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Original Article

An Interpretative Phenomenological Analysis (IPA) of the Experiential Perspectives of Volunteer Befrienders, Pertaining to Causes of Suicidality and Prevention

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Abstract

Background and Objectives: *Suicide is the 2nd leading cause of death for people age 15 to 29 and is estimated to be responsible for 800,000 deaths, annually. With each death by suicide, there are approximately 20 attempted suicides. In the United Kingdom, suicide is the leading cause of death for men aged 20 to 35 and for women aged 35 to 49. The dominant research and preventative initiatives exist through a medical lens; a perspective that often receives criticism for not incorporating social and culturally relevant variables. To date, research into alternative methods of support for the suicidal is scarce. This study seeks to obtain information pertaining to suicidality from the perspective of volunteer befrienders at MayTree Respite Centre, a London-based charity known for offering non-medical support for the suicidal. The objectives of the study were to explore the common causal themes of suicidality, perspectives of the medical model approach to suicide, as well as the limitations and advantages of the MayTree model.*

Materials and Methods: *Data was collected through 8 semi-structured individual interviews with MayTree Volunteers. The interviews were audio-recorded and subsequently transcribed verbatim. The transcripts were then analysed using Interpretative Phenomenological Analysis (IPA) approach.*

Results: *A total of 4 superordinate themes emerged: suicide as a means through which to escape one's problems; causal attributions of suicidality, which contained adverse life experiences, low self-concept, as well as isolation and not being heard; perceptions of the medical model, which included a reductionist correlation between biology and suicide, as well as stigma; limitations to the MayTree model, encapsulating their drug and alcohol policy, as well as duration of stay/follow-ups; and advantages to the MayTree model, reported as the benefits of be-friending and of a non-judgmental atmosphere.*

Conclusion: *It was highlighted neither model could be deemed superior to the other, rather that these approaches would be more effective if greater collaboration was evident. Collaborative efforts do appear to be demonstrated by MayTree, through its recognition of the complexity of certain cases of suicidality, and professional care needed when this arises.*

Key words
Suicide, Prevention, Medical Model, Psychosocial, MayTree Respite Centre, Be-frienders, Interpretative phenomenological analysis, Qualitative exploration

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Introduction

Globally, suicide is recorded as the 2nd leading cause of death for those aged 15 to 29 years old. It is estimated that approximately 800,000 people take their own lives annually, equating to one every 40 seconds [1]. Based upon the predicted figure, it is expected that by the year 2020, over 2% of the global burden of disease will be attributed to suicide [2]. Though these statistics are staggering, international suicide rates are argued to be under-represented due in part to variations in legal frameworks, societal attitudes, religious beliefs, and forensic resources [2]. It is estimated that with each death attributed to suicide, there are approximately 20 people who attempt to take their life [2], and attempted suicide is said to be one of the strongest predictors of subsequent death by suicide [2]. According to the Office for National Statistics [3], within the United Kingdom, 6,507 deaths were registered as suicide in 2018, a statistically significant increase of 686 (11.8%) from the 5,821 suicides registered in 2017 [3]. Moreover, suicide is identified as being the leading cause of death in the United Kingdom for people between the ages of 20 and 35 years, and for males aged between 35 and 49 years [4]. In the UK, males are three times more likely to take their own lives than females [5]. A similar theme was highlighted when auditing admissions into major trauma centres for attempted suicide [5], which found that hospitalisation through attempted suicide was also more common amongst males than females. It is, however, concerning that the suicide rate among females is increasing and it is at its highest rate in a decade [4].

Medical versus Psychological Approaches to Suicide and Suicide Prevention

Broadly put, two bodies of knowledge exist in relation to suicide risk factors and preventative actions, the medical model, which currently dominates suicide literature, and the less popular psychosocial perspectives [6]. The medical model of suicide understanding and interventions operates from a tautology of mental illness and suicidality [7]. In this view, the presence of ill mental health is the platform from which suicidal behaviors have the potential to be manifested and, in turn, suicidal behaviors provide an insight into one's ill mental health. Often, biological risk factors for suicide are identified through psychological autopsy results following a death by suicide, which identifies a range of pre-existing pathological disorders [8]. Post-mortem examinations, for instance, often reveal major depressive disorders as a common attribute among those who die by suicide [9]. Moreover, it is estimated that as many as 50% of people suffering from a major depressive disorder will attempt suicide during their lifetime [10]. Though biological abnormalities may be a contributing factor in many incidents, the medical model receives criticism for being too simplistic to form a sturdy platform from which comprehensive preventative measures can be developed. It is posited, for instance, that if not all depressed individuals take their own lives, then significant contributors must exist externally to the disorder [7]. It is argued that a unidimensional focus on suicidality, centered around one's pathological status, ignores a person's negative contextual circumstances which may be influential in a person's suicidal crisis [6]. Furthermore, the role that socio-cultural and political milieus play in understanding the meaning of suicide and how to prevent it in the local context, should not be underestimated [11, 12].

