entrapment* also entails striving to manage the violence, protect the family, and manage their mental health symptoms.
Abuser Entrapment contradicts the sense of self-blame inherent within the learned helplessness theory. While women felt that they contributed to problems within the IPV relationship, they were aware that the abuser’s behaviour was harmful and wrong. Regardless of inner strengths or deficits, the certitude of being without options as a result of an abuser’s coercion leads to feelings of being out of control, a process supported by Stark’s (2013) theory on IPV coercive control. The literature supports Abuser Entrapment with descriptions of literal forms of being trapped, including choking and barricading women in the home, and figurative forms of being trapped, including losing access to loved ones and finances (Stark, 2013). Despite awareness of being trapped, complete hopelessness does not set in as women in the present study remained vigilant for changing circumstances that may provide an opportunity for escape. Women did not learn to be helpless, but rather kept fighting in the face of Abuser Entrapment.

Knowledge of the relationship between trauma and psychiatric pathology originates from the literature on childhood abuse and war veterans (Herman, 1992), overlooking the gendered nature of violence and other socio-political factors (Moulding, 2016). Without a critical analysis of the determinants of health, the complexities of suicidality, depression, and other mental health difficulties are overlooked, including a minimization of past trauma. Hunting to Feel Human allows for a broader conceptualization of IPV and validation of women’s realities; for example, Abuser Entrapment emphasizes external factors that are exerted upon women rather than attributing women’s precarious situation merely to internal factors that render them helpless. Wuest et al. (2003) used a feminist approach to identify how ongoing harassment, health consequences of past trauma, social and economic difficulties of
single parenting, and bureaucratic barriers within community services intruded upon women’s lives, contributing to negative health consequences. A feminist approach in the present study involved a contextual analysis of constraining external factors related to IPV, challenging the myth that the solution is to leave the relationship. With little opportunity to free from the violence, even after leaving the relationship, intersecting forces inhibiting women’s capacity are acknowledged with the term *Entrapment* as it implies being contained and restrained from all sides. Loved ones’ expectations to keep the family intact, HCPs’ minimization or disbelief of IPV, and the threat of having children removed from the home as a result of seeking help are evidence of societal misconceptions that amplify the *Abuser Entrapment*. Confirmation of the power impact of socio-political factors on the negative health consequences related to IPV is an important contribution to the literature.

An unexpected finding with *Abuser Entrapment*, that the perceived intensity level of IPV did not determine the intensity level of suicidality, is supported by findings from Cavanaugh et al. (2015). Some participants who perceived lower levels of IPV experienced high frequencies of suicidal thoughts and others who perceived higher levels of IPV had experienced lower levels of suicidal thoughts. These findings are reinforced in a study that found levels of violence intensity did not determine help-seeking patterns (Ford-Gilboe et al., 2015) and another study that found responses to traumatic events vary depending upon the person’s context (Stein, Friedman, & Blanco, 2011).

**Trauma Entrapment.** *Trauma Entrapment* provides a unique perspective on a heavily studied topic, suicide, and also aligns with features of current suicide theories. The term *Trauma* is an acknowledgement of the impact of IPV on suicidality, an
important addition to the literature as the role of IPV in suicide assessment and intervention is absent. The work of Durkheim (1951, 2001), a pioneer epidemiologist in suicide, aligns with the recognition of socio-political influences on *Trauma Entrapment* as he identified patterns of suicidality across various populations and deduced wider social determinants that influenced this phenomenon. Gendered factors, however, were not the focus of Durkeim’s theories, a missing piece within the literature that *Trauma Entrapment* addresses. The present study deconstructs the homogeneity of how men and women’s experiences are represented within suicide research. The dominant focus in the suicide literature is on deaths in comparison to suicide thoughts and attempts, reflecting men’s experiences more so than women’s considering men die by suicide more frequently (WHO, 2014, 2017). *Trauma Entrapment* helps fill this gap with women’s perspectives of suicidality within the context of pre-existing power imbalances of having experienced gendered violence. Other socio-political factors recognized within *Trauma Entrapment* are reinforced in a study in which female gender and immigrant status contributed to suicidality related to a loss control over education, marriage, and career (van Bergen & Saharso, 2016).

The term *Entrapment* aligns with many suicide theories in relation to feeling hopeless, having restricted choices, and believing that all avenues lead to pain. The commonality that threads through most suicide theories is lack of access to alternative options in managing life’s difficulties and escaping psychological pain (Gunn, Lester, & Yang, 2014), a notion that substantiates *Trauma Entrapment*. *Trauma Entrapment* is particularly supported by the Theory of Despair and Entrapment, a model that is used to explain depression and characterized by a “desire to escape from a situation, while
perceiving that all possible means of escape are being blocked” (Gunn et al., 2014, p. 38).

Although not widely recognized within the psychiatric literature, this theory has been found to account for depressive symptoms (Bernstein, Lee, Park, & Jyoung, 2007; Carvalho et al., 2013; Kouwenhoven, Kirkevold, Engedal & Kim, 2012) and suicidality (Lester, 2015; Ng, Simplicio, McManus, Kennerley, & Holmes, 2016; O’Connor, Smyth, Ferguson, Ryan, & Williams, 2013; Panagioti, Gooding, & Tarrier, 2015; Yaseen, Galynker, Briggs, Freed, & Gabbay, 2016; Zaheer et al., 2016), particularly in women (Lester & Leenars, 2016). The Theory of Despair and Entrapment purports that depression is imprisonment of the mind due to the hopelessness and despair of being controlled within a disparaging situation (Gilbert & Allan, 1998), including within a depressed state (Gilbert & Gilbert, 2003). The sense of being trapped (Crona, Stenmarker, Öjehagen, Hallberg, & Brådvik, 2017; Gooding et al., 2015b) and dehumanized (Zaheer et al., 2016) also correlates with suicidality in other studies. In response to feeling out of control, suicidality has been found to be an attempt at gaining control (Pavulans, Bolmsjö, Edberg, & Öjehagen 2012), a finding that supports the present concept of *Trauma Entrapment*.

The Interpersonal Theory of Suicide (Joiner, 2005), one of the more current suicide models gaining traction within mental health (Michel, 2011), attributes the desire to die or continue living with the quality of relationships (Michel, 2011) and describes suicide as an interpersonal act (Glaesmer et al., 2017; Jobes & Ballard, 2011). Joiner wrote that thwarted belongingness, feeling disconnected from others, and burdensomeness, the thought that others would be better off without the person, are associated with suicidality. Thwarted belongingness (Chu et al., 2017; Hill & Pettit,
2012; Woodward, Wingate, Gray, & Pantalone, 2014), burdensomeness (Gunn, Lester, Haines, & Williams, 2012; Lester & Gunn, 2012), and both of these factors combined (Chu et al., 2017; Monteith, Bahraini, & Menefee, 2017; Silva, Ribeiro, & Joiner, 2015) have been validated within research, supporting the essence of Trauma Entrapment. The interpersonal aspect of Trauma Entrapment is also supported by the finding that burdensomeness and thwarted belongingness were associated with PTSD symptoms in women seeking shelter from IPV (Smith et al., 2016).

Trauma Entrapment conflicts with theories that give the impression that suicidality is a sign of weakness or one is deserving of personal blame. Learned helplessness, a theory that also applies to depression, is thought to be the result of subordination that leads to a sense of defeat and reduces the inclination to escape (Forgeard et al., 2011; Gilbert, 2000; Maier, 2001; Maier & Seligman, 2016). Although Hunting to Feel Human aligns with the conception that coercive powers limit self-determination, it refutes the implication within learned helplessness that past failed efforts to avoid adverse events lead to passivity and renunciation of protecting oneself. Behaviours within Trauma Entrapment are active and often effective in reducing levels of despair and loss of control. Aware of the Entrapment caused by fatigue, psychological pain, and flashbacks, women in the present study persisted in regulating adversity and dehumanization.

Minimization of external factors and the implication within the literature that responsibility for suicidality resides with the individual is refuted within Trauma Entrapment. The standard for suicide treatment based on the ideology that suicidality is the result of faulty thinking, CBT (Beck, 1976, 2016), places ownership of one’s
suicidality with the individual. Deficient in reasoning abilities, the suicidal person’s view of the future is distorted, leading to hopelessness and withdrawing from life (Beck, 1976; 2016). While Trauma Entrapment involves cognitive distortion and hopelessness, it expands beyond internal factors exploring wider ranging suicide influences. The importance of seeing beyond cognitive abilities is supported by Rudd and Brown (2011) who wrote that CBT fails to support the most important aspect of suicide treatment, the therapeutic relationship.

**System Entrapment.** The invalidation within System Entrapment is substantiated by well documented accounts of women’s experiences being minimized while seeking help for IPV (Kelly, 2011). System Entrapment however, is a new addition to the body of knowledge on IPV because literature is scant regarding help-seeking specifically for suicidality after IPV. Specifically, the concept of being trapped while seeking help for health problems related to IPV is new. Alternatively, several characteristics of System Entrapment are supported by much of the literature on the treatment of suicidality and other mental health crises.

Schools of thought on treatment for suicidality that assist in comparing System Entrapment to the current literature are: (a) medical and (b) relational. System Entrapment occurs in the context of the medical model, a paradigm that centers on symptomology. Feeling Human and moving away from System Entrapment aligns with the relational school of thought, focusing on strengths and interactions with others. The relational school of thought is essentially a critique of the medical model, challenging underlying assumptions that maintain power imbalances within society and the health care system. Ocampo and Pino (2014) align with System Entrapment by writing that
mental health problems are portrayed as medical illnesses that can be cured by scientific knowledge and technologies, touting the HCP as having rescued the mentally ill while ignoring others ways of knowing within marginalized populations. Tseris (2013) parallels the commentary within *System Entrapment* that feminist treatments, such as relational counselling where problems are managed through connections with others, are overshadowed by bio-physiological based treatments.

The main focus within *System Entrapment* is supported by the literature on clients’ perspectives of mental health treatment. Nearly all Canadian studies between 1997-2014 reported that clients had received unhelpful treatment within psychiatric units due to coercive rules and difficult relationships with the HCPs (Cutcliffe et al., 2015). Feelings of worthlessness and the perception of being personally attacked when being controlled within *System Entrapment* is similar to Synder and Dishion’s (2016) description of coercion: controlling others by manipulating their emotions. Coercion is not limited to hospital psychiatric units. Women in a forensic unit felt that their trauma experiences were not recognized, preventing them from accessing urgent health care (Rossiter, 2015).

Concepts from the field of bioethics provide new insights into the ethics of gender-based oppression within health care, reinforcing *System Entrapment* indicators. Autonomy and freedom have become increasingly more significant with modern health care ethics (O’Neill, 2002; Secker, 1999), principles that women in this study perceived to be deficient during help-seeking due to being told what to do and how to feel. The justification to sacrifice autonomy for what the HCP considers important for the client’s *own good* is a theme within the body of knowledge on suicide, a paternalistic rational that
supports the meaning of System Entrapment. Feminist ethics principles expose a hierarchical dynamic where the clinician is assumed to be the expert and the client is a passive recipient of knowledge (Griscti, Aston, Warner, Martin-Misener, & McLeod, 2017; Norcross, 2010). The expert-patient dyad and the dominant brain-based model of mental health are challenged, exposing broader factors that contribute to women’s trauma responses (Tseris, 2013).

**Coercion.** The risk of harm in relation to restraint and consent are well documented, supporting the coercion that occurred within System Entrapment. Women in the present study were treated as if they were unaware of their needs and not permitted to make their own treatment decisions, a finding supported by other studies where clients were coerced into entering psychiatric services (Fiorillo et.al., 2012; Gowda, Noorthoorn, Kumar, Nanjegowda, & Math, 2016; O'Donoghue et al., 2014). Coercion through an involuntary psychiatric admission may be legal when the risk of suicide is high; however, the precipitating factors for physical restraint (Hottinen et al., 2013; Simpson, Joesch, West, & Pasic, 2014) and involuntary status (Seo, Kim, & Rhee, 2013) have been found to not meet legal criteria. Women were not given the dignity-of-risk or respect that comes with being afforded the opportunity to make their own decision regardless of the potentially harmful outcomes (Deegan, 1992; Ibrahim & Davis, 2013; Slayter, 2007). These studies parallel not having a voice and feeling trapped within the Hunting process.

A more frequent and impactful form of coercion occurs within a relational context, as in the case of not feeling heard or being taken seriously. Coercion perceptions were also found in the literature to be positively associated with HCPs’ disrespect more so than involuntary status or other forms of physical restraint (Höfer, Habermeyer,
Mokros, Lau, & Gairing, 2015; Lorem, Hem & Molewijk, 2015; Sheehan & Burns, 2011; Strauss et al., 2013; Tinglef et al., 2017). The interpersonal nature of System Entrapment is recognized within the literature: that different levels of harm derive from coercive interactions, including deteriorating the therapeutic relationships (Hotzy & Jaeger, 2016) to feeling imprisoned within a tyrannical mental health system (Nyttingnes, Ruud, & Rugkåsa, 2016). System Entrapment that occurs even before approaching the health care system is supported by findings that pre-existing fears of family physicians’ treatment of depression influenced help-seeking (Rogers, May, & Oliver, 2001). Participants felt humiliated by coercion within mental health services including being forced to take medication during a crisis, an intervention that they perceived to cause more harm (Nyttingnes et al., 2016). System Entrapment provides additional insight into the context of coercion through conceptual relationships with Trauma Entrapment and Feeling Human, illustrating a process of losing control and managing the problem.

Lacking in the literature is the impact of HCPs’ subtle judgments such as those discovered in System Entrapment. Among the sparse studies examining the impact of HCPs interactions, moralizing statements worsened suicidality in clients on a psychiatric unit (Vante & Naden, 2014). Clients in an addiction treatment program felt judged by HCPs who pressured them to stop using substances while neglecting to help them meet basic needs including food and shelter (Lago, Peter, & Bógus, 2017). Tseris (2013) brought to light how women diagnosed with a personality disorder characterized by chronic suicidality are judged as being incapable and blamed for their emotional problems. She writes that women in crisis as a result of past trauma and expressing psychological pain are judged as “attention seeking, as opposed to [having] a genuine
psychiatric illness” (Tseris, 2013, p. 155). This literature is consistent with System Entrapment which demonstrates the negative impact of feeling judged, increasing the pain of not being heard and the desire to die. The insidious dehumanization and invalidation while seeking help is missing from academic and clinical treatment of suicide; therefore, insights from System Entrapment add to the present body of knowledge.

Findings of this study that the feeling of being controlled occurs more often within acute psychiatric units is reinforced historically in well documented notions of psychiatric units being restrictive and inhumane. Nguyen-Finn (2012) writes detailed accounts of the mistreatment of people with psychiatric illnesses within asylums and institutions since the Middle Ages. Michel Foucault was the first to identify power imbalances within psychiatry and that treatment in institutions is more disciplinary in nature than therapeutic (Foucault et al., 2006). It is widely understood that psychiatric units are intimidating due to the fear of being locked in, stigmatization, and of HCPs making all the decisions. Power imbalances were identified within Johnston and Kilty’s (2015) feminist analysis of an Ontario forensic psychiatric unit revealing a paternalistic culture where staff valued physical intimidation and behaviour modification over partnerships with the clients. Tubbs (2013) also wrote about psychiatric treatment: “The needs of the system become ends-in-themselves, replacing the needs of those that the system is supposed to serve.” (p. 478). This literature substantiates the findings of the current study where women believed that the routine of the unit took precedence over personalized care.
The finding that System Entrapment also occurred within the community, including waiting lists and unaffordable counselling, is supported by a few studies on non-institutional coercion. One study demonstrated that homeless women with a history of violent trauma perceived a lack of urgent help; for example, being mandated into counselling in exchange for health care without helping them with higher priority needs including shelter (Huey, Fthenos, & Hryniewicz, 2013). Clients were found to have perceived coercion while on a community treatment order, a law that mandates treatment outside of a locked facility (Pridham et al., 2016). System Entrapment provides evidence that coercion and dehumanization can occur in non-acute settings.

**Parallels with Abuser Entrapment.** Difficulty accessing help within the system after having experienced past trauma is not new. The feminist literature recognizes how the trauma of being oppressed within systems and institutions combined with violent trauma make women particularly vulnerable to negative health effects (Brown, 2017). System Entrapment illustrates how women were dehumanized within the system after having been dehumanized within an abusive relationship; the latter increasing vulnerability for the former. Likewise, a large body of literature on trauma-informed care draws awareness to the risk of re-traumatization within health services in people with past trauma (Harris & Fallot, 2001). Distrust in others as a result of past trauma or fear of reaching out due to fears of being re-traumatized is also well established (Clapp et al., 2014; Kantor, Knefel, & Lueger-Schuster, 2017).