Psychosocial risk factors are referred as environmental catalysts that contribute towards one's suicidality and range from, though are not limited to, family discord,

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financial problems, loss of a loved one, relationship difficulties, educational downfall and unemployment [13]. The authors state that stressful life events are identified as being included in as many as 80% of deaths by suicide. However, similar to medically focused research, investigations into psychosocial risk factors do not exist without critique. Negative social occurrences can increase the likelihood of engaging in substance abuse, alcoholism, and developing psychiatric disorders; therefore, researchers have difficulty distinguishing whether suicidal behaviors are the consequence of adverse life events, the result of debilitative behaviors or the mental health effects that followed those events [14].

As previously mentioned, relative to medically orientated literature, psychosocial perspectives are not as popular in suicide literature. Information, therefore, on how to support a person experiencing a crisis, who does not present the symptoms associated with a diagnosable disorder, is scarce [15]. One approach that is gaining attention, however, is a humanistic model [16]. A humanistic approach to intervening in a suicidal crisis is one that does not conform to a professional-client dyad, which often involves advice being imparted from an expert to a person in need [16]. Don Richie, a man nicknamed the 'angel of the gap', was not the first individual to utilize the humanistic approach during a suicide intervention scenario. However, his experiences do demonstrate the benefits that may be attained through the application of the method [6]. According to these authors, Don Richie intervened in over 160 suicide attempts in Sydney, Australia, at a notorious location for suicide known as 'the gap' [6]. Don Richie attributed his success to lending an empathetic ear, providing compassion, connection, and focusing on the goodness of people [6].

MayTree Respite Centre

MayTree Respite Centre (https://maytree.org.uk) is a charity-funded organization, created specifically as a sanctuary for individuals' who are contemplating suicide. The charity was established in 2002 by its co-founders Paddy Bazely and Michael Knights and is within a quaint terraced house that offers a free, one-off, four-nights stay for those who are deemed likely to benefit from the experience. Potential guests (the label used by this organization) are gradually assessed by both volunteers and trained coordinators over the course of three telephone conversations, through which an individual is evaluated on their capacity to meet the entry criteria. Admission is dependent upon a person being abstinent from a dependency on drugs or alcohol for eight weeks prior to their residency, not being homeless and looking for somewhere to stay, or those experiencing severe mental illness. However, in the case of a person meeting such excluding criteria, they are directed to an alternative service that may be better suited to support their needs. During phone calls, as well as during a stay at MayTree, support is provided by volunteer befrienders who seek to engage with the suicidal individual in a natural, non-intrusive and non-judgmental environment. Volunteers are trained to explore the guests' life experiences and to encourage the elaboration of potentially challenging circumstances that may typically be neglected in the routine of everyday life. MayTree seeks to offer an atmosphere where people can clarify their thoughts through discussion and come to terms with the negative aspects of their lives that may be causing suicidal thoughts.

It is important to note that MayTree does not boast a humanistic approach; in fact, it draws upon no specific popularized framework to support its guests. Its unique ethos does, however, promote an environment that echoes the key principles of humanism, such as valuing the importance of being non-judgmental and

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encouraging meaningful interactions [6]. Moreover, MayTree's message is not one that explicitly advocates suicide prevention; it rather seeks to support those who are experiencing a crisis, to make their own autonomous decisions.

An argument can be made that a be-friending model is too simplistic a strategy to deal with the complexities of suicidality. However, non-intrusive, non-judgmental, and trusting care have demonstrated significant efficacy to alleviate emotional distress during stressful and life-threatening circumstances [17]. Moreover, research that has analysed MayTree from the experiential perspective of previous guests, found that the unique approach taken by the organization was able to reduce suicidal ideations. An investigation into MayTree's capacity as a suicide intervention service concluded that MayTree offers to those who are experiencing suicidal thoughts, both short- and long-term relief from their distress. In some cases, guests described their stay at MayTree to be a positive transformational point, from which the recovery from their suicide crisis began.

Aims of the Current Study

As previously mentioned, a large proportion of contemporary research that is concerned with the topic of suicide exists around the medicalized model, whereas little is available from psychosocial perspectives. The current investigation seeks to build knowledge around this latter model through exploration into the perspectives and experiences of befrienders' volunteering at MayTree Respite.

Materials and Methods

This study was granted ethical approval by the Psychology Department's Research Ethics Committee at the Middlesex University (Project ID: 3645)

Data Collection

Throughout the month of April 2018, a total of eight semi-structured individual interviews were conducted to explore the experiences of befrienders that volunteer their time at MayTree Respite Centre, in relation to their interaction with suicidal individuals. Semi-structured interviews are highlighted as an effective data-collection tool for idiographic research by offering the researcher the capacity to adapt their dialogue to meet the narrative flow of the participant, as well as to allow for probing when elaboration is required [18]. The content of the interviews was audio-recorded and subsequently transcribed verbatim. Audio-recordings were chosen as a suitable technique to document the interviews, in accordance with the identification that it can reduce the likelihood of misrepresentation during the data analysis [19].

Participants

The entirety of MayTree's volunteer befrienders were given the opportunity to contribute to this study through a recruitment e-mail that was distributed via MayTree's online shift-scheduling database, Three Rings. The e-mail outlined the intentions of the investigation, with information regarding what would be expected from potential participants; the researcher's e-mail address was included in the event that the volunteer wished to contribute with their experiences. Following a response from an interested volunteer, a follow-up e-mail was supplied with a detailed overview of the study in the form of a participant information sheet, along with a participant consent form that would be signed if they felt that they were still interested in taking part. Subsequent to this recruitment process, dates, times and venue suitable to the participants were scheduled for the interviews. When conducting exploratory analysis, six to eight participants is highlighted to provide the researcher with a large enough sample to encourage validity of data, whilst equally being small enough to allow for sufficient analytical depth of each individual experience [19].

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The sample consisted of five males and three females, with an age range between 23 to 61, and a combined experience at MayTree of 11 years and three months. The participants' nationalities were a combination of 6 British individuals, 1 American, and 1 Sri Lankan. The ethnicities represented in the sample were 6 Caucasians, 1 mixed-race, and 1 Sinhalese. The method of communication used for the interviews was comprised of 5 face-to-face interactions, 2 Skype calls, and 1 telephone call. Pseudonyms were created through the 'Baby Name Wizard' software, which provides a name suggestion based upon gender, age, and the first letter of a preferred name, which in this case was the first letter of the participant's original name.

Data analysis

To evaluate the data obtained from the aforementioned interviews, Interpretive Phenomenological Analysis (IPA) was conducted. IPA is a qualitative hermeneutic, idiographic technique that facilitates the exploration of themes within a homogenous group, whilst maintaining the integrity of an individual's experience [20]. For these reasons, IPA is argued to be an effective method for exploring phenomena from the perspective of those who have experience with it [20]. The researcher is expected to take two separate stances during the IPA process [19]. During the period of data collection, an emic position should be maintained, in which the researcher attempts to immerse themselves within the personal experience of the participant [19]. However, during the data analysis stage, the researcher is advised to view the data from an outside perspective, through a psychological lens [19]. No official procedure was used in this study to assess data saturation.

Reflexivity

The researcher's reflexivity increases the transparency in any potential biases and is necessary during IPA investigations due to the interpretative nature of the method [20]. The primary researcher is a 27-year-old male Psychology student who volunteers at MayTree Respite Centre, alongside the secondary author who has volunteered since 2015. Prior to the current investigation, the researcher adhered to a perspective in which, for the most part, suicidality is a social phenomenon, and that understandings that concentrate solely upon the relationship between biology and suicide limit the scope of supporting the suicidal. This is not to say that biological perspectives are to be ignored, as one's unique genetic disposition may influence the way in which they infer environmental experiences. The researcher's perspective, rather, is that suicide understanding and support should respect the complex, multifaceted role that either, or a combination of both biological and environmental factors may contribute towards one's suicidality. In order to minimize the impact of the researcher's beliefs, questions asked to MayTree volunteers were open-ended, ensuring that they were given ample opportunity to provide their unique perspective.

Analytic Process

The analytical process outlined below followed the IPA principles set forth by Pietkiewicz and Smith [18]. Following the completion of all eight interview transcripts, the content of each participant interaction was read and then re-read ideographically. Whilst reading, the researcher began to make notes pertaining to the initial content orientated observations across the interviews, such as particular metaphors and repetitions. These notes were then organized into emergent themes, wherein statements are clustered in relation to broader psychological concepts; though insurances were made to keep these themes grounded in the details of each participant's contribution.

At this stage, an occurrence described as the hermeneutic circle began to transpire wherein, the

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inference of the whole is influenced by the prevailing details, and the prevailing details are influenced by the interpretation of the whole [18]. The 'whole' represents the transcripts, whilst the 'prevailing details' depict the emergent themes [18]. Conceptual similarities were then made from the emergent themes, also referred to as subordinate themes, which were then further clustered and assigned a descriptive label, which created a superordinate theme. A master table was then created to demonstrate these allocated superordinate and subordinate themes; along with the identifiable page number, line numbers with associated participants' quotes, in order to maintain a phenomenological stance. A selection of transcripts and superordinate and subordinate themes were then discussed and revised with the second author, which resulted in the final master table (Table 1).

Results

As indicated in Table 1, four superordinate (Causal attributions of suicidality; Perceptions of the medical model; Limitations of the MayTree model; Advantages of the MayTree model) and nine subordinate themes emerged.