Although coercion is known to occur in an IPV relationship and during treatment for suicidality, the invalidation and dehumanization process during these periods adds new understandings. A vital insight is that feeling controlled within System Entrapment
through the perception of HCPs’ invalidating behaviour is strikingly similar to IPV control. Keeling and Fisher’s (2015) study supports this finding as they found that women perceived HCPs’ dismissive responses to their IPV disclosure as “align[ing] to the behaviour of the perpetrator” (p. 2370). *System Entrapment* mimics IPV through emotional, cognitive, spiritual, and physical coercion that leads to worsening psychological pain and suicidality. In all, *System Entrapment* is a rare look at the barriers in women’s help-seeking for suicidality after IPV, providing rich, substantive theory to the current body of knowledge on suicide.

**Feeling Human and Philosophy of Humanity**

Exploring the literature on humanity, a fundamental feature of philosophy scholarship, is helpful in understanding *Feeling Human* and how it fits within the body of knowledge of women’s help-seeking. Ontological inquiry about humanity in philosophy provides insight into the meaning of being alive, ethical concerns, consciousness, and behaviour. For example, feminist literature acknowledges that Western conceptualizations of humanity have been created through power inequities, excluding women and other oppressed groups from receiving or achieving humaneness (Antony, 1997; Walker, 2002). Comparing the meaning of *Feeling Human* to the literature on humanity, including sections on morality/self-value, reason, separatism verses holism, dependency, and interpersonal aspects, illustrates how *Feeling Human* is situated within the literature.

**Morality and self-worth.** Many interpretations of humanity are conceptualized in relation to morality. Morality is defined as codes of conduct by which people ought to live (Gert & Gert, 2017) or to do the right thing (Kuic & Simon, 1986). Within *The
Blackwell Dictionary of Western Philosophy, humanity is described as exemplifying morality (“Humanity,” 2004). Mill (1863) writes, “the end of human action is necessarily also the standard of morality” (trans. p. 17). Kant’s deontological school of thought that has influenced Western society with the ideology that humanity embodies morality or to be human is to do the right thing (Glasgow, 2007; Hill, 2006) contradicts Feeling Human. Kant purports that humanity is based upon good intentions regardless of consequences (Glasgow, 2007; Hill, 2006), whereas Feeling Human exists regardless of right or wrong behaviours. Intentions, actions, and consequences are not value laden or judged as being good or bad as Feeling Human does not discriminate. Human worth is justified by having human needs and emotions. The quest to Feel Human is not motivated by good will, but rather the urgent need to no longer be dehumanized. Nonetheless, Kant’s categorical imperative that human beings are to be ends in and of themselves or people ought to be treated in a way that recognizes the inherent dignity within all human beings (Hill, 2006) aligns with what women sought while help-seeking, to Feel Human.

Aristotle wrote that all people are equally human (Ward, 2008) and that to be human is to have internal needs (Hacker-Wright, 2009) and a predisposition for self-love or self-preservation (Drum, 2013), an ideology that parallel women’s need for belongingness within Feeling Human. Aristotle also believed that human need is consistent with what is right (Hacker-Wright, 2009) and to be human is to flourish through the use of virtues (Lemos, 2007; Spencer, 2007). Philosophies using language about what is right or wrong may be misinterpreted as being judgemental because people who are suicidal might be alerted to the value-laden language, fearing that they are expected to act in a certain manner. Feminist literature supports Feeling Human with the
contention that socio-political factors beyond one’s control influence one’s humanity, rendering people who do not fit the mould or the dominant natural law as being less valuable (Antony, 1997; Weitzel, 2003). The language within the *Hunting* theory conveys that to be human is sufficient and that there is no expectation to be *more* human. Tubbs (2013) wrote that a person’s humanity exists because the person exists, but mere consciousness of this existence leads to a sense of objectification, whereas attaching meaning to this consciousness avoids objectification and dehumanization. This notion parallels the finding that *Feeling Human* is awareness of one’s value simply for being human. Further, Aristotle’s notion that the goal of humanity is happiness and that humanity is an end in and of itself (Spencer, 2007) reinforces the goal of *Hunting*, to feel better by *Feeling Human*.

Carl Rogers (1951), a psychologist who had the greatest impact on the study of human behaviour during the 20th century (Witty & Adomaitis, 2014), strongly supports *Feeling Human* with the theory that providing unconditional positive regard for the client is the most effective way to help (Martin, 2017; Rogers, 1962). Rogers also wrote that achieving self-worth in the context of relational power dynamics is a goal of humanity (Kass, 2015; Rogers, 1962: Rogers & Skinner, 1956), a belief that strengthens the *Hunt to Feel Human* by freeing from the disempowering social isolation and stigma related to suicidality. Similarly, Benson, Gibson, and Brand, (2013) wrote that awareness of one’s existence is fragmented during suicidality, leading to a low sense of agency and creating the desire to gain control by re-integrating with the world. A contrast is Rogers’ (1962) idea that becoming human or becoming “fully himself” involves obtaining the approval of others or being “socialized” based upon the need to be liked by others (p. 30). Shaping
one’s behaviour to attain acceptance of others within society (Rogers, 1962; Rogers & Skinner, 1956) is an important part of living in community and getting along with others; however, it differs with the crux of Feeling Human. Feeling Human involves feeling valued despite displaying feelings and behaviors related to suicidality that are stigmatized and misunderstood by other’s within society. Not having to meet expectations in order to be accepted makes Feeling Human possible. Similar to a morality context, humanity risks being interpreted as being conditional or something that is earned. Feeling Human offers a different lens for understanding help seeking, unconditional acceptance obtained through validation of all and any suicidal experiences.

Acceptance is central to DBT (Linehan, 1993a, 2015), a treatment that some of the participants of this study received. One of the goals in DBT is to lessen suffering by accepting the reality of one’s distressing situation, in particular events that are beyond one’s control (Linehan, 1993a, 2015). Clients learn to analyze their problems with rational thinking by observing the event and describing it without judgment (Linehan, 1993a, 2015). Some women in this study who received DBT found that the skills they acquired were used against them upon seeking help in crisis. Women who sought help in crisis after exhausting all of their coping strategies including DBT skills were met with HCPs’ expectations to deal with the problem by using their skills without offering other guidance or support. Finally, DBT runs the risk of undermining Feeling Human if women are encouraged to accept things beyond their control without providing space for identifying socio-political barriers to their well-being.

**Reason.** Philosophers who influenced Western thought, including Kant (Frierson, 2005; Spencer, 2007; Stekeler-Weithofer, 2007), Hegel (Stekeler-Weithofer, 2007) and
Marx (Elias, 2016; Leiman, 2011) believed that the essence of humanity is reason and deliberation. Kant’s theory of humanity posits that reason is the driving force for making decisions on one’s own behalf (Hill, 2006), resulting in freedom (Frierson, 2005). This study is reinforced by Kant insofar that freedom is implicated with *Feeling Human* and is the result of no longer feeling *Entrapped*; however, logic has limited influence in this process. The extent to which reason is valued within society has the potential to shape the way that help-seeking is conceptualized. People in crisis might be looked down upon and not taken seriously when their cognitive abilities are compromised. The HCP might be perceived as being the “reasonable” expert, rendering the person in distress with less power. Judging groups of oppressed people as being less reasonable than another group “risks contributing to the tradition of epistemically discrediting these people” (Hay, 2011, p. 28). While reason aids in help-seeking and deliberation is crucial for *Gauging Validation* opportunities and developing agency, *Feeling Human* is a sense of value derived from a feeling of belonging and validation. Although Aristotle recognized reason as being an important aspect of human flourishing (Drum, 2013; Ward, 2008), he along with Hobbes (Tucker, 2016), believed desire motivates human action. Their work supports the importance of self-worth and acceptance within *Feeling Human*.

**Separatism verses holism.** *Feeling Human* is reinforced by Hegel’s school of thought that humanity is holistic, a unification of the internal self and the exterior world (Tucker, 2016) and Aristotle’s belief that the mind and body create a whole person (Gillet, 2013; Merker, 2012). *Feeling Human* implies that humanity cannot be broken down into individual sections because one’s internal and external surroundings, including biology and cultural forces respectively, cannot be separated. Mental and physical health
is simultaneously impacted in response to internalizing HCPs’ validation; for example, when feeling valuable and accepted, self-harm diminishes. Descartes held an opposing belief that the mind and body are dualistic (Simmons, 2013). Conceptualizing personhood as comprising individual parts can be dehumanizing (Simmons, 2013). Women in this study felt dehumanized when the treatment was limited to physical survival, including a suicide-watch with an HCP who they perceived as being invalidating. Being observed and feeling objectified in this way may be a symptom of Marx’s idea that one is controlled and dehumanized as one is processed through the system (Wild, 2011). Alternatively, women felt a sense of unity and Feeling Human when their emotions, trauma experiences, and relationship needs were acknowledged in addition to the need for physical safety.

 Dependency. The concept of humanity within Feeling Human is an understanding of people in relation to others, a notion that contradicts the way that independence and self-determination are highly valued as a part of humans’ potential within Western society. While self-determination or autonomy has an important role in feeling more in control within the Hunt, Feeling Human is supported by the concept of relational autonomy. Relational autonomy recognizes that self-determination and independence are heavily influenced by social factors and relationships with others (Meadow, 2014). Similar to feminists’ account that all of humanity is connected (Tubb, 2013) and Aristotle’s viewpoint on dependency that relatedness to others is essential to humanity (Saunders, 1999; Spenser’s, 2007), Feeling Human involves a sense of control through an existential sense of belonging to others. Aristotle writes that humanity is motivated by the need for self-worth that derives from reliance on others (Kleinrichert,
that is, relational dependency (Hacker-Wright, 2009). Potter (2015) also writes that relational autonomy is associated with a personal sense of value. *Feeling Human* takes these ideas a step further by clarifying that self-determinism or a sense of being in control stems from worthiness attained through connecting with others. Autonomy within the context of the individualist medical system represents agency (Walter & Ross 2014), contradicting *Feeling Human*. Escaping from *Entrapment* requires the integration of others to strengthen self-determination. Finally, an example within the clinical literature that supports the interdependency of *Feeling Human* is Rogers’ (1977) call for clinicians to embrace clients’ functioning limitations. Rogers (1977) believed that clients may have many complex needs while simultaneously having the capacity to help themselves within the context of a highly personal therapeutic relationship.

**Interpersonal.** *Feeling Human* occurs within the context of interpersonal connections. *Feeling Human* is supported by the rich literature on the healing outcomes for suicidality within a therapeutic relationship with an “empathetic human being” (Michel, 2011, p. 19), specifically the healing impact of acceptance and a non-judgmental attitude (Chi, 2014). In response to in-patients’ perception of disconnection from humanity, nurses “re-connect[ed] the person(s) to humanity” (Cutcliffe et al., 2007, p.20) through personal contact and compassion. The critical impact of interactions with HCPs was also demonstrated through suicidal participants’ reported need for interactive support online (Harris, McLean, & Sheffield, 2014). Help-seeking behaviours (King et al, 2015) and a sense of belonging (Baker & Fortune, 2008) were found to have increased after accessing HCPs’ support online during periods of suicidality. Likewise, the sense that
someone is listening and taking the situation seriously upon reaching out increased *Feeling Human*.

Rogers reinforces *Feeling Human* through his development of client-centered therapy, a treatment style that focuses on humanity where the helper approaches the client “as a person to a person” (Rogers, 1962, p. 22). Rogers (1962) writes that relating to a client as a “scientist to an object of study” is not suitable for the promotion of growth, supporting the finding in this study that women felt dehumanized when they were not treated as a person (p. 22). Connection with the HCP is an indicator of humanity within both client-centered therapy and *Feeling Human*. Rogers (1962) also believes that trustworthiness is a fundamental part of humanity. People have an inherent ability for their own growth and trusting or being aware of their ability to become fully human helps them to heal (Rogers, 1962). Rogers believed in the capacity to fulfill one’s potential within trusting interpersonal relationships despite experiencing a mental health crisis and low levels of social power (Martin, 2017; Rogers, 1962). Rogers explains that humanism involves intersubjectivity between the helper and clients or a shared consciousness of their difficulties and strengths, enabling clients to make meaning of their experiences (Mather, 2008; Rogers, 1962; Rogers & Skinner, 1956). This reinforces the search for purpose during the *Hunt to Feel Human*.

The interpersonal quality of *Feeling Human* parallels the small number of studies on women’s suicidality after experiencing IPV, for example, their psychological well-being was found to have been enhanced through acceptance (Davis et al., 2009; Kaslow et al., 2010), understanding, and a sense of belonging (Ilardi & Kaslow, 2009). Another study found that spirituality helped women during periods of suicidality after IPV.
(Arnette et al., 2007). Spirituality was not a central finding within *Feeling Human*; however, increased self-worth as a result of HCPs’ validation leads to finding meaning in life.

The significance of interpersonal connections in *Feeling Human* is supported by studies that have shown those who are suicidal reported that they seek a trusting person, not to be humiliated, to be heard (Vatne & Naden, 2016), to be taken seriously, and treated as an equal (Vatne & Naden, 2014). Participants’ objective of help-seeking in Vante and Naden’s (2016) study was to attain an “experience of connectedness” with “someone who cares,” elements included within *Feeling Human* (p. 300). A small number of studies that found the HCPs’s empathy enhanced the therapeutic relationship and overall treatment of people with mental illnesses (Gerace, Oster, O'Kane, Hayman, Muir-Cochrane, 2018; Montross et al., 2014) parallels the key to *Feeling Human*, validation. Further, collaborating with people seeking help for suicidality as partners in the treatment plan has been found to be a need on crisis hotline (Deuter, Procter, & Rogers, 2013).

Seeing beyond the professional role and getting to know the HCPs as fellow human beings, the strongest indicator of *Feeling Human*, is contentious within the literature. Some academics and clinicians within the filed of psychology believe that stepping outside of the professional role by sharing personal information with the client can weaken treatment and harm the client (Pope & Keith-Speige, 2008). Gutheil and Gabbard (1993), pioneers in boundary violations, warn about the risks of entering into a social relationship with clients that is based upon self-interest. Clients in therapy have been found to perceive HCPs’ self-disclosure as minimizing their experiences
(Wandschneider, 2008). In spite of this, HCPs’ self-discourse has been found to help clients learn coping skills, normalize difficult feelings, and equalize the relationship (Wandschneider, 2008). Clients have also been shown to connect with HCPs on a more personal level based on the messaging by the HCPs that they are not just doing their job, but rather that they genuinely care (Giorgi, 2011). Lawrence and Lee (2014) found that knowing the therapist as a human being helped participants to have greater self-compassion, thus transforming their self-concept. These studies support the importance of mutual humanity with HCPs in Feeling Human. Feeling Human through HCPs’ flexibility with their professional boundaries does not imply a social relationship or learning intimate information about the HCP, but rather making a personal connection.

Another interpersonal factor in Feeling Human, peer support, is reinforced within the literature. The foundation of peer support was laid in ancient times when Plato said that people learn about themselves through their reflection in others (Kirschner & Martin, 2010). Specifically, women with past trauma were found to have obtained validation and understanding in a mental health peer support group (Eaton & Cox, 2015). Women who have experienced IPV prefer to receive help from others with the same experiences (Cripe et al., 2015; Ford-Gilboe et al., 2015) and gain hope, sense of belonging, and validation within a peer lead support group (Tutty, Ogden, Wyllie, & Silverstone, 2017). These examples mirror the role of peer support within Feeling Human.

**Hunting Actions**

The term, Hunting, connotes a fight for survival and is supported by findings within mental health research that accessing help for mental health problems is a battle, counteracting the myth that people who have psychological problems are powerless
victims. Some aspects from the help-seeking literature, namely taking initial steps in reaching out, parallel the Hunting sub-processes. The rich understanding of what is known about how women manage the barriers in getting help for suicidality after IPV gleaned in the current study is new to the literature. Similar to studies that have demonstrated women’s capacity to protect themselves from the negative mental health effects of violence (Campbell, Sharps, & Parsons, 2009; Peterson, 2013; Wuest et al., 2003), Hunting is a means of finding relief from the pain of suicidality.

Gauging. Gauging for Validation, is bolstered by the findings that seeking help for suicidality was influenced by participants’ perception of stigma (Downs & Ellsenberg, 2012; Han & Olliffe, 2015; Reynders, Kerkhof, Molenberghs, & Audenhove, 2014). The act of having perceived or picked up on stigma is akin to Gauging. Gauging is also consistent with help-seeking for health problems after IPV. Ford-Gilboe, Wuest, and Merritt-Gray (2005) found that women who feared losing their children in the aftermath of IPV calculated the risk of seeking help based on their need for help versus the risk of appearing incapable as a mother. Mothers experiencing IPV were also found to weigh the risks and benefits in making health decisions for their children during precarious situations (Bentley, 2017). Catallo et al. (2012) found that women weighed the need to seek help in the emergency department (ED) for problems related to IPV with the risk of the HCPs finding out about the abuse, a process that increased their sense of control. Likewise, clients within a psychiatric unit weighed the risk of whether to engage in relationships with HCPs, fearing that they might be judged and rejected for having abused substances (Chorlton, Smith, & Jones, 2015). Aiming to avoid HCPs’ judgments, feeling pressured to leave the abusive relationship and, the high possibility of escalating
violence if police were involved, women hid the IPV until the HCP was assessed to be trustworthy (Catallo et al., 2012). These studies reveal very similar processes to Gauging for Validation with respect to assessing risk.