Causal Attributions of Suicidality

When asked, based on their experience of interacting with individuals experiencing a suicidal crisis, what they believed to be reoccurring, contributing factors of suicidality, volunteers provided information that can be merged into three particular subordinate themes: *adverse childhood experiences, low self-concept,* as well as *isolation and not being heard.*

Adverse Childhood Experiences

When discussing causal attributions of suicidality, many of the volunteers referred to adverse events, often occurring in one's childhood:

'…it pretty always stems from something that's not been quite right in childhood…' (Tina p.1/Lines 31, 32).

Adverse experiences were regularly described as occurring domestically:

'…in their past, one or both parents would have been emotionally abusive in some way…' (Shirley p.2/Lines 69, 70)

Lastly, volunteers often made reference to abuse when providing their thoughts upon causal attributions. There was not much emphasis upon a particular category of abuse, but rather to its various forms:

'…I'd say at least half, roughly, probably some sort of abuse, um, sexual abuse, physical abuse, bullying, emotional abuse.' (Harry p.2/Line(s) 39, 40)

Low Self-Concept

A further causal attribution that arose in volunteers' responses generally incorporated the suicidal person's low opinion of themselves. Though low self-concept emerged in response to the question of causal themes that could be attributed to one's suicidality, it was occasionally mentioned alongside an event or pain. This could connect one's low self-concept to the previous sub-theme, as perhaps adverse life experience could lead to low feelings of oneself.

'Low self-esteem, low self-worth um, suppression of past traumas. That's the main thing.' (Karl p.1/Lines 26, 27)

In particular, the construct used to represent MayTree's service users' low self-concept, was worthlessness:

'…an opinion of one's self, very often, a really low opinion um, of worthlessness…' (Tina p.2/Lines 34, 35)

Low self-concept was occasionally described alongside not valuing one's individual influence on the world, or their purpose in life:

''they don't feel very often valued or worthy or deserving of any kind of help and support'' (Tina p.2/Lines 40, 41)

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Worthlessness was occasionally interlinked with the next sub-theme, *isolation and not being heard*, particularly if solitude and not speaking to others was a choice because of the perception that, as Tina suggests above, support is undeserved.

Isolation and Not Being Heard

The final sub-theme of *causal attributions of suicidality* was that of *isolation and not being heard by others*. Isolation and not being heard were two factors that were often mentioned together within close proximity to one another, or their connection was implied by describing a lack of available support, such as:

'…the stem of it without a doubt would be just not having that structure and support, you know, healthy structure and support.' (Shirley p.3/Lines 89-91)

Moreover, Shirley's emphasis upon lack of support as a re-occurring theme is made more prominent by the importance expressed below by Mandy that suicidal people should have adequate opportunities to be heard:

'I think particularly with suicide, there's a lot of isolation and having that chance to connect with people and have their experiences recognized can be valuable.' (Mandy p.6/Lines 215-217)

It was not expressed that suicidal people often experience physical isolation from others, where for instance, there was no one else around in the immediate vicinity to hear their voice. Rather, volunteers mentioned what could be described as an emotional solitude, whereby a person experiencing a crisis was not heard even when others were present in their lives:

'…not being able to talk to people, even if they're around.' (Amy p.2/Lines 45, 56)

Perceptions of the Medical Model

Volunteers were asked to provide their thoughts, based upon their experiences at Maytree, on the medical model and their perspectives on mental health and suicidality. Each of the emergent themes that were clustered around the medical model appears to orientate around its limitations as opposed to its benefits. Although cases of ill mental health were not directly dismissed as a potential factor of suicidality, volunteers regularly alluded to the unidimensional nature of the medical model, seen under *a reductionist correlation between biology and suicidality*:

'Does somebody need to have a mental health problem in order to be suicidal? Is being suicidal a mental health problem?' (Kelly p.3/Lines 94, 95)

The affiliation between *perceptions of the medical model* and the subordinate theme pertaining to its reductionist nature was comprised in light of volunteers, not necessarily arguing against the relevance of mental health awareness within preventative efforts. Instead, it was chosen based upon their critique as to the limiting nature of ill mental health as an absolute causal attribute of suicide. *The reductionist approach to understanding suicidality,* therefore, can be two-fold. Firstly, the point is made that one does not necessarily require a mental health condition in order to feel suicidal:

'I think you can say suicidal thoughts can be present whether to everyone else you're in good mental health or whether you've got a whole raft of diagnoses.' (Tina p.3/Lines 109-111)

Secondly, reductionism was argued through the suggestion that suicidality could be attributed to both adverse life experiences as well as mental health, and is not limited to solely one or the other:

'Often, there is this idea, right, that there is something wrong with the um, the chemicals in the nervous system or there's something biologically altered about them (…) And, in a way, I'm not sure how helpful that it is, because it might be descriptively true, but it might also be that the cause of that imbalance is um, events in that person's life for example.' (Mandy p.2/Lines 66-69)

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Mandy's analogy below appears to refer to the necessity of a more holistic understanding of suicidality:

'…if someone has a diagnosis of a broken leg, they may have gotten that broken leg from a car crash and those are two things that have both happened.' (Mandy p.3/Lines 109-111)

Experiences were given that depicted a stigma that is often attached to the musicalized approach to suicide, which may impede suicidal people actively seeking this particular method of care as indicated below.

A Fear of Stigmatization

During the discussion pertaining to the medical model, it was highlighted that suicidal individuals may be worried about the stigma that is attached to medical support, particularly in relation to mental health care provision**:**

'We have an awful lot of people who work in the caring professions who, for instance, if they tell their line manager in the hospital, it will go on their hospital records.' (Tina p.6/Lines 226-228)

The onus of stigma in relation to the medical model may be considered to be socially orientated, as opposed to directly involved with the biomedical stance. The following excerpts appear, however, to suggest that one's apprehension is orientated around being considered to be mentally ill for having suicidal thoughts, a worry that may be stimulated through the medical model's biological understanding of suicidality:

'He's terrified of being sectioned and... You know, cause that was muted at one point when he was threatening on a daily basis to kill himself and yeah, I think that's a real fear for a lot of people, um, because it is… it feels like it's a very sick process that you can't… it's just very linear and…and there's no… What should I say? There's not a lot of understanding around it – a lot of stigma still.' (Shirley p.9/Lines 322-327)

Limitations to the MayTree Model

Volunteers were asked if they felt that there was any limitation to the MayTree model in relation to supporting those who are feeling suicidal, to which their responses were grouped and categorized under two subordinate themes: *the drug and alcohol policy*, and *the duration of stay for house guests/follow-up communication with previous houseguests*.

Limitations of the Drug and Alcohol Policy

When volunteers discussed their perspectives upon the drug and alcohol policy being a potential limitation, it appears that the issues stem from not being comfortable with the idea of turning people away based upon dependency:

'I always feel it's quite difficult – telling people that we can't help them because they've got alcohol or drug problems.' (Andrew p.4/Lines 154-156)

Moreover, Tina and Harry further elaborated on the judgmental nature of turning people away based upon drug and alcohol usage. A worry was also portrayed that there may be an interrelationship between drugs and alcohol and suicidality and that turning people away on this premise, would mean turning away those in need:

'I think there is a lot of overlap between suicidality and substance use, and I think when I first came to MayTree, I thought that we'd be trying to reach the people who were in the greatest need.' (Mandy p.5/Line) 160-162)

Each participant that offered the drug and alcohol policy as a potential limitation, also followed up on their comments with statements that seemed to support the necessity of the policy, as presented below.

Understanding the Drug and Alcohol Policy

The explanations that were offered in support of the drug and alcohol policy were centered around the concept that Maytree's approach could place a suicidal person in further danger if that individual were not able to engage with, and share their thoughts in a sober, and lucid manner:

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'…but we understand why those restrictions are in place.' (Andrew p.5/Line 180)

The Duration of Stay for Houseguests and Follow-Up Communication with Previous Houseguests

MayTree's protocol for the duration of guest residency and previous guest's follow-ups were grouped within this subordinate theme as both were described as a limitation for similar reasons, through feelings of a sudden termination in the be-friending process. It would appear that volunteers appreciate the value of MayTree's approach to supporting the suicidal, particularly because those experiencing a crisis may not readily encounter the environment that a stay at the charity facilitates. However, through valuing this unique approach, uncertainty arises in the limited time that such care is offered to those that will benefit from it:

'…it does kind of unsettle me that it is so cut and dry that they do leave and that's it.' (Kelly p.9/Lines 349, 350)

Understanding the Duration of Stay and Follow-Up Policy

Similarly to that of the drug and alcohol policy, the identification of *the duration of stay for houseguests/follow-up communication with previous houseguests* as potential limitations was followed by an explanation as to the necessity of these procedures. The supporting clarifications often referenced the duration of stay and limited follow-ups as necessary in order to avoid MayTree becoming an attachment for people experiencing difficulties.

'Thinking about that, I think possibly the length of stay is fine cause any longer, I think people can develop a bit more of a dependency and can find it really, really hard to leave.' (Kelly p.8/Lines 300-302)

Advantages of the MayTree Model

Volunteers were asked to share their experiences as to the advantages of the MayTree model in relation to supporting those that are suicidal. Two particular prompts were available in the eventuality that deeper exploration was necessary; these were 'be-friending' and 'a non-judgmental environment'.