Gauging for Validation is supported by human behaviour theories. The act of appraisal in Gauging for Validation is reinforced by Hegel’s idea that a person “constantly gauges the outer and inner world” (Merker, 2012, p. 162). Indeed, evaluating the connections between all matters in one’s environment determines actions (Gilbert, 1992, 2017). Conscious and unconscious evaluations of the world yield a variety of emotions that inform how to bring balance or wholeness to the person (Merker, 2012), an idea that matches Gauging. The utility of assessing emotions in meeting one’s needs during suicidality is in contrast to other human philosophies where reason is the most important tool in deciding how one ought to behave. The primacy of emotion in Gauging is also in contrast to standard psychological treatment of depression and suicidality. For example, CBT involves evaluating one’s thoughts without the interference of emotions in order to assess the distressing situation and problem solve (Wright, Brown, Thase, & Ramirez Basco, 2017).

Suicidality is determined through the person’s evaluation of their own self-worth and feelings of defeat (Gunn et al., 2014), an appraisal that parallels the Gauging process. Racial minorities assessed the nature of their suicide and the level of need before making the decision to reach out in another study that supports the self-assessment process within Gauging (Chu et al., 2011). Overall, aspects of the Gauging process are identifiable within a small amount of suicide literature and align with theory on human behaviour. Further, Gauging provides detail on how Hunting sub-processes are performed.
**Distancing.** The main process behind *Distancing from Help* or reluctance to seek help is fairly well documented including in the IPV literature. Female teens who had experienced dating violence were found to have an aversion to seeking help (Alleyne-Green, Fernades, & Clark, 2015). Women who left an abusive partner have been found to avoid seeking help for mental health problems for fear of losing custody of their children (Catallo et al., 2012; Liverpool Mental Health Consortium, 2014; Irwin & Varcoe, 2002; Wuest et al. 2004), a finding that also occurred with each mother who *Distanced from Help*.

Avoidance of help-seeking for suicidality is also well documented and is associated with shame (Han & Olliffe, 2015), fears of being judged (Calloway, Kelly, Ward-Smith, 2012), distrust of care providers (Gilchrist & Sullivan, 2006; Rancāns, Lapinš, Renberg, & Jacobsson, 2003), and a conviction that help will be ineffective (Downs & Ellsberg, 2012). Feeling blamed and fearing judgement also contributes to *Distancing* by not disclosing IPV to HPCs (Bradbury-Jones, Duncan, Kroll, Moy, & Taylor, 2011; Catallo et al., 2012; Locke, Wan, & Hayter, 2012; Othman, Goddard, & Piterman, 2014). All of these findings support *Distancing* as the objective of this sub-process is to avoid feeling worthless and rejected. In contrast, another reason for avoiding help relates to valuing self-reliance or managing personal problems independently (Calloway et al., 2012; Han & Olliffe, 2015), was not a primary reason for *Distancing from Help*. While women felt shame for requiring assistance, they were aware of the urgent need of others’ support even when they *Distanced from Help*.

Higher suicide risk has been found to correlate with lower help-seeking behaviours (Atay et al., 2014; Pavarin et al., 2014; Reynders, Kerhof, Molenberghs, &
Audenhove, 2015; Seward & Harris, 2016; Schmeelk-Cone, Pisani, Petrova, & Wyman, 2012); however, the same was found with lower suicide risk (Encrenaz et al., 2012; Ko, 2016; Pagura et al., 2009). These contradicting findings support Distancing from Help as this sub-process occurs during all levels of suicidality. Reynders et al. (2014) found that help-seeking is lower in countries with a higher suicide rate, suggesting that lack of help-seeking does not imply a lack of need for help. Indeed, suicide attempts occur while Distancing from Help. Atay et al. (2014) and Reynders et al., (2015) found that avoiding help-seeking positively correlated with past suicidality. Similarly, Joubert, Petrakis, and Cementon (2012) found that after having sought help in the ED for suicidality, attendance at a series of follow up appointments decreased significantly within a short period of time. The reason for this drop in attendance may be the result of having negative experiences during previous treatment for suicidality. Studies that found an association between past help with suicidality and moving away from the system support Hunting to Feel Human. Women’s perception of HCPs’ invalidation in response to their help-seeking for past multiple suicide attempts deterred them from continuing to seek help.

**Enduring.** Enduring System Entrapment is a subtle action with little found in the suicide literature, possibly since it is not overt and thus is difficult to observe. Women faded into the background while conforming to the system’s rules. Enduring System Entrapment is a critical addition to the literature because women spend a significant amount of time and energy within this hidden sub-process. Some literature refers to feelings and behaviours that share similarities to Enduring, thereby, enhancing the credibility of this sub-process. Clients with suicidality felt powerless to resist perceived coercion on a psychiatric unit, believing they had to succumb to it (Lorem et al., 2015).
Clients seeking help within mental health services believed they had to capitulate to HCPs’ demands in order to receive help (Nyttingnes et al., 2016). In addition, Gilbert (2000) found that low self-concept and obeying others correlate with social anxiety, depression, and shame. While Enduring also includes feeling inferior, it is not passive obedience, but rather a proactive process of protecting against further dehumanization. This is an important contribution to the suicide literature.

Medical literature on physical health supports the findings related to Enduring System Entrapment. Clients on medical units were found to be compliant and accommodating so that they might maintain positive interactions with HCPs (McCreadie & Wiggins, 2009). HCPs perceived clients who were passive and submitted to the HCPs’ expectations as being good and labelled those who are non-compliant as being difficult (Lorber, 1975; Morley, Briggs, & Chumbley, 2015; Sointu, 2016).

Although clients’ behaviours within these studies appear similar to Enduring, the HCPs’ assumptions are contrary to the Hunting sub-process. Enduring is an active process to reduce the risk of dehumanization by avoiding challenging the HCP. Gilbert (1992) contends people naturally avoid challenging others to whom they feel inferior as not to lose further power in the relationship, a process that reinforces the actions and power dynamics within Enduring. Enduring goes further to explain the process of how losing power is avoided with a theoretical description of how women weighed the risk of bothering HCPs by reaching out for help versus putting up with feeling of being ignored by the HCPs.

Another classic study by Milgram (1963) demonstrated obedience to authority by research participants’ willingness to impart harm on others within an experimental
setting, findings that Haslam, Reicher, and Birney (2016) interpret as an engaged following instead of obedience, a process that supports the purposeful actions within Enduring. Haslam et al., (2016) theorize that research participants who are willing to inflict harm are not simply following orders, but rather are determined to be a part of a group’s larger purpose to conduct solid research. Enduring differs from Haslam et al. (2016) in that it does not occur as a result of being a part of a group’s contribution to a higher purpose, but rather self-protection against worsening harm.

To be clear, Enduring is not about making HCPs happy, but rather to prevent irritating them in hopes of gaining approval. This notion of Enduring is supported by Leroux’s (2007) study that found participants obeyed and tolerated HCPs’ position of authority in hopes the HCPs would return the favour with validation. The concept of obedience within the psychology literature aligns with the self-protective response to subjugation, within Enduring. Alternatively, Banerjee and Basu (2016) wrote that obedience is empowering as surrendering to the therapist is a sign of a trusting relationship, motivating the client to go along with the therapists’ will. Enduring is neither an obedient action nor within the context of a trusting relationship. Obedience implies following HCPs’ demands, whereas Enduring is more about tolerating the dehumanization of feeling invalidated by the HCPs.

The most striking aspect of this sub-process is that Feeling Human occurred most frequently as a result of Enduring System Entrapment, a novel finding because there is little research on suicidality help-seeking behaviours that specifically precede mental health HCPs’ compassionate care. Meyer (2016) found that women minimized their trauma in front of HCPs who blamed them for being abused in order to attain HCPs’
support, a finding that mirrors women’s intent on avoiding irritating HCPs in Enduring. While women might appear to have accepted HCPs’ treatment by hiding their displeasure about feeling invalidated, they are actually managing agonizing System Entrapment as their self-worth plummets. In all, Enduring adds a critical commentary on patriarchy in the literature. The large majority of psychiatrists who treated women in this study were male. Psychiatrists are responsible for initiating treatments that participants perceive as coercive, including being legally obliged to take medication or remain in a locked psychiatric facility. Enduring the perception of being coerced by a powerful male HCP parallels efforts to keep the peace in a relationship with an abusive male partner.

Grasping. The literature on requesting help during suicidality, represented in this study as Grasping for Help, largely consists of statistics on HCP visits and access barriers, but not the process of communicating needs and receiving services. The way that Trauma Entrapment outweighs System Entrapment during Grasping is supported by the finding that despite difficulties in getting help for IPV, greater levels of depressive symptoms led to increased help-seeking (Ford-Gilboe et al., 2015). Hames et al. (2015) also found that thwarted belongingness and burdensomeness predicted increased help-seeking behaviours. The finding in the present study that hope in the system’s ability to be helpful motivates Grasping is supported by the finding that believing a potential helper will be supportive led to increased help-seeking for suicidality (Pisani et al., 2012).

The most common outcome of Grasping for Help, feeling invalidated, is an important addition to the literature as this demonstrates the extent of access barriers within the system. Meyer, Teylan, and Schwartz (2015) found that reaching out for help was associated with an increased risk of future suicide attempts; however, the reasoning
was not indicated. Nevertheless, this study’s findings parallel the way that the
dehumanization as an outcome of *Grasping* is a factor in escalating suicidality. The
outcome of *Grasping* is also supported by the findings that 72% of first time suicide
attempters who sought help from the ED were discharged home without being admitted
to the psychiatric unit or receiving other urgent care (Aay, Bacik Yaman, Demgrada, &
Akpinar, 2013) and that only 52% of people who sought help in a Canadian ED after
attempting suicide were hospitalized (Rahme et al., 2016). In the current study, women
perceived that arriving at the ED for treatment of suicidality was the most legitimate way
to convey the need for help and when they were discharged from the ED without more
than a prescription, they perceived this as evidence that they were worthless and alone.

The lack of literature on how help is sought despite stigma, difficulty in
functioning while depressed, and the many access barriers may be a reflection of the
relentless misunderstanding of suicide. The interface of reaching out to an HCP and
purposefully requesting help for suicidality is demonstrated with *Grasping*, informing the
literature of the strength and skill required to fight for support. *Grasping* challenges the
assumption that communicating an urgent need for help with suicidality will result in
help. In this way, the most critical contribution to the literature is that among all of the
hunting sub-processes in seeking help for suicidality, *Grasping for Help* yields the least
amount of validation.

**Counter-Pressure.** The way that *Applying Counter-Pressure* involves putting
pressure on the system while seeking-help is documented to some extent within the
literature; however, this is interpreted significantly differently from the essence of the
*Hunting to Feel Human* theory. Assumptions are made within the past and current body
of knowledge on suicide that non-lethal attempts at killing oneself or self-harm are non-compliant, attention seeking, and manipulative behaviours. Sifneos (1966) explained his study findings of what he believed to be calculating suicide attempts: “Patients who manipulate … seem to discover the power that suicide commands as a weapon in social maneuvers” (p 533). Describing suicidality as manipulation is to accuse clients of faking suicidality to get their own way (Johns & Holden, 1997). Among the reasons for wanting to die by suicide as indicated on the validated Columbia Suicide Severity Assessment Rating Scale include “to get attention or revenge” (Posner et al., 2011; Posner et al., 2014). Applying Counter-Pressure is a process of influencing others; however, it conflicts with the assumption that the intended outcome of self-harm is to get attention or revenge.

Part of the reason non-lethal suicidality is not taken seriously might be influenced by studies that measured the motivators behind suicide attempts. In comparison to people who attempted suicide for one reason, to die, the risk of future death by suicide is lower (Holden & Kroner, 2003; Levinger & Holden, 2014) or insignificant (Holden & McLeod, 2000; Kene, 2011) for people whose suicide attempt was motivated by additional reasons besides the desire to die. Labeling suicidality as manipulative is dangerous as it may lead to an underestimation of suicide risk and reduced vigilance in care provision (Cummings & Thompson, 2009), minimization that women perceived while Applying Counter-Pressure. Caution is needed, however, since suicide behaviour that is labelled manipulative has been found to positively correlate with suicide deaths (Dear, Thomson, & Hills, 2000; Wedig; Frankenburg, Reich, Fitzmaurice, & Zanarini, 2013), supporting Applying Counter-Pressure. Indeed, the willingness to die by attempting suicide for the
chance to be noticed and validated by HCPs is not merely an innocuous attention-seeking behaviour. *Applying Counter-Pressure* is a sign of feeling dehumanized and is reinforced by a few researchers (May & Klonsky, 2013; O’Connor, Smith, Ferguson, & Ryan; 2016; Wedig et al., 2013) who reject the label manipulative and view suicidality as a request for greater connections with others.

Accusations of being manipulative when pushing for help might be a manifestation of gender role expectations. Feminist authors have written about the messages women receive at an early age and expectations throughout their lives to be obedient, polite, and passive (Fodor, 1974; Pompper, 2016), rendering them to appear aggressive when they assert their needs. *Applying Counter-Pressure* and doing what it takes to get help reflects Wedig et al.’s (2013) view that suicidality is indicative of an urgent need for a sense of belonging. Fighting to be believed and taken seriously represents a feminist deconstruction of the system; that the health effects of trauma are real and women are not simply seeking attention or being overly emotional when they seek help for suicidal thoughts. *Applying Counter-Pressure* is a crucial addition to the body of knowledge on suicide as it differentiates between acting *badly* and communicating an urgent need.

**Soaking in.** *Soaking in Validation* is a *Hunting* sub-process that occurs once validation has been received and is the first step in healing from suicidality. *Soaking in Validation* allows for a powerful transformation from feeling worthless to *Feeling Human*. This is a behaviour that is not outwardly expressed and difficult to observe, possibly accounting for the limited literature on this process and its clinical implications. Surgenor (2015) found that therapists’ empathy, positive regard, and genuineness lead to
a decrease in clients’ suicidality, aligning with the outcome of *Soaking in Validation*. This and other quantitative studies on the positive mental health outcomes of therapeutic interactions, however, do not account for what clients do with the support once they have received it. This *Hunting* sub-process expands on current studies by focusing on the period of time when the HCP’s care is received and the suicidal thinking begins to change.

Findings from qualitative research that the interpersonal nature between the client and HCP is central to successful treatment (Nocross, 2010) support *Soaking in Validation*. Most of these studies evaluate the importance and benefits of a trusting relationship with an HCP, particularly in the context of psychotherapy. A few studies evaluate the client’s role in acquiring these benefits, including gaining trust by actively engaging with the HCP. People receiving treatment on a medical in-patient unit (Berg, Skott, & Danielson, 2007) and a mental health service (Giorgi, 2011; Lawerence, 2014; Yakeley & Wood, 2011) identified that developing a trusting relationship involved being open emotionally to and accepting of the HCPs’ compassion. These findings support the concept of *Soaking in* where women allowed themselves to feel gratitude, humility, and worthiness while gathering the rewards of HCPs’ validation. Clients perceived that a therapeutic relationship was created through a process of interactions over time (Berg et al., 2007; Chorlton et al., 2015). While *Soaking in Validation* is also a process, it does not necessarily occur over multiple interactions, but may be the result of a single event with an unfamiliar HCP. The difference may be that *Soaking in Validation* does not equate with an established therapeutic relationship, but rather that trust in the HCP is ignited. *Soaking in Validation* is fortified by study findings that clients’ recognition of their
emotions and awareness of the HCPs’ empathy help to develop the therapeutic relationship (Giorgi, 2011; Lawerence, 2014). Through this awareness, participants discovered new aspects of their identity and began to accept themselves (Lawerence, 2014; Sun & Long, 2013; Yakeley & Wood, 2011), findings that parallel taking notice of Feeling Human while gaining a sense of worthiness by Soaking in the HCPs’ validation into their self-concept.

Soaking in Validation fills some gaps in the body of knowledge on receiving mental health support. While the literature includes studies on a broad range of populations, they do not inform on specifically women who seek help for suicidality after leaving an abusive partner. The literature also focuses on receiving help from therapists for individual counselling, representing only a fraction of the support women in this study sought for suicidality. Soaking in Validation is also an important addition to the literature as it is a hidden process that may be taken for granted. Occurring after the HCP is validating and before the suicidality begins to worsen, Soaking in is a period when humanity is absorbed and integrated within the self.