The Advantages of Befriending

When discussing the advantages of Maytree's be-friending approach, contributions provided can be categorized into two particular benefits; the first being a safe space to be listened to:

'It's a space to genuinely think and you have lots of different people from different backgrounds asking questions and listening…' (Harry p.10/Lines 375, 376)

Secondly, volunteers described a unique caring environment that is facilitated by be-friending, allowing individuals to experience compassion.:

'He spoke to many people before and he said, "This is unique," I think because we're not professionals. We're just people, you know, that care and want to help. I think that quite touches them a little bit.' (Karl p.4/Lines 130-132)

The Advantages of a Non-Judgmental Environment

A safe place to talk and to be listened to was then exacerbated by the advantages of being non-judgmental, because not only are people given the opportunity to talk, but their experiences were going un-judged, meaning that they can share sensitive issues that they may not be able to share elsewhere:

'It's very out of their normal lives, so there is this sense that you can say things that you couldn't say to a family member or a close friend or in the workplace and that you can be able to leave it there. It's not going to be something that someone can drag up and go, "Oh, when you said…" Um, I think that allows people to be more open.' (Tina p.2/Lines 53-58)

This was particularly apparent through the volunteers' emphasis upon guests disclosing information that they had not done previous to their stay at MayTree:

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'…in my experience, it's often been the first time that they can talk about the stuff that they feel or do without someone going, "What?!" or shutting them down…' (Shirley p.8/Lines 271-273).

Table 1. Master table with superordinate (in bold italic) and subordinate (regular) themes

Themes	Page/line	Participant quotes
Causal attributions of suicidality		
Adverse childhood experiences	p.3/line(s) 83, 84	Tina - *'definitely family discord, abuse of all types. It could be neglect or physical or sexual and often, when it's sexual abuse in childhood'*
	p.2/line(s) 49-51	Kelly - *'In my experience, I think something that is a common theme that occurs is possibly sexual abuse and childhood trauma um, neglect um, sometimes domestic violence within the family.'*
	p.2/line(s) 41-43	Andrew - *'I figure 75 to 90% of people have some kind of a trauma that is…is, you know, started young, you know, early childhood-based trauma, family-based trauma'*
Low Self-Concept	p.2/ line(s) 34-35	Tina - *'an opinion of one's self, very often, a really low opinion um, of worthlessness.*
	p.3/line(s) 97-100	Kelly – *'you feel so worthless and you've got absolutely no reason... You have absolutely no.. You feel that you haven't got any impact on anything. You think, you know, it wouldn't matter if you weren't here anymore.'*
	p.5/line(s) 170-171	Karl - *'They're judging themselves and they feel worthless'*
Isolation and not being heard	p.6/line(s) 215-217	Mandy - *'I think particularly with suicide, there's a lot of isolation and having that chance to connect with people and have their experiences recognized can be valuable.'*
	p.1/line(s)32-37	Andrew - *'key thing that most of the people I speak to um, tend to experience is isolation of one form or another, and that doesn't mean literal isolation. People might have friends or family, so they're not necessarily on their own, but I mean isolation in terms of people they can share what they're going through with. Um, yes, often, there's a lack of support for people'*
	p.2/line(s) 45-46	Amy - *'not being able to talk to people, even if they're around'*
Perspectives on the medical model		
A reductionist correlation between biology and suicidality	p.4/line(s)145-148	Kelly - *'just because somebody doesn't have a diagnosis or isn't on medication, it doesn't necessarily mean that they are going to be coping with having an arse of a neighbor or um, having lost their job. You know, these…these can be triggers in themselves'*
	p.3/line(s)111-114	Tina - *'I suppose you would say that most people who feel suicidal are also going to be feeling depressed, but I don't know that you could say, "Depression therefore leads to suicide…suicidal thoughts." I think that's a very trite way of looking at it.'*
	p.2/line(s) 66-69	Mandy - *'Often, there is this idea, right, that there is something wrong with the um, the chemicals in the nervous system or there's something biologically altered about them.'*
	p.2/line(s) 71-73	Mandy - *'And, in a way, I'm not sure how helpful that it is, because it might be descriptively true, but it might also be that the cause of that imbalance is um, events in that person's life for example.'*
A fear of stigmatization	p.6/line(s)226-228	Tina - *'We have an awful lot of people who work in the caring professions who, for instance, if they tell their line manager in the hospital, it will go on their hospital records'*
	p.8/line(s)229-304	