Letting Go. Little information exists on how clients’ release some decision-making capacity in response to trust in HCPs’ during periods of suicidality; however, studies that touch this process support the process of Letting Go. Relinquishing the power that painful events have over one’s life has been explored within psychology literature (Kelley-Lainé, 2014; Waelde, 2015). Women gained a sense of trust and took charge of their lives by releasing past trauma or not allowing the painful past to control their fate (Srivastava, 2015). In contrast, Letting Go is about trusting first, followed by relinquishing control of a crisis situation to an HCP. Rogers (1951), one of the first
authors to write about clients’ oppression and power dynamics in therapy, contended that without feeling the need to control the treatment intervention, clients begin to set their emotions free and express themselves. This freedom relates to *Letting Go.*

Rogers’ idea to help the client feel free to express emotions influenced the creation of Motivational Interviewing (MI), a dialogue technique in helping people who are ambivalent about change by allowing them to steer their treatment (Arkowitz, Miller, & Rollnick, 2013; Millner & Rollnick, 2013). The objective of MI is to draw out clients’ reasons for changing by helping them to explore their needs and desires, a process that motivates clients to move beyond their problem sustaining behaviours (Millner & Rollnick, 2013). The MI technique is influenced by Rogerian ideals that the HCP is not the expert and what is needed to help clients resides within the client themselves (Millner & Rollnick, 2013). The HCP avoids telling clients what to do because pressuring people to change does not work, whereas allowing people to make their own decisions increases the chance of behaviour change (Millner & Rollnick, 2013). While the intent in MI is to help the client feel more comfortable, the underlying assumption or goal remains to be that the helper acts in a way that will influence a change in the client’s undesirable behaviour. Alternatively, Rogers (1977) believed that HCPs’ job is to have *limitless* acceptance and respect for clients, treatment that lessens the pressure to change and increases *Feel Human.* The importance of acceptance and self-worth is acknowledged in the literature; however, less evident is how a sense of agency translates into getting better, a process that is explored within *Letting Go.*

One of the conditions of *Letting Go,* decreasing perception of restraint and judgement, is documented within other studies on perceived coercion. Perceived coercion
changed from high to low levels as symptoms improved in clients hospitalized for high risk of self-harm (Fiorillo et al., 2012; Gowda et al., 2016). Gowda et al. (2016) found that when recalling treatment intervention in the hospital, discharged clients who rated coercion levels as high during their stay decided that the restraint that they experienced had been warranted and helpful. Without clear causality of the reduction of coercion perception within these studies, associated factors included having received help or getting better. *Letting Go* also involves having received help and getting better, but the difference is that the contributor to this *Hunting* sub-process is known: validating interactions with HCPs. Some women who had received coercive treatment in the psychiatric unit justified the use of this treatment after they had reached *Letting Go* because the *Feeling Human* that resulted from the validation overrode the dehumanization of the coercion.

*Letting Go* contributes greater understanding of the role of power dynamics. Acceptance of HCPs’ control over some aspects of the treatment released the need to change this dynamic. *Letting Go* makes it clear that not all interventions where clients’ decision-making capacity is limited equals *System Entrapment*. Women recognized and welcomed HCPs unilateral decision-making in order to keep them safe during a suicide crisis, feeling that they were being taken seriously and were deserving of help. *Letting Go* adds to the literature in how receiving validation leads to trusting the HCP or the process that occurs between feeling validated and being more open. *Letting Go* also informs the suicide literature on the importance of partnering with women who have experienced trauma who are at high risk of self-harm. This finding is supported by studies that found clients accepted restrictive interventions when they had a sense of working in partnership.
with the treatment team (Lay et al., 2015; Lorem et al., 2015; Mielau et al., 2016). While women initially refused to go to the hospital with the police after attempting suicide, they *Let Go* of the need to escape this trapped feeling when they encountered a validating HCP within the ED. *Letting Go* is another reminder of women’s active role in benefitting from HCPs caring attitudes. Whereas it is established in the literature that an HCP’s empathy is critical in recovery, *Letting Go* clarifies that women do the work of *Feeling Human* by allowing others to help them.

**Discussion Summary**

The theory of *Hunting to Feel Human* is a vital addition to the literature because very little has been studied on women’s help-seeking for suicidality after IPV. The theory’s unique conceptual processes and rich descriptions yield a clear understanding of women’s everyday feelings, thoughts, and actions while seeking help. A thorough analysis of in-depth interviews and PV discussions captured a detailed account of the help-seeking journey from women’s perspectives, a unique standpoint in contrast to the medical or expert lens through which the majority of suicide knowledge is viewed.

Suicide research traditionally involves measurement tools with pre-conceived notions about suicidality, narrowing the scope of what can be discovered. In this way, much is known about risk factors and outcomes of suicidality, including effectiveness of treatment interventions; however, a deeper analysis of what happens during the process of being suicidal and getting help has been lacking.

A feminist lens was helpful in discovering the various dimensions that intersect to influence women’s help-seeking for suicidality. Considering the strong relationship between IPV and suicide, an exploration of help-seeking in the context of having been
abused depicts a journey relevant to a significant portion of women’s suicidality. A critical and contextual analysis of women’s help-seeking provides a broader understanding of the socio-political factors influencing suicidality, an approach overshadowed in the literature by a bio-medical framework. *Hunting to Feel Human* expands on what is known about access barriers to getting help for suicidality by delving deeper into the difficulties interacting with the health care system. Getting help for IPV and other gendered trauma has been explored through a feminist lens within research and other literary discourses; however, the literature is limited in understanding system navigation while in a suicide crisis. *Hunting to Feel Human* is a critical rendering of how help-seeking is influenced by the power dynamics related to suicide stigma and IPV.

One of the strongest contributions to the literature is the positive impact of HCPs’ validating interactions. While the importance of the therapeutic relationship is well documented, *Hunting to Feel Human* takes this relationship further by revealing the healing impact of relying on HCPs, a stark contrast to the dominant ideology that individuals are autonomous beings responsible for their own destiny. The assumption that dependency is pathological is dismantled in this study, challenging the belief that seeking validation is a sign of weakness and manipulation, and instead is one of ingenuity and strength. The limitations and potential harm associated with individualized service provision and the value of relational treatment modalities are highlighted.

Along with rich description of women’s journey, *Hunting to Feel Human* is also abstract in nature, illustrating dynamic relationships between the theory’s categories and concepts. The concepts and processes within this study are backed by other studies of different mental health conditions and circumstances, demonstrating the theory’s
potential for generalizability. *Hunting to Feel Human* may contribute to an enhanced understanding of help-seeking for mental health crises during periods of anxiety, depression, or PTSD without the presence of suicidality. This theory might also be applicable to seeking help for mental health problems in the wake of various forms of past trauma aside from IPV, including other forms of abuse, witnessing violence, or experiencing childhood attachment problems. The need for self-worth and a sense of belonging as identified within *Feeling Human* is a constant within the literature; therefore, this could be applicable to various groups of people who desire help during periods of suicidality.

This study informs current knowledge on *Feeling Human*, achieved through various ways of fighting for help despite intense suicidality, past trauma, and access barriers. This study contributes an understanding of women’s intentions in seeking help within various contexts and how interactions with the system and relationships with HCPs influence their suicidality and potential for *Feeling Human*. Accessible language and an illustration of basic categories and their relationships, makes the theory easily comprehensible and adaptive. During *Trauma and System Entrapment, Hunting to Feel Human* is effective.
Chapter Seven: Implications

*Hunting to Feel Human* is a substantive theory that has implications for women’s help-seeking for suicidality at different levels of intensity, with various HCPs across a variety of settings. The theory also has broad application within health care, from interactions with clients to policy and education. The focus of all implications from this study is to foster *Feeling Human*, a sense of belongingness and self-worth, for women with a history of IPV who seek help for suicidality. Implications are not driven by attempts to end suicidality, but rather to end dehumanization through validation within a variety of contexts. The greatest impact on *Feeling Human* is HCPs’ interactions and their capacity to validate. Structuring services and creating policies sensitive to power dynamics is important in providing space for women’s voices. Service models that are flexible, promote clients’ strengths, and embrace the clients’ perspectives create a culture of safety within the health care system that is vital to HCPs capacity to be validating. Ethical considerations related to power dynamics, dependency, and social factors are explored throughout the chapter.

**Paradigm Shift**

Implications to the *Hunting to Feel Human* theory must be embedded within a cultural and socio-political landscape that goes beyond micro-level or individual changes within mental health programs. Helping women who are suicidal with a history of IPV requires a paradigm shift in the way their help-seeking is understood. *System Entrapment* exists across clinical settings, geographic locations, and among a variety of HCP disciplines; therefore, a multi-pronged approach may be the most comprehensive and consistent way of providing services. *System Entrapment* is also rooted within mental
health stigma and gender disparities, necessitating widespread changes to attitudes and traditional service provision practices that contribute to dehumanization. An overhaul of service delivery models with systematic frameworks that guide HCPs’ approach to health concerns may help to establish treatment standards and organize care delivery (Ritzer, 2007).

Hunting actions begin with *Gauging for Validation* opportunities, a constant process of scouring the surroundings and absorbing input from the environment; therefore, HCPs’ capacity to be validating should be built into the model from the very first contact. Judgments based upon the information *Gauged* guide the process of *Taking the Path of Least Entrapment*, making the validation level within the environment a significant influence on women’s risk level and help-seeking behaviours. The most significant source of validation or invalidation is felt directly from HCPs’ interactions within the immediate environment. A service delivery model ought to have capacity for women to feel empowered and in control of their help-seeking within a relational context, including relationships with HCPs, family, friends, peers, and the greater community.

The Recovery Model, a framework of addictions and mental health service provision that focuses on the capacity to gain control over one’s life despite ongoing adverse effects of the condition (Anthony, Rogers, & Farkas, 2003; Rogers, Farkas, & Anthony, 2005; Snynder, Schaetman, & Young, 2015), has potential to meet the needs outlined within the *Hunting* theory. The Recovery Model can be used as a framework from which to build upon in order to meet the needs of women seeking help for suicidality after IPV. With the interjection of critical theory and a trauma informed
approach, this model has potential to provide opportunities for relationships, awareness of how society impacts recovery, and safe spaces in the *Hunt to Feel Human*.

The Recovery Model has roots back as far as the 1800’s when John Perceval, a person living with schizophrenia and the son a British Prime Minister, began advocating for more humane mental health treatment (Gault, 2008). People living with mental illness pushed for the Recovery Model in the late 1900s; however, it has struggled to remain alive in the 2000s (Field & Reed, 2016). The Recovery Model is person-centered, strength-based, and contradicts the illness-based medical model (Stylianidis, Lavdas, Markou, & Belekou, 2016) where *System Entrapment* thrives. Within the past couple of decades, the idea behind the Recovery movement was that people with severe mental illnesses, including schizophrenia and biopolar disorder, could rehabilitate outside of the confines of health care institutions (Anthony & Mizock, 2014). No longer limited to any particular groups of people who receive psychiatric treatment, the Recovery movement is gaining traction as a way of delivering services to all people who seek help for mental health problems (Mental Health Commission of Canada, 2015).

The Recovery Model fits with *Hunting to Feel Human* by minimizing dehumanization and promoting self-value. Central concepts within this model are hope, personal strengths, and feeling supported (Anthony & Mizock, 2014). The intent is to avoid identifying people according to their mental illness and instead relating to their difficulties as being something that they live with, focusing on the commonalities that they share with all people (Anthony & Mizock, 2014). Believing that people living with mental health problems have better health outcomes when they take an active role in their treatment, HCPs using a Recovery lens provide opportunities for people to build self-
awareness and the skills they need to fulfill their dreams (Anthony, 1993; Anthony & Mizock, 2014). Calling for recovery-orientated systems of care, people living with mental health problems seek help not only to reduce the symptoms of their illness, but to finding meaning in life (Anthony, 1993; Gagne, While, & Anthony, 2007). In this way, the Recovery Model is a promising framework for creating services that promotes Feeling Human.

The notion of HCPs as being experts in clients’ treatment is rejected in the Recovery Model; instead clients’ knowledge is recognized as being crucial to an effective treatment plan (Mental Health Commission of Canada, 2015; Stylianidis et al., 2016). Partnering with HCPs facilitates Feeling Human, helping to alleviate clients’ sense of burdensomeness and to foster their sense of being a valuable contributor to the treatment process. The need to connect with others is recognized as essential to the Recovery Model (Young, Schactman, & Synder, 2014), a notion that parallels Feeling Human.

In 2012, the New Brunswick Department of Health introduced The Recovery Model to both NB health authorities, Horizon Health Network and Vitalité. Despite the Mental Health Commission of Canada’s (2015) endorsement of the Recovery Model, the New Brunswick Department of Health is the only jurisdiction to have adopted this framework within Canada. Addiction and mental health representatives have created local Recovery groups in every region of the province, partnering with clients to create strength-based services at a grass roots level. Although some partnerships with clients resulted in a few recovery-orientated projects, including creating a warmer atmosphere in community mental health clinics and reconstructing an in-patient nursing station to be an open concept, addictions and mental health services are far from being recovery-
orientated. Addictions and mental health services are overpowered by the greater health care system that runs on a medical model, making it difficult to partner with clients. In my experience, developing partnerships requires a genuine effort to view clients as colleagues who help the HCP to figure out how to manage their crisis. Penetrating the dehumanizing effects of Trauma and System Entrapment necessitates an enhanced intimacy within HCPs’ interactions, a relationship that may be uncomfortable for many HCPs.

The Recovery Model has the capacity to address the important implications of this study: the need for validating HCP interactions and a critical shift within service delivery models. The collaborative nature of the Recovery Model can enhance therapeutic relationships; however, a critical lens ought to be added to this guiding framework to target potential power imbalances. With the integration of other approaches that are supportive of Feeling Human, the Recovery Model provides a starting point to helping women experiencing suicidality after leaving an abusive relationship. Service provision recommendations, including how HCPs interact with clients are reviewed in the proceeding section, followed by an exploration of how feminist theory and trauma informed care reinforces this model.

**HCPs’ interactions.** HCPs’ interactions have the most influence on Feeling Human. The HCP is the intervention tool and the interaction is the treatment. Educating, supporting, and nurturing HCPs’ capacity to be accepting, non-judgmental, and validating is the most pressing recommendation for Feeling Human. Feeling Human is not dependent upon the content of a treatment plan, the type of medication prescribed, or the form of therapy delivered, but rather the quality of interacting with women during the
provision of these services. Removing barriers that contribute to System Entrapment by dismantling assumptions about suicidality and taken-for-granted practices will help to clear the way for validating interactions. Services within a Recovery Model adapt to the client’s needs (Mental Health Commission of Canada, 2015) instead of the client being expected to adapt to the system. A significant barrier to Feeling Human is not being believed and judged as being manipulative.

**Manipulation label.** HCPs require education on Grasping for Help and Applying Counter-Pressure specific to the common misconception that suicidality is manipulative. Not being believed is associated with being judged as manipulative and contributes a significant part to System Entrapment. Several women reported that their suicidality was judged to be nothing more than acting out behaviour and used as a devious tool to get attention. HCPs may be more validating if they learn that women are willing to risk death with what appears as a non-lethal suicide attempt for the chance to Feel Human by being taken seriously.

HCPs may have more patience if they understand that women fought to end suicidality on their own long before seeking help and that they did not seek help until they had no other options. Teaching HCPs that suicidality is not usually a chosen behaviour used to deceive and control others may change their attitudes of blame. Whereas women’s Grasping for Help was most often met with System Entrapment, HCPs could benefit from workplace training showing that punishing women through invalidation may contribute to worsening suicidality. When conveyed as an immoral, weak, and disingenuous chosen behaviour, suicidality elicits invalidating responses. The
best way to take women seriously, convey that HCPs believe them, and to validate their distress, is through empathy.

**Validating with empathy.** Empathy is fundamental to *Feeling Human*. Teaching empathy requires a dismantling of the assumption that HCPs know best and learning to suspend clinical judgment in order to accept women as active participants in their treatment. People in helping roles are inclined to work toward fixing clients’ problems, making it difficult to convey acceptance without the expectation of change (Miller & Rolnick, 2013). Leaders and educators must allow for an exploration of how to uphold the ethical standard to *do good* and to relieve HCPs’ of the unrealistic responsibility to remedy the client’s suicidality. Feeling less pressure to fix the client, HCPs will avoid pressuring the client.

Dehumanization within the *Hunting* process by neglecting to empathize or to offer unconditional acceptance is coercive and contributes to *System Entrapment*. Consequently, women hide their suicidality during *Distancing* for fear of being kept in an institution and hide IPV experiences for fear of being pressured to leave the abusive partner. Women are more apt to *Grasp for Help* by communicating their suicidal thoughts in response to an HCP’s empathy, increasing the validity of risk assessments and opportunities to *Soak in Validation*. Women’s increased willingness to discuss suicidal thoughts with a validating HCP is supported by Ganzini et al.’s (2013) study that found trust in the HCP increased the effectiveness of suicide assessments in veterans. Although empathy contributes to trusting the HCP and *Soaking in Validation*, a higher level of trust is required for *Letting Go* through mutual humanity.
Rogers’ (1962) client-centered therapy is an excellent example of validating with empathy. Rogers (1962) believed that HCPs need to portray an attitude of unconditional acceptance toward their clients and to focus on their strengths. Clients are understood to have innate abilities to heal themselves (Rogers, 1962), a perspective contrary to the idea that the clinician knows best. The objective is to create a validating and secure environment where clients at the center of the treatment plan have greater capacity to identify what is needed and to discover ways to meet their goals (Rogers, 1962; Rogers & Wallen, 1946). Rogers sees treatment goals not as static, but as evolving realities, decreasing expectations to behave in a particular way due to changing circumstances (Rogers, 1962). Instead of pressuring clients to change by choosing to avoid negative consequences, Rogers (1962) contends that their desires and values ought to guide how they meet their own goals. HCPs practicing within acceptance-based models embrace clients’ realities and adapt the treatment interventions to match their needs, in lieu of forcing the client to adapt to the system.

Validation and empathy are central to DBT (Linehan, 1993a, 2015) and may promote Feeling Human. Helpers validate clients’ distressing experiences and assist them to validate themselves through acceptance. This process is enabled through mindfulness, a distress tolerance strategy within DBT used to build inner strength by being aware one’s immediate experiences (Linehan, 1993a, 2015). Limited to a focus on the individual, mindfulness can be adapted to meet women’s need for emotional connectedness with others through “embedded relational mindfulness” (Ogden, 2015, p. 43), an awareness of present emotions and thoughts within the therapeutic interaction. Mindfulness can also be used within a feminist lens by facilitating awareness of social
influences within the practice, allowing clients to understand how subjugation within society may have affected their health (Crowder, 2016). Exploring how gender, ethnicity, and other multicultural factors influence clients’ suicidality may also be integrated within traditional therapies (Remer & Oh, 2013), facilitating the reduction of self-blame. HCPs can help clients identify gender power imbalances within the home, the health care system, and in society (Maier, 2016). Acknowledgement of social factors in seeking help for suicidality does not imply ignoring the individual. Cripe et al. (2015) writes that a two-tiered system of community or group interventions and individual therapy in conjunction with acknowledging social factors that influence health outcomes provides the most comprehensive care related to women’s experiences with IPV. In all, the integration of feminist approaches is critical to HCPs’ interactions with clients as blame is taken off the individual through the acknowledgment and targeting of multifaceted influences.

Mutual humanity. Mutual humanity is received when HCPs convey their own emotional vulnerabilities, reducing the differences with client, and conveying their shared human value. This yields the highest levels of Feeling Human. Mutual humanity is also promoted with the person-centered approach within the Recovery Model, encouraging clients’ involvement with all aspects of their care, including the creation, provision, and evaluation of service delivery (Mental Health Commission of Canada, 2015). Instilling humanity and vulnerability into the relationship and collaborating with clients in their treatment requires adopting an open mindset and braving new territory by disrupting coercive, dehumanizing, and invalidating practices that sustain suicidality.
Although HCPs’ sharing of their humanity contributes to *Feeling Human*, they must heed caution as not to develop a social relationship. Women did not want to feel the burden of HCPs’ problems; therefore, HCPs must ensure that the goal of every interaction with the client is focused on women’s recovery and need for validation. Learning how to appropriately step outside of the traditional and rigid professional stance to share their personal side with the client requires self-reflection and guidance. Even though developing a friendship with a client is inappropriate, the intention to maintain ethical standards by maintaining a strictly professional relationship may result in holding back mutual humanity (Canadian Psychological Association, 2017; McInnis-Perry, Greene, & Santa Mina, 2014; Nurses Association of New Brunswick, 2015). The fear of crossing boundaries may inhibit HCPs’ humanity or personal side, resulting in appearing closed, elite, and uncaring. Women felt distant, dehumanized, and undeserving of care when the HCPs behaved in an objective manner by withholding their emotional responses. HCPs may perceive such behaviour as a hallmark of professionalism, a myth that is unhelpful in making ethical decisions (Proctor & Keys, 2013; Remer & Oh, 2013). The potential for harm within the *Hunting* process is higher when emotional support is missing from the therapeutic relationships in comparison to the potential harm in being too close to the client.

Peers, non-professional HCPs who have had mental health problems and volunteer or are employed to work within the care team, are central to the Recovery Model (Mental Health Commission of Canada, 2015) and promote mutual humanity. Peers use their personal recovery experiences to help others, a service that promoted *Feeling Human*. Peers are in a unique position to demonstrate humanity and connect on a
personal level by virtue of having shared similar experiences and being unhindered by
traditional professional boundaries that restrict the use of self-disclosure. Despite the
importance of the personal experience in fostering intimate connections, some mental
health professionals fear that the peers will become too involved with clients and risk
promoting dependency (Scott & Doughty, 2012). Again, all HCPs must challenge the
assumption that dependency is negative during periods of urgent need for help. Help from
peers ought to be made accessible in a variety of forms, including support groups, crisis
phone lines, and mentor programs where a peer partners with a client to help navigate the
health care system. Women ought to have opportunities to participate as peers, as helping
others is a powerful way of *Feeling Human*.

**HCPs’ interactions conclusion.** Extending one’s humanity, being vulnerable by
sharing a personal experience, and being emotionally present all help to acknowledge
clients’ worth and promote *Feeling Human*. Boundary limitations may restrict the ability
of HCPs to create an appropriate intimate therapeutic relationship, calling for a
dismantling of fallacies created within a society that values independence and
incorporating peers who share personal experiences. Learning how to accept and validate
women in a suicidal crisis is of utmost importance. HCPs could also be more effective in
helping women who have experienced IPV through education on social justice
(Richmond, Geiger, & Reed, 2013; Sparkes Wenzel, 2013), identification and
intervention of abuse (WHO, 2013b), and ongoing anti-stigma education (WHO, 2014).

**Critical shift.** The Recovery Model has the potential to promote *Feeling Human*
with the integration or expansion of a critical approach. Indeed, critical approaches to
service delivery are missing from the consciousness of the people working within the
health care system, limiting the capacity to target power imbalances that are characteristic of *System Entrapment*. The Recovery Model touches on critical aspects of mental health problems by recognizing intersecting social, economic, and cultural factors (Mental Health Commission of Canada, 2015); however, these factors are not understood in relation to gender and other power dynamics. Advocacy for clients’ equality is also a central feature of the Recovery Model (Anthony, 1993; Stylianidis et al., 2016); however, it is limited in its acknowledgement of women’s experiences of disempowerment. Opportunities for amending the Recovery Model are available as it is meant to be “complemented by other approaches” (Mental Health Commission of Canada, 2015, p. 11). An integration of feminist ethical theory would facilitate the dismantling of power and control within *System Entrapment* and promote *Feeling Human* with empowering-orientated services. Feminist ethical theory parallels the Recovery Model with its critique of labels and would boost this model with a recognition of socio-political influences.

Expanding a critical lens in the Recovery Model may occur through a reconstruction of how mental health problems are identified, including a deconstruction of how mental illnesses are diagnosed. The *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; *DSM-5*; American Psychiatric Association, 2013), a guide referred to as the *bible* of psychiatry, pathologizes individuals’ mental health experiences (Miller, 2015) and may contribute to dehumanization. Pre-set conceptualizations of people’s identify and personhood as a result of fitting them into DSM diagnostic categories (Tseris, 2013) may affect populations in unequal ways (Lafrance & Mckenzie-Mohr, 2013). Rather than applying psychiatric diagnoses singularly to the individual, acknowledging the aetiology behind the presenting symptoms is more comprehensive and accurate. For
example, *acute trauma response* might replace an anxiety disorder diagnosis, and *social* or *relational disconnection* might be more accurate than one of the depressive disorders, conditions that involve a sense of worthlessness, guilt, and social isolation. Language is recognized within feminist theory as having power (Arslanian-Engoren, 2002), including the use of psychiatric diagnoses as a way of controlling women (Goicoechea, 2013). Diagnoses that reflect a person’s experience or forgoing psychiatric labels altogether may be less stigmatizing. The Recovery Model also recognizes the negative impact of psychiatric labels on a person’s identity (Mental Health Commission of Canada, 2015); therefore, it can be easily partnered with a feminist approach.

A feminist ethical theory integrated within the Recovery Model would also broaden service provision beyond the scope of the individual and address multifaceted factors related to the *Hunting* process. Even though the Recovery Model seeks to break down institutional barriers and create non-traditional services according to clients’ input, clients may not be conscious of the socio-political forces that influence their problems. Help-seeking implications related to gender ought to be challenged, for example, re-conceptualizing the myth that non-lethal suicide attempts are feminine gestures not to be taken seriously (Canettl, 2015). HCPs ought to be educated on gender bias in the treatment of women’s suicidality as 75% of people labeled as having BPD, a condition marked by chronic suicidality, are women (American Psychiatric Association, 2013) and whose emotional expressions are negatively characterized as being dramatic and feminine.

Although the Recovery Model strives for clients’ empowerment through autonomy and individual choice (Kaplan & Racussen, 2013), the integration of feminist
ethical theory would promote a more realistic approach to self-determination that acknowledges the relational nature of autonomy and the influence of others in decision-making. With the intent to uphold autonomy, HCPs are encouraged to maintain objectivity so that their viewpoints do not influence the client. The feminist perspective, however, rejects the illusion of objectivity while considering the personal standpoint of the HCP and how it influences the client’s decision-making (Bhola & Raguram, 2016). Interdependence might be overlooked without the feminist approach, leaving women feeling pressured to cope alone and unaware of how external factors influence their decision-making. In lieu of attributing blame toward clients for their cognitive dysfunction, a feminist approach considers “cultural sources of individual dysfunctional beliefs” (Canettl, 2015, p. 228). For example, women are strengthened when they are able to recognize how gendered violence, IPV, and mental health stigma contribute to feelings of worthlessness, instead of these feelings being attributed to faulty personality traits. Overall, a critical awareness of past trauma and how it contributes to System Entrapment may strengthen the capacity of the Recovery Model to facilitate Hunting to Feel Human.

Services within a Recovery Model infused with feminist ethical theory would be even more validating with the addition of trauma informed care, an approach to service delivery that intentionally acknowledges the influence of trauma in people’s lives and their response to treatment (Wall, 2014). Trauma-informed care is based on an understanding of the whole person in relation to trauma theory (Elliott, Bjelajac, Fallot, Markoff, & Reed, 2005) and seamlessly fits within the client-centered lens of the Recovery Model. Instead of labeling behaviour as pathologic, for example, diagnosing
self-harm as a symptom of borderline personality disorder, trauma-informed care might interpret the behaviour as being a normative reaction to past abuse.

The constancy and universality of the trauma-informed approach (Classen & Clark, 2017; LeBel & Kelly, 2014; Reeves, 2015) matches the way that women continually Gauged for Validation opportunities regardless of the setting or the HCP providing care. Awareness of the impact of trauma reduces dehumanization by avoiding singling out suicidal women as being more needy than other clients. Women do not have to prove that they experienced trauma by Applying Counter-Pressure in order to be treated in a trauma-sensitive manner. An example of trauma-informed services within an emergency department (ED) setting is to have the hospital security guards dress in street clothes instead of intimidating uniforms and the HCPs to check in with the client in the waiting area at intervals determined in collaboration with the client. Promoting Feeling Human is smoother within a trauma-informed environment because barriers that impede access to treatment are removed (Cadiz et al., 2004) and the existence of trauma is validated (Elliot et al., 2005; Herman, 1992). Within a trauma-informed approach, women’s knowledge is valued, goals are established collaboratively (Conradi & Wilson, 2010; Poole, 2010; Regan, 2010), and women are involved in designing the services (Clark, 2008; Elliot et al., 2005; Fallot & Harris, 2004), a process that matches the collaborative nature of the Recovery Model.

**Paradigm shift conclusion.** The Recovery Model infused with feminist ethical theory and a trauma-informed care approach provides capacity for Feeling Human. A paradigm shift away from the dominant medical model where emphasis is placed on symptoms rather than the whole person is needed to decrease System Entrapment. The
Recovery Model is a client-centered service delivery framework focusing on strengths and collaboration with the HCP. Although the Recovery Model is critical in its deconstruction of traditional taken-for-granted approaches, including aiming to adapt the system to fit people’s needs instead of making people adapt to the system, it lacks awareness of power imbalances. To rectify this, feminist ethical theory ought to be integrated into the model to address the socio-political factors influencing *Trauma* and *System Entrapment*. The impact of IPV on women’s help-seeking must be acknowledged through the addition of a trauma-informed approach, which would enhance the understanding of how the environment contributes to crisis responses and may decrease the stereotype that suicide behaviour is manipulative. Administrators need to welcome clients to policy committee meetings and prioritize educational opportunities regarding recovery, feminist, and trauma-informed care in support of HCPs’ capacity to challenge restrictive practices. Successful implementation of a new way of delivering services and making cultural changes is contingent upon leadership and support from administrators and other organizational officials (Clossey & Rheinheimer, 2014).

**Application of the Theory as a Tool**

The pictorial depiction of the *Hunting to Feel Human* theory (Figure 6) can be used as a tool to guide HCPs’ care with women’s help-seeking for suicidality after IPV. The *Hunting* sub-processes illustrate the context of women’s help-seeking, providing an understanding of how their journey changes within each stage. The diagram can be used with clients to explore how they relate to the theory and to clarify details of their health care needs, contributing to HCPs’ assessment of the crisis and treatment planning. Women can also use the diagram as a reference for future safety planning and as an
educational tool to help explain their needs to caregivers and other support people.

Further explanations of how to apply the theory as a tool are separated into each Hunting sub-process in sequence from the left-hand side of the diagram beginning with Distancing from Help and ending on the right-hand side with Letting Go.

**Helping during Distancing.** People working within health care need to give women a reason to believe that accessing help is less dehumanizing than managing suicidality without formal support. Clients may feel more in control of their help-seeking with information on the process of being admitted to the hospital, the rules of involuntary status, the expected wait time for individual therapy, and treatment methods available for suicidality, trauma, and mental illnesses. Fears about being locked in an institution upon disclosing suicidality to an HCP may dissolve with reliable information on what to expect. Community outreach through positive messaging on government of health websites, in physicians’ offices, mental health clinics, and through other health care providers may convey the message that mental health services are welcoming and is an opportunity to provide information on how to access services. Maintaining contact with discharged clients from the hospital may keep them engaged and give a sense of belonging, reducing reticence of reaching out again in the future.

**Helping during Enduring.** Services ought to be created to respond with continuous validation regardless of the setting and not merely during Enduring System Entrapment, to avoid the sense that Feeling Human must be earned. Heightening HCPs’ awareness that clients are most often rewarded with validation when they follow the rules and withhold communicating their needs may help HCPs to correct this pattern. Advocating for least restrictive interventions in psychiatric facilities might help to reduce
the need to *Endure*. Mental health administrators and HCPs must consider the ramifications of clients’ perception of coercion and the myth that suicide risk justifies the use of restraint or that safety is necessarily upheld with the use of restrictive treatment measures (Callaghan, Ryan, & Kerridge, 2013). Women might feel more secure with help exploring factors that influence the pressures to conform to institutional norms. Helping women to recognize the social factors that limit their capacity to get help may reduce self-blame. Engaging women in a deconstruction of societal gender assumptions, including the expectation for women to cooperate and avoid conflict, may reduce the feeling of being weak and a burden.

**Helping when women reach out.** Particular attention on supporting HCPs’ capacity to be helpful during the *Hunting* sub-processes *Applying Counter-Pressure* and *Grasping for Help* is important as their responses during this time most often contributed to *System Entrapment*. Before HCPs can validate women when they reach out, HCPs must be available when *Grasping* occurs in the first place. Cross et al. (2017) increased access to supportive health care for women calling a domestic violence hotline by training the workers on suicide prevention and intervention. Preparedness for responding to women’s suicidality within Cross et al.’s (2017) study entailed having the skills to respond at the right place, at the right time. When women felt the urgency to reach out to the hotline, HCPs with appropriate skills were available.

Understanding the reasons for women’s behaviours and emotions while they reach out will help HCPs to convey acceptance. Realizing that *Grasping for Help* is self-protection against *Trauma Entrapment* may help HCPs to have more compassion. Realizing that aggression during *Applying Counter-Pressure* is self-protection against
System Entrapment may help HCPs not to take the behaviour personally and avoid defensive responses. Helping HCPs to understand suicidality might be easier if they are given similar examples of physical health problems. Just as medication would not be withheld from clients experiencing pain after a car accident, clients with suicidality also deserve to have their needs for validation met.

HCPs can help simply by receiving and acknowledging the request. Regardless of whether they understand reasons for Grasping for Help, HCPs can learn that reaching out during suicidality is a way of attempting to fulfil one’s needs and is an opportunity for the HCP to promote Feeling Human. HCPs are encouraged to stop blaming women for their problems under the guise of holding them accountable for their actions and instead help them examine how stigma, gendered violence, and other social influences impact suicidality and trauma.