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	p.5/line(s) 185-189	Shirley - *'he's terrified of being sectioned and... You know, cause that was muted at one point when he was threatening on a daily basis to kill himself and yeah, I think that's a real fear for a lot of people, um, because it is… it feels like it's a very sick process that you can't… it's just very linear and…and there's no… What should I say? There's not a lot of understanding around it – a lot of stigma still.'* Karl - *'you've got low self-esteem, you're sensitive to everything, of other people's opinions of you and what people think or what people might think or, you know… That's very on your radar, so the thoughts of exposing yourself to somebody or people finding out or getting labeled or whatever… Yeah, it's terrifying! You just don't want to.'*
Limitations of the MayTree model		
Drug and alcohol policy	p.4/line(s)137-139 p.7/line(s) 168-173 p.4/line(s) 154-156	Tina - *' I also personally find it very hard to be 100% with the recreational drug and alcohol-free for eight weeks. To me, that is de facto judgment'* Kelly - *'I mean, there was one thing that I find a little bit difficult to swallow um, when I initially started and that was the fact that they won't accept anybody who uses any kind of recreational drugs or drink and um… I remember in my training when I asked one of the trainers, I said, "If somebody just needs a joint or a glass of wine just to relax and just to get them to sleep, is that not allowed?'* Andrew - *'I always feel it's quite difficult – telling people that we can't help them because they've got alcohol or drug problems'*
Duration of stay for house guests and follow-up contact for previous guests	p.5/line(s) 183-184 p.5/line(s) 209-211 p.4/Line(s) 130-137	Amy – *'It really shocked me in training actually, to find out that after five days, that was it. I was really taken aback at the time'* Andrew - *'I also very often see the way people as soon as they begin to open up, by day three or whatever, they're then being distressed about leaving on day four'* Tina - *'with so many people there who are willing to listen to you without any judgment on what you have to say that it does then feel to me sometimes like we abandon them. Um, however hard we try and explain how this service operates and however hard we try and ensure that they've got some support when they go back, that always worries me – that thing of you may never have felt so held and such warmth and interest in you and for them to lose that is… I think can be very painful.'*
Advantages of the MayTree model		
Advantages of befriending	p.5/line(s) 217-220 p.8/line(s) 334-336 p.10/Line(s) 363-366	Amy - *'if one of the key points of feeling like you want to end your life is feeling alone and unheard and unable to share things that are buried so far down that, you know, they're rotting, then I think probably yeah, speaking to someone intensely or a group of people every day is vital.'* Andrew – *'You know, just being listened to in a safe space for a limited period of time is really, really… is really unique and really positive, and I think it does good for people'* Harry – *'they experience the fact that it is possible to be cared for and loved and…and…and be respected and…and…and have an existence that is not only about pain, and MayTree gives them the opportunity to experience that'*
Advantages of a non-judgmental environment	p.2/line(s) 53-58 p.8/line(s) 271-273	Tina - *'it's very out of their normal lives, so there is this sense that you can say things that you couldn't say to a family member or a close friend or in the workplace and that you can be able to leave it there. It's not going to be something that someone can drag up and go, "Oh, when you said…" Um, I think that allows people to be more open.'*

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p.12/line(s) 464-467	Shirley - *'in my experience, it's often been the first time that they can talk about the stuff that they feel or do without someone going, "What?!" or shutting them down'* Kelly - *'just to feel completely at ease to be able to just spill out maybe for the first time your deepest, darkest thoughts um… That is incredibly powerful. It's so powerful and I don't think that there is any other organization out there that can do that where you can feel that safe.'*

Discussion

The objectives of this study were to contribute knowledge to suicide literature external to that of the medical domain. In particular, the topics explored were as follows, the common causal themes of suicidality, and perspectives of current support accessible by those who are suicidal through Maytree.

The causal attributions of suicidality offered by volunteers', as well as literature pertaining to the prevalence of psychosocial risk factors in suicide, demonstrate the vital position of non-medical respite centers like MayTree in contemporary efforts to support the suicidal. The first subordinate theme, *adverse childhood experiences*, encapsulates familial childhood abuse, occurring in various forms, as having a contributory relationship with the suicidality of houseguests. Each of the types of childhood abuse that were identified – sexual, physical and emotional – has indeed been highlighted by research as significant risk factors for suicide [9]. In fact, domestic violence is a major precipitating factor for suicide, in all its forms, and therefore, anyone involved in suicide prevention must be aware of this widespread issue and how to respond to it [21]. The above literature details the importance of considering psychosocial factors, identification that was consistently alluded to by MayTree volunteers not solely when discussing casual attributions, but also when discussing what they perceive to be the limitations of the medical model. This was particularly evident under the subordinate theme, *a reductionist correlation between biology and suicide*. Although this may be the case in practice, it is important to note here that more contemporary ideation to action models, often used clinically, do take psychosocial risk factors into consideration when assessing suicidality. Joiner's (2005) interpersonal theory of suicide, for instance, posits that the most dangerous suicidal ideation occurs in the presence of two particular interpersonal constructs, thwarted belongingness, and perceived burdensomeness; particularly if a person feels hopeless about those states [22]. Also, the integrated motivational-volitional model of suicidal behavior incorporates environmental factors within its pre-motivational phase, as well of perceptions of entrapment and defeat in its motivational phase [23].

Maytree's drug and alcohol policy was presented as a potential disadvantage to supporting suicidal people. This policy, however, coupled with the guidelines that encourage referral of those with complex psychiatric disorders onto professional care services, demonstrate that the charity recognizes biological factors, as well as the specialized assistance necessary to address them. MayTree has been described, for instance, as a support system that has effectively shown promise, despite its non-medical approach to suicide [24]. Yet, the authors do recognize that for some individuals experiencing a suicidal crisis, more complex than that of psychosocial adversity, talk-centred strategies may not be adequate.