Helping during Feeling Human. HCPs can continue to assist women during the hunting sub-processes that occur once validation is received and Feeling Human begins. Consistent and ongoing validation throughout Letting Go and Soaking in Validation is required to maintain trust as System Entrapment quickly leads to dehumanization, requiring a reengagement process. Caution must be taken not to rush into problem solving once the person acquires a sense of belonging and desires to live. Well-intended ideas or plans to improve the crisis situation risks increasing System Entrapment as the person may not be ready to make changes. When a person is not able to make changes during risk for self-harm, continuing to validate and help the person access safeguards within the hospital environment or the community are important interventions for suicide prevention. If HCPs are unsure of how to handle boundary limitations or feeling
helpless to change the client’s situation, they need encouragement to reflect on their thoughts and feelings about the client’s situation and find ways to manage these more effectively. HCPs who respond to suicidality consistently with validation, acceptance, and compassion may be criticized as being naive for allowing clients to manipulate them and feeding into clients’ attention-seeking behaviour. Knowledge that their validating interventions leads to *Feeling Human* and observing other positive outcomes may increase HCPs’ confidence in providing care that may contradict colleagues’ or employers’ expectations. HCPs can explore shifting the clinical ideology from prioritizing independence toward accepting clients’ reliance on the therapeutic relationship. An important support would be a clinical supervisor who might help HCPs challenge personal values and beliefs that perpetuate judging and disbelieving or minimizing women’s suicidality.

**Summary of tool application.** A pictorial image of the *Hunting to Feel Human* theory is an intervention guide. The diagram may be used to educate HCPs on women’s help-seeking and to interpret women's intent and needs during suicidality when the HCP is unsure how to intervene. The diagram also serves as an assessment tool to be used in collaboration with women, ensuring that the HCP understands their perspective of the problem. HCPs can use the diagram to inform treatment team members about women’s needs and as a framework for care planning. Interventions for each hunting sub-process can be used to target women’s specific needs within the different contexts. Treatment interventions ought to be flexible to adapt to the changes in women’s help-seeking while validating interactions remain constant.
Study Limitations

Like all research, this study has limitations. Participants from each region within Horizon Health Network were recruited through convenience sampling. Convenience sampling may have resulted in excluding those who did not feel comfortable sharing their experiences, as well as excluding First Nations women since advertisements were not placed within First Nations communities. Because the study was conducted in English, non-English speaking women from Francophone and other ethnic communities may have been excluded. Women who experienced higher levels of trauma intensity may not have had the capacity to reach out to a researcher and stranger. Anger and a desire to improve the system may have been the motivation for women to respond to the study advertisement; therefore, this study may be biased with a disproportional sample of women who were dissatisfied with the health care services they received. Also excluded from this study might have been homeless women who had not received formal help, as most of the women had responded to an advertisement within a health care setting. Although some of the women had experienced homelessness at some point, hearing from women who remained without shelter and had never visited an HCP may have revealed different perspectives.

Future Research

Further research on women’s help-seeking for suicidality after IPV is needed to test the reliability and consistency of the Hunting to Feel Human theory and to deepen the understanding of this process. Replicating this study and comparing the findings to the Hunting to Feel Human theory might highlight similarities to strengthen trustworthiness and offer opportunities to explore contradictions. Conducting similar
studies with samples from three different populations is suggested. First, a study with women who had sought help for suicidality without a history of IPV but rather a different form of abuse might shed light on indicators that separate IPV from other types of violent trauma. Although suicidality intensity was not directly associated with IPV intensity in the current study, discovering whether the intensity of other violent trauma is directly related to suicidality intensity might help in safety planning. Second, considering that violent trauma is associated with mistrust of others, a study with suicidal women who had not experienced abuse might shed light on how hypervigilance and Gauging for Validation opportunities relate specifically to suicidality. Third, replicating this study with women seeking help for non-suicidal PTSD symptoms related to past IPV might parallel patterns within the Hunting, widening this study’s generalizability. A study with this sample might also reveal differences that separate suicidality with other mental health crises.

Of most significance for the implications of Hunting to Feel Human is the need for HCPs to provide validating interactions. Evaluating HCPs’ emotional responses to their clients and restrictive professional boundaries that act as barriers to HCPs’ capacity to demonstrate their humanity may help them to be more validating. The influence that HCPs’ fear of fostering dependence has on the interpersonal relationship might clarify potential barriers to validation. More research on clients’ self-determination and HCPs’ responsibility within the therapeutic relationship may provide insight on avoiding coercion and neglect (Hoffman & Kress, 2010). Interventions based upon the outcomes of suicide research that are aimed at improving help-seeking for suicidality ought to be evaluated for efficacy (Hom, Stanley, & Joiner, 2015). Evaluating outcomes of HCPs’
capacity to communicate empathy after an education session on *Hunting to Feel Human* might demonstrate the applicability of the theory on HCP interpersonal practice. Overall, little research exists on women’s help-seeking for suicidality after IPV, therefore exploring different ways of meeting their needs for acceptance, security, and a sense of belonging may help HCPs to assist women to *Feel Human* and continue living.

**Research Design: Lessons Learned**

A combined GT and PV qualitative multiple method design with the philosophical underpinning of feminist ethical theory was a productive research approach in capturing women’s help-seeking for suicidality. Each research approach (GT, PV, and feminist ethical theory) is critical, and when combined, created a substantive and consciousness-raising theory developed deep within the collective voice of the participants. Joining PV with GT strengthened the research by adding rigor to the data collection, enriched the analysis, and provided a rewarding experience for the participants. The feminist ethical theory facilitated awareness of power imbalances throughout the entire research process.

**Combining research approaches.** Using GT as the core component of the research design provided a solid process for the development of a substantive theory based on women’s everyday lives within different contexts; thereby, yielded meaningful application to helping women. The supplemental component of the multiple method design, PV, offered thickness and richness to the theory. Participants shared intimate details and in-depth accounts of their help-seeking during the individual interviews, but the most profound data collection was during the consciousness raising that occurred within the PV meetings. Using different ways of collecting and analyzing data, including
interviews, PV group discussions, photo images, and the group’s collective analysis, strengthened my understanding of the *Hunting* process and increased the trustworthiness of the findings.

Adding PV data to the GT analysis was a smooth process as most of the PV data consisted of group meeting transcripts that were analyzed the same as the interview transcripts. Most of the PV meetings consisted of my active engagement within the discussions and clarifying my observations with the group. Hypothetical relationships or hunches between the concepts that began to stand out within the PV discussions were tested against existing relationships that had been emerging from the interview analysis. I relied on my observations and the rigorous step-by-step GT process while analyzing the interviews, giving me confidence in the development of the theory. For example, the importance of taking control by immediately reaching out while in a suicidal crisis was discussed while showing the images of the phones. *Taking control* and *reaching out* were tested against similar categories from the interview analysis, *grasping for a life-line* and *seeking relief*, and woven together within a larger category, *Grasping for Help*.

In addition to women’s participation in collecting the data and explaining their images, they also participated in the research analysis through a collective conversation, raising each other’s consciousness and generating new insights that I may not have noticed while they were being discussed. Since the women had a shared understanding of their help-seeking, they did not always have to explain their thoughts in as much detail as if they had been sharing with someone who had never been abused or suicidal. For this reason, I may not have fully understood the women’s insights and conclusions about their help-seeking at the time or I may have thought that I understood, but was not aware of
having missed a part of their analysis. For example, the PV women discovered that they perceived medication as an element of control and invalidation by the system. They also realized that they had been taking advantage of the medication by not using it as prescribed, but rather used it as a tool to meet their needs in unconventional ways. Feeling stuck within their Trauma and System Entrapment, they overdosed on the medication, sedated themselves with the medication as a way of escaping partner violence, or reported dangerous side effects of the medication as a way of proving they needed help. The women became aware that they were using a dehumanizing treatment as a way of self-protection.

Up to that point in the analysis process, I had hypothesized that the basic social-psychological problem was losing control related to feeling judged and alone, to which women’s response was to shut down. I had not picked up on women’s discovery that they used medication to fight for help; however, theoretical sampling helped me to make sense of it. The PV findings, fighting back with medications and taking advantage of medications, were tested against the categories that had been emerging from the analysis of the interviews, including withdrawing from HCPs and putting up with coercion. Constantly comparing the categories allowed for an understanding that they used whatever was at their disposal to avoid Entrapment or to take advantage of the situation, a process that eventually emerged into Taking the Path of Least Disempowerment.

Participants’ self-generated images were used within the GT analysis insofar as they elicited discussion and subsequently generated transcripts. The images were also beneficial as examples in writing the theory. While the GT process generated a rich theory that elicits the reader’s attention with a pictorial rendering of women’s journeys,
the self-generated images illustrate women’s everyday realities. The images bring the reader closer to the meaning and intensity of Hunting to Feel Human and are a powerful medium to quickly grasp the relationships within the theory. Cassie’s image of her T-shirts with the collars cut out (Figure 21) is representative of the impact of Abuser Entrapment on her mental health and is a tool for engaging HCPs in trauma informed care. HCPs may learn from this image to stop and think before automatically putting a hospital gown on the client and instead asking her if she is comfortable having it tied at the neck.

**Integrating a critical approach.** Infusing a critical approach or an awareness of power imbalances, one of the core principles of feminist ethical theory, fits within the combined GT and PV design. A critical approach through engaging the PV group in a discussion about socio-political influences promoted the group’s consciousness raising, fueling their ideas about what changes are needed within the system and validating their struggles. Many of the women had not been aware of how stigma contributes to Abuser, Trauma, and System Entrapment or how societal attitudes ought to be changed to promote Feeling Human. Awareness of how their problems relate to a multitude of factors outside of their control was empowering and reduced self-blame.

Feminist ethical theory helped me to remain aware of gender-related power imbalances that I may have taken for granted; for example, I explored how gender norms related to HCPs’ invalidation of women’s emotional expression. I remained aware of how my biases as a clinician and policy maker risked blinding me to dehumanizing clinical habits within my practice, resulting in my defensive reactions upon discovering System Entrapment. The contradiction within the data between feeling controlled by HCPs
versus women’s need for HCPs’ guidance initially confused me, while feminist ethical theory helped me decode these initially conflicting findings. I learned that although women strive for autonomy within an oppressive system, self-determination is relational, hence the need to rely on HCPs. Dignity, another core principle of feminist ethical theory, helped me to make sense of what it means to Feel Human.

Overall, a critical approach allowed me to prioritize the researcher-participant relationship. This allowed me to gain women’s trust and give back to them by helping them gain access to resources in the community. Women also felt rewarded by knowing how their participation in the research helps to make changes within the health care system.

Conclusion

Hunting to Feel Human is the socio-psychological basic process of women’s help-seeking for suicidality after experiencing IPV, a dynamic process used to manage the basic socio-psychological problem, System Entrapment. This substantive theory helps to fill gaps in understanding chronic suicidality and trauma in women and has critical implications for HCPs. To Feel Human is to have a sense of personal value and belonging, a goal that is sought in overcoming System Entrapment, feeling stuck within dehumanization as a result of feeling invalidated within the health care system. System Entrapment exists within the context of past Abuser Entrapment, feeling stuck within IPV, and Trauma Entrapment, feeling stuck within suicidality, creating a vulnerability to dehumanization while seeking treatment. The journey toward Feeling Human is attained through Hunting, a visceral fight for validation through several sub-processes including Distancing, Grasping for Help, Applying Counter-Pressure, Enduring System...
Entrapment, Soaking in Validation, and Letting Go. The sub-processes are a way of Taking the Path of Least Disempowerment, a journey that is guided by Gauging Validation opportunities. Depending upon the ratio of System and Trauma Entrapment that is Gauged, the Hunt will retreat from or move toward the system.

A multiple method qualitative design using GT and PV infused with feminist ethical theory rendered socio-political constructs of women’s help-seeking. Transcripts from individual interviews with 30 women, seven of whom participated in the PV portion of the study, were analyzed using the constant comparative method of GT. Although little is written about the combination of GT and PV, the research approach was responsive to capturing the complexity of managing past trauma, suicidality, and overcoming dehumanization within a culture that stigmatizes these difficulties. The PV approach aligned with the philosophical underpinning of the study, feminist ethical theory, as the self-generated images and consciousness raising within the meetings helped to broaden the scope of the research beyond the individual and situated women’s voices within the developing theory. Feminist ethical theory heightened the awareness of oppression and provided a lens through which to dismantle harmful assumptions about the value of independence and reason; ideology with historical roots within Aristotelian and Kantian ethics. Acknowledging that emotions are not equated with weakness, but rather a response to trauma, and that autonomy is relational helps to understand the need for HCPs validation in Feeling Human.

Implications of the Hunting to Feel Human theory involve an overhaul of service provision culture, necessitating a movement from the dominant medical model toward one based on the Recovery Model. Rejecting labels and adapting services to the client’s
needs, rather than expecting the client to adapt to the system, is a practice within the Recovery Model that avoids dehumanization. Integrating a feminist ethical theory approach with the Recovery Model is needed to raise awareness of power imbalances by tying in gender and other socio-political factors that critically impact *Feeling Human.* Finally, integrating a trauma-informed care lens to this Feminist Recovery Model helps HCPs to be aware of how trauma impacts women’s help-seeking experience, an approach that prevents client blaming. This combined service delivery model ought to prevent *System Entrapment* by focusing on promoting *Feeling Human* instead of focusing on death prevention that may lead to restrictive interventions and pressure to change. As well, easing restrictive professional boundaries within the therapeutic relationship will be more validating since sharing mutual humanity has the power to inspire women to continue living.
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Appendix A

Data Collection and Analysis

Data collection through recorded interviews of women from all HHN areas

Data collection through self-generated photos from photo groups with Moncton area women

Women’s recorded discussions of their analysis of the photos

GT analysis of all transcripts
Appendix B

Recruitment Flow Chart

Recruitment through advertisement

Interested woman contacts me via phone. Eligibility Screen (Stage 1 & 2).

Meets criteria. Book appointment for interview.

Does not meet criteria. Thank her and explain reasons. Validate her reasons for participating.

Eligibility Screen (Re-assess Stage 2)

Does not meet criteria. Utilize Suicide Safety Protocol

Meets criteria

Interested woman contacts me via phone. Eligibility Screen (Stage 1 & 2).

Fill out Demographic Form. Give her Consent and Information Form. Answer her questions. Woman signs consent. Proceed with Interview.

Women outside of Moncton

Agrees and signs PV consent form. Schedule 1st PV meeting

Moncton woman does not wish to do PV group.

After interview: Moncton women: Invited to do PV group

PV meetings
1st: Camera training & assignment #1 given
2nd: Assignment #1 analysis; 2nd assignment given
3rd: Assignment #2 analysis; 3rd assignment given
4th: Assignment #3 analysis; wrap up

Individual follow up contacts via phone, email, or face-to-face to refine evolving theory.
Appendix C

Letter of Invitation for Interviews

Note: This advertisement is to be left in doctor’s offices or to be handed out to eligible women by health care workers within mental health clinics, etc.

You are invited to consider taking part in a research study,

I am a registered nurse in a PhD program at the University of New Brunswick. As a nurse, I have worked with people seeking help for depression for almost 20 years. My main interest is helping women who are suicidal and who have been abused by their spouse, common law partner, or dating partner. People working in the health field need to know more about how women seek help when they feel like ending their lives so that they can help women better when they are in crisis. Your participation could help in this.

I wish to talk with women 19 years of age or older who are no longer with an abusive partner and are willing to talk about their help-seeking for suicidal thoughts. You will be invited to share what you have been through during a private one to two hour interview with me. If you agree, I may contact you again to review what we had talked about.

I would like to meet with you because your experience can add to our understanding. If you are interested, phone or email me so that we can set a time to meet.

Thank you,
Petrea Taylor
962-4690 (Moncton area)
###-###-#### (Toll free & private voice mail)
petrea.taylor@unb.ca

“This project has been reviewed by the Research Ethics Board and is on file as REB 20xx-xxx.”
Appendix D

Advertising Notice

Title: Seeking women who have sought help for feeling suicidal and have left an abusive relationship.
I am a nurse doing research with the University of New Brunswick. I wish to talk with women 19 years of age or older who are no longer with an abusive partner and are willing to talk about their help-seeking for suicidal thoughts. Women in this study will be invited to share through a private one to two hour interview with me at a time and place that they choose. If you live in the Moncton area, you will be invited to take pictures of things as a way of telling others about your help-seeking. You can also choose to share these pictures with a group of women who have been in the same situation. You will be given $30.00 for you time. If you want to know more about this study please call this private line: (506) 962-4690–toll free at ###-####*) or email (petrea.taylor@unb.ca).
Note: This project has been reviewed by the Research Ethics Board and is on file as REB 20xx-xxx.

The following are example locations where the recruitment advertisements will be placed:

- Family Services Moncton groups for abused women
- Community Mental Health Centre DBT and other groups
- Support to Single Parents
- Coalition Against abusive relationships (outreach worker that intervenes),
- SANE in the ER programs at The Moncton Hospital and
- Victim services
- Local psychiatrist’s offices
- Local Family Physician offices
- Salvus Clinic
- MAGMA (Multicultural Association of the Greater Moncton Area)
Appendix E

Eligibility Screening Form (Stage 1)

This form will be filled out by the researcher during the potential participant’s initial phone call.

ID ______________________

Which surrounding area do you live? Moncton___ Fredericton___ Saint John___ Miramichi___

1. Are you a woman 19 years or older? Yes _____ No ____
   If Yes, move onto #2.
   If No, thank the woman for her interest in the study.

A. Abuse Assessment Screen

Did a boyfriend, marital, or common-law partner ever:
   a) hit, kick, or otherwise physically hurt you? Yes No
   b) force you to have sexual activities against you will? Yes No
   c) do things to make you feel afraid of him? Yes No
   d) do things to try to intimidate you or to control your thoughts, feelings or actions? Yes No
   e) do anything else that you feel was harmful or abusive? Yes No

If no to all parts of Q2, thank the woman for her interest in the study and offer resources.
If yes to any parts of Q2, move to Q3.

3. Living apart from an abusive partner for at least six months? Yes ___ No ___
   If Yes move to Q4.

B. Past help-seeking for suicidality

Since the first time you were abused by a partner, have you sought help from a doctor, hospital, mental health clinic, counsellor, or other health service for the following?

- Thoughts that you wanted to die
- Feelings that you wanted to go to sleep and never wake up or to ‘end it all’
- Planning of killing yourself
- Harming yourself (cutting, burning, etc.)
- Attempting to kill yourself

Yes ___ No ___

If No, thank her for her interest in the study.
If Yes, move to Stage 2 of the Eligibility Criteria (Appendix F) to assess for current suicide risk. If the woman scores a low risk on this scale, proceed in scheduling a face-to-face interview.
Appendix F

Eligibility Screening Form (Stage 2). Suicide Assessment Page 1

Assessment will be completed with the women during the initial contact over the phone and again before the face-to-face interview begins to verify the inclusion criterion of having a low suicide risk.

<table>
<thead>
<tr>
<th>Assessment of Risk for Suicide</th>
<th>Low Risk (1 point)</th>
<th>Moderate Risk (2 points)</th>
<th>High Risk (3 points)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Assessment Factor</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Suicidal ideation</td>
<td>No current thoughts</td>
<td>Intermittent or fleeing thoughts</td>
<td>Constant suicide thoughts</td>
</tr>
<tr>
<td>Prior suicide attempts</td>
<td>None</td>
<td>Past attempts – low lethality</td>
<td>Past attempts – high lethality</td>
</tr>
<tr>
<td>Suicide plan</td>
<td>No plan</td>
<td>Has plan but no access to planned method</td>
<td>Has thought out plan with access or potential access to method</td>
</tr>
<tr>
<td>Lethality of plan</td>
<td>Superficial scratching</td>
<td>Swallowing pills, reckless driving</td>
<td>Hanging; gun; jumping; carbon monoxide; gas</td>
</tr>
<tr>
<td>Intention to Act</td>
<td>None (for the future)</td>
<td>Soon if situation deteriorates</td>
<td>Immediately</td>
</tr>
<tr>
<td>Has a counselor</td>
<td>Seeing one, aware of suicide ideas</td>
<td>Seeing counselor, not aware of suicide ideas</td>
<td>Not seeing one</td>
</tr>
<tr>
<td>Support system</td>
<td>Several friends, coworkers and relatives available</td>
<td>One or two friends, coworkers and relatives available</td>
<td>None available</td>
</tr>
<tr>
<td>Substance Use</td>
<td>None</td>
<td>Active Use</td>
<td>Heavy use</td>
</tr>
</tbody>
</table>

**Scoring Directions:**
Assess each factor. Circle one best description for each factor. Assign the points and add to calculate the score.
Scoring Key:
8-11 = low risk
12-17 = moderate risk
18 or above = high risk

If Low Risk:
1. Proceed with participation in study
2. Remain alert of changing status

IF Moderate Risk:
1. Tell the woman that you believe her safety may be at-risk
2. Ask her to identify people in her social network who can help her.
3. Advise her to seek help from the appropriate mental health service.
4. Provide information about services as needed.

IF High Risk:
1. Tell the woman that her safety is at immediate risk & that you are very concerned.
2. Follow the Suicide Safety Protocol (Appendix I)

Suicide Protective Factors (Factors that lower suicide risk):

- Close relationships: I will assess the women for relationships in their lives that they perceive as being a positive resources, sense of belonging, and generally being supportive. “Who do you go to for help when you are having difficult times? Who helps you to feel more hopeful?”

- Positive thinking skills: I will assess for women’s ability to think of the good things in her life despite being in a difficult situation or the ability to see her strengths during challenging times. “How do you handle difficult situations? What strengths do you draw on when things get ‘bad’?”

- Spirituality: I will assess women for what brings them meaning and hope in their lives. “What do you turn to in difficult times that brings you hope? If you believe in a higher power, tell me about this helps you?”

- Sense of purpose: I will assess women for what gives them a sense of purpose. “What important goals do you have? What do you do that brings you a sense of purpose in life or makes you feel productive, worthy, or valuable as a person?”

- Self-esteem: I will assess women’s feelings of self-worth. “What do you or others like about you (yourself)? What are your strengths?”

- Problem solving skills: I will assess women’s ability to manage difficult situations. “How have you overcome difficult situations in the past? How do you tackle a problem or challenge that comes your way?”

Note: regardless of the score, if, in your professional judgment, the woman is in immediate danger, follow the high risk protocol.

Adapted from Hatten, CI & Valente, SM (1984)
Appendix G

Example of Resources Handout (Moncton and Surrounding Area)
Crisis Services (to be given to the PV participants)

Hospital Dr. G.-L. Dumont ER (24 hours/day, 7 days/week) 962-4114
The Moncton Hospital ER (24 hours/day, 7 days/week) 857-5111
Sackville Memorial Hospital ER (24 hours/day, 7 days/week) 364-4100
CHIMO: NB crisis phone line (24 hours/day, 7 days/week) 1-800-667-5005
Beausejour Family Crisis Resource Centre Shediac (24 hours/day, 7 days/week) 533-9100
CARA Helpline: crisis phone line for the Moncton area (4 pm – 8 am) 859-4357
Crossroads for Women (domestic violence shelter) 853-0811
Coalition Against Abuse in Relationships Inc. (CAAR) (provides safety planning guidance) 855-7222
RCMP 1-800-665-6663

EMERGENCY 911
Non-Crisis Services

Community Mental Health Centre, Moncton (Mon-Fri 8:15 am – 4:30 pm) 856-2444
Community Mental Health Centre, Richibucto 1-866-662-1166 (Mon- Fri 8:15 am – 4:30 pm)
Albert County Health & Wellness Centre (7:00 am – 6:00 pm) 882-3100
Victim Services (Mon-Fri 8:15 am – 4:30 pm) 856-2875
Mental Health Mobile Crisis Team (2 pm – 10 pm, 7 days/week) 1-866-771-7760
Support to Single Parents 858-1303
Family Services Moncton (Mon-Fri 8:15 am – 4:30 pm) 1 (800) 390-3258 or 857-3258 (domestic violence support group)

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Appendix H

Participant Tracking (4 pages)               ID ______________

Research Project: Help-seeking for Suicidality in Women who have Experienced Intimate Partner Violence

Initial Contact over the phone.

Date: ____________________  Name used in the study: __________________________

Address:_______________________________________________________________

Phone (H): _________________ (Cell): ________________ E-mail: ________________

Demographics

• Age ______
• Ethnic/cultural background ____________________________
• Language spoken at home ______________________________
• Diagnosed with a mental illness________________________
• other health conditions? _______________________________
• Length of time since leaving an abusive partner relationship ___________
• Were you ever legally married to your abusive partner(s)? Yes ☐ No ☐
• Current relationship status with ex (abusive) partner(s): married ☐
  • separated ☐
  • legally separated ☐
  • divorced ☐
  • widowed
  • Other.

Describe________________________________________________

Ongoing abuse/harassment since being apart from the ex-partner? No ☐ Yes ☐ if yes,
describe:__________________________________________________________________

C.    Involved in any legal proceedings (e.g. restraining order, divorce, custody, support, etc.)?

__________________________________________________________________

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What is the best way to contact you in the future? Home phone, cell, e-mail □ other…

_____________________________________________________________

Do you have a preferred day or time for contact? ________________________________

Is it all right to contact you 1-2 days before the next meeting as a reminder? Yes □ No □

Is it safe to leave a message for you on your answering machine? _________________

What is your preferred place/day/time of day for meetings? ______________________

What would you like us to do if our phone call is terminated by someone?

_____________________________________________________________

Where would you like to keep your information letter about the study? Home □ Other □

Explain:

_____________________________________________________________

Who will be caring for your child(ren) during our meeting(s)? Not applicable

_____________________________________________________________

What will you do if it you feel it is unsafe to attend the meetings? (e.g., someone stops you from coming or you are followed) ________________________________

Information related to ex-partner to update before each visit with women:

Date: ___________________________ ID ______________________

● Is harassment and abuse ongoing by ex-partner, his family or friends?

_____________________________________________________________

● Does abuser live in same city or area?

_____________________________________________________________

● Is there a restraining order? Yes □ No
● Custody agreement?

______________________________

● Are there ongoing disputes or court cases?

______________________________

● Are there weapons in the participant’s home?

______________________________

● Is the abuser familiar with weapons and does he/she have access to them?

______________________________

● Has ex-partner threatened to kill you or your children?

______________________________

Alternate Contacts (update as needed)

Name: __________________________ Relationship __________________________
Address: _________________________ Phone _______________ E-mail: _______________

Name: __________________________ Relationship __________________________
Address: _________________________ Phone _______________ E-mail: _______________

Name: __________________________ Relationship __________________________
Address: _________________________ Phone _______________ E-mail: _______________

Name: __________________________ Relationship __________________________
Address: _________________________ Phone _______________ E-mail: _______________
Meeting Arrangements

For reminder calls: Check current safety around the call, ask for any changes in safety/harassment and/or changes in contact information.

<table>
<thead>
<tr>
<th>Date/time of next meeting:</th>
<th>Does participant need: Y/N</th>
<th>Details</th>
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<tbody>
<tr>
<td></td>
<td>24-hour reminder call?</td>
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<td></td>
<td>Post-meeting debriefing</td>
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<td>Notes:</td>
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<td></td>
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<tr>
<td>Notes:</td>
<td></td>
<td></td>
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Appendix I

Suicide Safety Protocol

• Disable access to means of self harm (e.g. assist in the removal of guns in her environment, restrict access to ropes, razors, etc.).

• Assess for the amount of time she is able to remain safe and implement resources accordingly. (e.g. if only able to agree to avoid self harm for a few hours, ensure she is not alone for this amount of time)

• Assess for supportive resources

• Contact a support person so that she is not alone

• Go with her to the ER, or a walk in clinic if needed

• Provide her with Suicide Hotline Number and other crisis services.

• Reinforce distress tolerance strategies (Appendix K).

• Ask permission to follow up with a supportive phone call later on in the day or the next day, etc.
Appendix J

IPV Safety Protocol (a guide for the researcher)

A. I will have the number of the local transition house and other services for abused women with me during all contacts with participants and will provide information and referral as needed.

B. Participants will be able to contact me through my office phone, cell phone, e-mail, or regular mail. The women will be asked to indicate their preferred means of being contacted (telephone at home or other, e-mail, or regular mail) and the best time to contact. Each woman will be told that a message will only be left for her if she gives permission (i.e. “Please call Petrea at [number] about the women and health care study”). Otherwise, I will call back repeatedly until she is reached.

C. During the 1:1 initial meeting with the women, I will:

1. Complete the Participant Tracking and Demographic form (Appendix H) that will help in assessing need for specific safety measures, including asking permission to make a reminder call a day or two before each group meeting.
2. Discuss the most appropriate and safest place for group meetings. As necessary, we will encourage the woman to consider her visibility, the chances of being followed, and the safest mode of transportation.
3. If needed, develop a safety plan regarding:
   i. Where she would like to keep her copy of the letter of information (i.e. take home or keep on file at a predetermined office)
   ii. What the researcher should do if a phone call is suddenly terminated or (e.g. call back, wait for woman to call back, call a designated person [from list] to check on her, call police).
   iii. Care of children while participating in the study. (I will carry a cell phone and this number will be provided for participants to leave with children/care givers in case the women need to be contacted by them during interviews or group sessions). This allows us to keep the meeting setting confidential.
   iv. What the woman will do if she decides on the day of the meeting that the situation is unsafe (e.g. someone comes to her home at the scheduled interview time; she is followed to the interview, or seen by someone who she perceives is a threat).
   v. I will request names, contact numbers, and addresses of up to 3 people who would know the woman’s whereabouts and could be contacted if unable to reach her or her telephone service has been disconnected. She will be asked to inform these people that she has provided their names.

D. If there is permission for a reminder phone call, I will at each call:
1. Determine if it is safe to talk at the beginning of the conversation
2. Ask if there she has any current safety concerns
3. Confirm date, time, and location of the next meeting

E. Debriefing at the end of each interview or group meeting.
   1. Check in with the women at the end of each interview and group meeting to see how they are feeling after the discussion. While the past or ongoing abuse is not a focus of the data collection, it may come up in discussions.
   2. Acknowledge that talking about the abuse and their suicidality may produce emotional distress for the woman by communicating, “People sometimes have strong emotional reactions in the first few days after they have talked about the difficulties they have experienced.”
   3. Reinforce that this is a stress reaction that is completely normal. It does not imply that she is crazy or weak.
   4. Review the signs of stress reaction (Appendix K).
   5. Review the things that may help her deal with the signs of a stress reaction should they occur (Appendix K).
   6. Ensure that she has someone with whom she can talk about her experiences (family members, friends or professionals). If she has no one to turn to, offer information about professional support with her permission.

F. Researcher safety
   1. I will carry a cell phone during, and from any meetings, ensuring it is charged.
   2. Observe my surroundings before and after any meetings
   3. Be aware of my safety zone (3 feet around myself) in identifying and responding to a threat. If this space is threatened, I will follow my instincts to leave if I feel that something is unusual or am uncomfortable.
   4. Observing for anyone following me and going to a neutral site (e.g. coffee shop) rather than directly home.
   5. I will notify a ‘safety contact’ about my meeting schedule and touch base with them after the meetings and will discuss with this person what to do if I haven’t contacted him/her within a reasonable time.
   6. Decide on a safety code phrase to be used while speaking to my ‘safety contact’ person to indicate danger and to call the police (e.g., “Tell Paul I will call him later on in the week”)
Appendix K
Stress Reaction Handout

Common signs of a stress reaction that are completely normal are:

<table>
<thead>
<tr>
<th>Physical</th>
<th>Feelings</th>
<th>Thought-related</th>
<th>Behaviours</th>
</tr>
</thead>
<tbody>
<tr>
<td>nausea</td>
<td>fear</td>
<td>confusion</td>
<td>withdrawal</td>
</tr>
<tr>
<td>vomiting</td>
<td>guilt</td>
<td>nightmares</td>
<td>restlessness</td>
</tr>
<tr>
<td>dizziness</td>
<td>panic</td>
<td>hypervigilance</td>
<td>loss of appetite</td>
</tr>
<tr>
<td>weakness</td>
<td>anxiety</td>
<td>poor concentration</td>
<td>insomnia</td>
</tr>
<tr>
<td>palpitations</td>
<td>irritability</td>
<td>forgetfulness</td>
<td>increased appetite</td>
</tr>
<tr>
<td>sweating</td>
<td>grief</td>
<td>disorientation</td>
<td>increased sleep</td>
</tr>
<tr>
<td>difficulty breathing</td>
<td>anger</td>
<td>intrusive images</td>
<td>changes in activity</td>
</tr>
<tr>
<td>chest pain</td>
<td>loss of control</td>
<td>suspiciousness</td>
<td>increased alcohol use</td>
</tr>
</tbody>
</table>

Feeling as if you are experiencing the abuse again

What might help?

Do things that make you feel good such as:

- Physical exercise alternated with rest
- Listening to music
- Eating well balanced, nourishing meals
- Keeping busy: structure your time
- Be aware that numbing the pain with alcohol /drugs will complicate things
- Allowing yourself to feel rotten, and sharing your feelings with others
- Keeping a journal
- Talking to people, reaching out to others and spending time with them

Try the following distress tolerance strategies to help ‘manage the moment’ during a crisis situation.

- Distract yourself through different activities
- Practice acceptance of the situation
- Gently push away difficult feelings temporarily
- Contribute something for others
- Compare how you are better off than others
- Change the emotion by changing the thought
- Use imagery to imagine something pleasant or enjoyable
- Find meaning in the painful situation
- Try relaxation techniques
- Half-smile: communicate acceptance and calm to the brain by slightly turning up your lips with a relaxed face.
- Practice mindfulness by being present in what you are doing right now
- Practice self-soothing using your senses (vision, hearing, smell, taste, touch)
- Focus on your breath (notice breath while lying, sitting, walking slowly)
Appendix L

Interview Consent Form

Research Project: Help-seeking for Suicidality in Women who Have Been Abused by a Romantic Partner

Researcher: Petrea Taylor, Registered Nurse and PhD student, University of New Brunswick.
Phone: 962-4690 (Moncton area). Toll free ###-###-####, Email: petrea.taylor@unb.ca
Mailing address: Moncton Hospital- Unit 3200, 135 MacBeath Ave, Moncton, NB E1C 6Z8

Research advisors:

1) Lynne Duffy, Faculty of Nursing, University of New Brunswick.
2) Judith Wuest, Faculty of Nursing, University of New Brunswick.

Please check in the box for each item that you review and understand.

Purpose of the study:

● This study is about the experiences of women seeking help from the health care system for thoughts or actions around suicide and who have been abused by a romantic partner in the past.

What will happen during the study?

● I will be invited to talk about my help-seeking in a private interview with Petrea lasting about 1 to 2 hours.
● The interview will be taped and typed word for word in a file on a secure password-protected computer.
● If I agree, Petrea will call me one day after our meeting to check if I have any questions or concerns.
● Petrea will also contact me several weeks after the interview to check in with me about any other questions that may arise about what is found in the study.

Privacy

● Typed interview files will not be seen by anyone other than Petrea and her research advisors.
● My real name or contact information will not be on the interview file, only an ID code. For any writing of the study’s findings, I will be assigned a pretend name in order to protect my identity. Petrea is the only person who knows which interview is mine. This consent form, and any other forms with personal info, will be kept in a different and secure place from the interview files.
- Everything will be done to help ensure no one will be able to tell who I am in the final report or in any public use of the study findings.
- Interview recordings, interview transcripts, and photovoice transcripts will be kept in a password-protected file in secure computer for 7 years after the study, then erased.

**Benefits**

- Sharing my experiences in this study may assist others who are seeking help for suicidal thoughts.
- Talking about my experiences in this study might bring me comfort. Sharing my thoughts in this study might bring me comfort knowing that I am not alone in having gone through these hard times.
- Being in this study will help educate health care workers in how to improve services for women who have been abused and who are suicidal.
- I will receive $30 cash as a small ‘thank you’ for my time and to help with transportation and childcare if needed.

**What about risks?**

- Talking about the times when I was in crisis could cause me discomfort and stress.
- Petrea has supports on hand for me that can help me deal with discomfort or stress.
- Petrea will assess my risk for hurting myself before the interview. She will connect me with help if needed.
- I will not continue to be in the study if I have a suicide plan or strong thoughts of wanting to end my life. Petrea will help connect me to a crisis service if needed.
- I may contact any one of the crisis services if I need to discuss concerns or stressful feelings that come up while being in this study. A list of these services (Resources Handout) has been provided to me.

**Other notes**

- I know that the study’s findings will be shared with others through formal talks, including educating others, and in writing, such as articles.
- I agree that transcripts without my name and any identifying info, can be used for other studies. In the case of another study, Petrea would apply for ethics approval before using the info.
- I may withdraw from the study at any time without having to give a reason. I know that I may choose not to answer any question. If I do withdraw this will not affect future care or interactions with Horizon Health Network or the University of New Brunswick.
● If I experience any distress during the interview, Petrea will ask how I would like to proceed. She will offer a break from the questions and offer me support. I can choose to stop at any time or do the interview at another time.
● If I wish, I will have copy of the final report summary at the end of the study.
● I have been given a chance to ask questions and all have been answered to my satisfaction. I know that I can call the following numbers if I have any more questions about the study:
  o Petrea Taylor at 962-4690
  o Petrea’s supervisor, Lynne Duffy at 856-2682
  o The Dean of Interdisciplinary Studies, Linda Eyre at 506-453-5161 or leyre@unb.ca

I, ____________________________________________, agree to take part in this study and have received a copy of this consent form.

(Printed name) ____________________________________________

Date: ____________________________________________

Researcher: ____________________________________________

Date: ____________________________________________

Would you like a summary of the study findings sent to you?  Yes ____ No thanks ____

This project has been reviewed by the Research Ethics Board and is on file as REB 20xx-xxx.
Appendix M

Interview Guide

● Tell me about seeking help for your suicidal thoughts.

● How did you go about seeking help for your thoughts of suicide?

● How did the mental health services influence your ability to get help when you felt hopeless or had thoughts of harming yourself?

● What was helpful?

● What was unhelpful?

● How did the mental health professionals help you to meet your goals?

● How do you think your experiences of being abused influenced your help-seeking when you were suicidal?

● Did you have a say in how you received help? Did you feel a part of the helping process? Tell me about this.

● What made it difficult to seek help?

● What made it easier to seek help?

● Is there anything else you would like to tell me?
Appendix N

Letter of Invitation for PV Group (with PV session guide)

Note: I will give this letter to women who live in the Moncton and surrounding area once they have completed the interview portion of the study and until there are 7-10 participants for the group.

Research Project: Help-seeking for Suicidality in Women who Have Been Abused by a Romantic Partner

This study has two ways of learning about women’s experiences of help-seeking for suicide; in words and in pictures. You have already helped improve my understanding through the interview. You are now invited to be a part of the “photovoice” portion of the study.

In the this part, you will be asked to take pictures of things that show how you got help for your suicidal thoughts. You will then share these pictures and the stories behind the pictures with myself and a small group of women who have similar experiences and are taking pictures as well.

If you decide to take part this group, a new digital camera will be provided for your use. This camera will be yours to keep at the end of the study. This group will be together at least four times in meetings that will last about 3 hours. You will help decide on the meeting times, intervals, and a safe place that is acceptable for everyone. The first meeting will be an introduction to the photovoice process and information on photography, use of the cameras, and other things to think about in community photography.

The information from the interviews and the photovoice part will be looked at together to deepen our understanding of women’s experiences.

Let me know if you are interested in the ‘photovoice’ group and I will answer any questions you might have.

Thank you.
Petrea Taylor
962-4690 (Moncton area)
###-###-#### (Toll free & private voice mail)
petrea.taylor@unb.ca

This Project has been reviewed by the Research Ethics Board and is on file as REB 20xx-xxx.
Photo voice Group Guide

Taking Pictures

1st Meeting

a) Camera and photo training.
b) Give assignment #1: Take pictures that represent your experience of help-seeking in the mental health system.
   ● The things you did to receive help
   ● The way you were helped or not.
   ● What got in the way of getting help.
   ● When you were getting help or after receiving help, what things were you thinking and feeling?

2nd Meeting

1. Give assignment #2: take pictures of things that represent what needs to change in the mental health system.
   ● What rules policies, or expectations from health professionals influenced your getting help?
   ● What was positive and/or negative about how you were helped with managing your suicidality?
2. Assignment #1 analysis

3rd Meeting

3. Give assignment #3: Looking at all your pictures, what might be missing?
   ● What else is important to include from your experience?
4. Assignment #2 analysis

4th Meeting

a) Assignment #3 analysis
   b) Organize photos into key issues and thematic areas.

Analysis of photos

1. Selecting photos
2. Contextualizing
   See what’s happening; How it relates to Our lives; Why the situation is occurring; what we can Do about it
3. Codifying
Appendix O

Photo voice Consent Form (4 pages)

Research Project: Help-seeking for Suicidality in Women Who Have Been Abused by a Romantic Partner

Researcher: Petrea Taylor, Registered Nurse and PhD student, University of New Brunswick.
Phone: 962-4690 (Moncton area). Toll free ###-###-####, Email: petrea.taylor@unb.ca; Mailing address: Moncton Hospital- Unit 3200, 135 MacBeth Ave, Moncton, NB E1C 6Z8

Research advisors:

1) Lynne Duffy, Faculty of Nursing, University of New Brunswick.
2) Judith Wuest, Faculty of Nursing, University of New Brunswick.

Please check in the box for each item that you review.

Purpose of the study:

● □ This study is about the experiences of women seeking help from the health care system for thoughts or actions around suicide and who have been abused by a romantic partner in the past.

What will happen during the study?

● □ I will be invited to take pictures as a way of telling others about my help-seeking experiences.
● □ I will be invited to discuss these pictures in a group of women who have been in similar situations. We will meet about four times for about 3 hours each time, with the first meeting involving a training session that may last about 4 hours.
● □ The group discussions will be taped and typed word for word in a file on a secure password-protected computer.
● □ If I agree, Petrea will call me one day after each meeting to check if I have any questions or concerns.

Privacy

● □ Interview files will not be seen by anyone other than Petrea and her research advisors.
● □ My real name or contact information will not be on the files of the group discussions, only an ID code. For any writing of the study’s findings, I will be assigned a pretend name in order to protect my identity. Petrea and the women in the group are the only people who know who I am. I can use the pretend name in the group as well. This consent form that I am signing, will be kept in a different and secure place from the files of the group discussions.
● □ I and others in the group will sign a form to protect privacy and confidentiality
of group members.

- Photos will be inputed into a computer that will be kept secure. Photos will be marked with a code that includes my own research ID number.
- Everything will be done to help ensure no one will be able to tell who I am in the final report or in any public use of the study findings.
- Recordings, interview files, and the files of the group discussions will be kept in a password-protected file in secure computer for 7 years after the study, then erased.

**Benefits**

- Sharing my thoughts in this study may assist others who are seeking help for suicidal thoughts.
- Talking about my experiences in this study might bring me comfort. Sharing my thoughts in this study might bring me comfort knowing that I am not alone in having gone through these hard times.
- Being in this study will help educate health care workers in how to improve services for women who have been abused and who are suicidal.
- I will receive a new digital camera to use during the study and to keep when the study is over.
- I will meet other women who have been through similar situations. Talking, listening, and sharing with these women may give me a sense comfort and a sense of belonging within the group.
- I will receive a CD of my photos.

**What are the risks?**

- Talking about the times when I was in crisis could cause me discomfort and stress.
- Petrea has supports on hand for me that can help me deal with this stress.
- If I am feeling suicidal, Petrea will help me to access a support person who will stay with me. She will also help me get help from other helpful services. If I agree, Petrea will stay with me until I get the help I feel I need. If I agree, Petrea will call me after the group to see how I am doing.
- I will not continue to be in the study if I have a suicide plan or strong thoughts of wanting to end my life. Petrea will help connect me to a crisis service if needed.
- I may contact any one of the crisis services if I need to discuss concerns or stressful feelings that come up while being in this study. A list of these services (Resources Handout) has been provided to me.

**Other notes**

- I know that the study’s findings will be shared with others through formal talks and articles.
- The photos may be used in public sessions or publications that will help others understand the results of this research project.
- I agree that transcripts without my name and any identifying info, can be used for other studies. In the case of another study, Petrea would apply for ethics
approval before using.

● ☐ If I experience any distress during the group discussion, Petrea will ask how I would like to proceed. I can choose to take a break or to leave the group.

● ☐ I may withdraw from the study at any time without having to give a reason. If I leave early I will return the camera to Petrea. I know that I may choose not to answer any question.

● ☐ If I wish, I will have copy of the final report summary at the end of the study.

● ☐ I have been given a chance to ask questions and all have been answered to my satisfaction. I know that I can call the following numbers if I have any more questions about the study: a) Petrea Taylor at 962-4690 b) Petrea’s supervisor Lynne Duffy at 856-2682 or c) The Dean of Interdisciplinary Studies, Linda Eyre at 506-453-5161 & leyre@unb.ca

I, __________________________________________, agree to take part in this study.

(Printed name) __________________________________________

Date: ____________________________________________________________________________

Researcher: __________________________________________ Date: _______________________

Would you like a summary of the study findings sent to you? Yes _____ No thanks

This Project has been reviewed by the Research Ethics Board and is on file as REB 20xx-xxx.
Participant Consent for Use of Photos

**Research Project:** Help-seeking for Suicidality in Women Who Have Been Abused by a Romantic Partner

First Name: _________________________________ I agree that the following photos may be made public by the research team:

**Assignment #1:** All photos _______ or the following photos with numbers:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

**Assignment #2:** All photos _______ or the following photos with numbers:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

**Assignment #3:** All photos _______ or the following photos with numbers:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Participant signature: ______________________________ Date: ___________________
Witness ______________________________
Appendix P

Group Confidentiality Form

Research Project: Help-seeking for Suicidality in Women who have Experienced Intimate Partner Violence

Purpose: To respect and protect private information of the research group.

As a member of this research group I agree not to tell others (including family and friends) any of the following:

1. the names of other group members
2. the place where we are meeting
3. the discussions we have when we meet
4. descriptions of photographs taken by others

Signature: ________________________________

Date: _________________________________

Witness: ________________________________
Appendix Q

Consent for Community Photographs (on UNB Letterhead)

Note for photographer: this form is for you to give to a person who you would like to have in your picture. The person in the picture will be asked to sign this consent form.

Research Project: Help-seeking for Suicidality in Women who have Experienced Intimate Partner Violence

It has been explained to me that photographs are being taken as part of a community research project through the University of New Brunswick

(Please check off the box after each statement to show your understanding and/or consent. Cross out any boxes you do not agree with).

1) I agree to have my picture taken and/or pictures of my personal property □
2) I agree that the photo(s) may be used in public sessions or publications that will help others understand the results of this research project. □
3) I have the right to withdraw this agreement at a later date. □

To do this I may contact: Petrea Taylor, Registered Nurse and PhD Student, University of New Brunswick. Phone: 962-4690 (Moncton and surrounding area). Toll free at ####-####-####, Email: petrea.taylor@gmail.com Mailing address: Moncton Hospital- Unit 3200, 135 MacBeth Ave, Moncton, NB E1C 6Z8

A copy of this form has been given to me. □

Your choices will be respected.

Print Name: _______________________________
Signature: _______________________________
Date: _______________________________
Witness: _______________________________
## Appendix R

### Hunting Sub-process Typology

<table>
<thead>
<tr>
<th>Sub-process</th>
<th>Distance</th>
<th>Endure</th>
<th>Endure / Conform</th>
<th>Applying Counter-Pressure</th>
<th>Grasping for help</th>
<th>Soaking in Validation</th>
<th>Letting Go</th>
</tr>
</thead>
<tbody>
<tr>
<td>Desired outcome (overall, goal is to Feel Human)</td>
<td>Get away from the system</td>
<td>Preventing System Entrapment from getting worse.</td>
<td>Keeping the peace</td>
<td>Increase access or decrease System Entrapment</td>
<td>More security from access to system</td>
<td>Maximize validation</td>
<td>Doing the healing work</td>
</tr>
<tr>
<td>Hope in system’s ability to be helpful (motivates approaching system)</td>
<td>Lowest</td>
<td>Bit more hope as they partly accept the System Entrapment</td>
<td>Higher than when only enduring because they hope to avoid more restraint</td>
<td>Higher than when enduring.</td>
<td>Higher than Applying counter-Pressure They have belief that HCPs will help</td>
<td>Much higher than when Grasping. They have hope for healing potential</td>
<td>Highest Hope for healing/ life</td>
</tr>
<tr>
<td>Level of System Entrapment</td>
<td>medium</td>
<td>Lower than when Distancing</td>
<td>Highest</td>
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<td>Lower than when Grasping</td>
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</tr>
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<td>Level of Trauma Entrapment</td>
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<td>Acute and community and crisis lines</td>
<td>Acute</td>
<td>Acute</td>
<td>Crisis lines and ER</td>
<td>Community</td>
<td>Community</td>
<td></td>
</tr>
<tr>
<td>Pleading my case for validation</td>
<td>Yes, but not always verbally</td>
<td>n/a</td>
<td>Yes: for reprieve from System Entrapment</td>
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<td></td>
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<td>Consequence that occurs most frequently</td>
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<td>Less System Entrapment. More Trauma Entrapment Most validation</td>
<td>System Entrapment not worse. Most validation</td>
<td>Worsening System Entrapment</td>
<td>Worsening System Entrapment</td>
<td>Start to Feel Human</td>
<td>Returning to humanity and start to do healing work</td>
</tr>
</tbody>
</table>

Indicators:
- Desired outcome (overall, goal is to Feel Human)
- Hope in system’s ability to be helpful (motivates approaching system)
- Level of System Entrapment
- Level of Trauma Entrapment
- Setting where sub-process occurs most frequently
- Pleading my case for validation
- Consequence that occurs most frequently

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Appendix S

Gauging for Validation coding map
Curriculum Vitae

Candidate’s full name: Petrea Taylor

Universities attended (with dates and degrees obtained):

- Bachelor of Nursing, University of New Brunswick, 1997
- Master of Nursing, University of New Brunswick, 2002

Publications:


Conference Presentations:

- Dissertation preliminary findings: Canadian Association Suicide Prevention, Webinar (oral and online) Presentation, November, 2014
- Trauma and suicide care oral presentation as keynote speaker in Edmonton, Alberta, March, 2014
• Suicide Nursing Care for women with IPV based on Thesis Theory, ‘Connecting with Hope’ oral presentation, Canadian Federation of Psychiatric/Mental Health, Toronto, Ontario, October, 2011

• Suicide Nursing Care based on Thesis Theory, ‘Connecting with Hope’ poster presentation, International Conference on Violence Against Women, Montreal, Quebec, May, 2011

• Suicide Nursing Care based on Thesis Theory, ‘Connecting with Hope’ oral presentation, Canadian Association of Suicide Prevention Conference, Dartmouth, Nova Scotia, October 7, 2010

• Psychiatric Core Competencies for Undergraduate Nursing Programs oral presentation, Canadian Association of Schools of Nursing, Winnipeg, Manitoba, May 2010

• Suicide Nursing Care based on ‘Connecting with Hope’ poster presentation, World Congress of Psychiatric Nursing, Vancouver, BC, March, 2010

• Methadone and Pregnancy oral presentation and panel discussion, Children’s Program and Family Health, Halifax, NS, March, 2010