From the perspective of MayTree volunteers, however, it appears that the medical model's perspective does not incorporate psychosocial factors within its practice. Indeed, despite the political, economic, and

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socio-cultural underpinnings, the medical model is yet to incorporate social and cultural factors into its understanding of suicidality [6]. During the National Confidential Enquiry into Suicide and Homicide by People with Mental Illness, it was identified that between 2001 and 2011, 72% of people who died by suicide were not in contact with mental health services within the year prior to their death [25]. For a person to be admitted into the health care system for suicidality, they must receive referral from their general practitioner, at which point they can then be assessed to receive treatment for issues pertaining to their mental health [7] – an occurrence that may neglect the need of a particular set of people, either those who do not demonstrate the symptomatology necessary to receive a diagnostic assessment, or those who are reluctant to seek mental health support because of stigmatization. Given the plethora of evidence to suggest that those experiencing psychosocial distress are at a high risk of suicide, it could be expected that the dominant framework for suicide support would have procedures in place to target those experiencing social adversity. Whilst support structures do exist that focus upon individuals within the community, formerly named regional crises support teams, these strategies exist as a product of the Mental Health Policy Implementation Guide [25]. Consequently, these teams operate from the medical model's perspective of suicide and, as such, they target those experiencing psychiatric symptoms deemed to be of a severity for which hospitalization would otherwise be necessary [25].

Another suggested reason that such a large portion of suicide rates occur without contact with mental health services is that people who are experiencing a suicide crisis have negative attitudes toward institutionalized care, potentially also because of fear of compulsory admission [26]. Attitudinal barriers are highlighted to be a leading cause for individuals preferring to manage their suicidal crises outside of a medicalized environment. It can be argued that stigma is the product of societal misinterpretation of mental health provision, making it a difficult area for health care professionals to address [26]. However, the literature suggests that internal stigma, on behalf of medical professionals, is also apparent. Research into service users' experiences with emergency department staff, following incidents of self-harm and attempted suicide, found that interactions were described by patients as non-empathic and humiliating [27]. Moreover, an international systematic review into the attitudes of staff that have interacted with patients subsequent to attempted suicide, found that medical professionals often referred to feelings of anger and irritation towards the service users [28]. It is important to acknowledge, however, that the identification of medical professionals' irritability does not necessarily call to question the desire to support those who are in need. Medical staff are often unable to provide support for patients to an extent that they would desire, due to increasing demand of a completely risk aversive environment, as well as limitations in time and resources available to them [6].

It is important to clarify here that an argument is not made to suggest that Maytree's model is superior to that of the medical model, rather MayTree's advantages can complement the limitations that appear to exist in a clinical environment. As previously identified, MayTree offers support from a psychosocial perspective and, in turn, can support those who do not meet the requirements or are unwilling to receive the specific support offered by the medical model. Moreover, MayTree is able to avoid stigma through not being centered on mental health, as well as being largely user-led, as opposed to relying upon professionalized care. MayTree seeks to ensure that its guests are in control of

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their suicidal crisis in that, guests have the right to make their own decisions as to how they cope with their problems, even if this means taking their own life [29]. The MayTree model also mitigates the likelihood of internal judgment, through the overriding ethos that is shared by staff and volunteers, which places a strong importance upon be-friending and being completely non-judgmental. The benefits of be-friending and non-judgmental practices being invoked when supporting people who are suicidal is not only evidenced by volunteers, but also in suicide literature that encourages humanistic principles as protective factors against suicidality. Indeed, guidelines for frontline staff advise them to explore the patient's life experiences in order to build a trusting empathetic relationship, and to attempt to establish an understanding of the person's context in relation to their suicidality, which is said to support a person to re-establish a sense of understanding and purpose [28].

Implications for Future Research and Practice

The implications that this research may have upon suicide preventative practice are founded within the evidence to suggest that psychosocial factors present a prevalent risk for suicidality, yet are overlooked by the dominant suicide intervention framework. Moreover, there are advantages and limitations to both non-medically based understandings of suicide and their associated preventative measures, as well as medically orientated knowledge and preventative care. Thus, a collaborative effort between these two approaches may offer a more inclusive preventative strategy for those experiencing different suicidal circumstances wherein, the advantages of one model may bridge the gaps evident within the other. Maytree's model, for example, can provide assistance for those experiencing environmentally provoked distress, as well as those who fear mental health-related stigmatization, areas where the medical model demonstrates weaknesses. The medical model can assist those experiencing a suicidal crisis pertaining to severe mental disturbances or substance abuse, where organizations such as MayTree do not have the capacity to intervene.

Limitation

The limitations of this investigation appear to originate from the study design. The small sample size, for example, that is necessary to effectively incorporate IPA as a data collection method also limits the investigation's ability to be generalized [18]. However, it should be stated that IPA investigations are more concerned with gaining an in-depth understanding of participants' lived experiences than with understanding generalized phenomena of large populations [19]. The contributions presented within this study were offered by volunteers at MayTree and as such, their statements cannot be used to represent the ethos of other supportive strategies that operate upon a psychosocial or humanistic perspective. Also, the contributions seen in this investigation were offered by active volunteers at MayTreee and it could, therefore, be argued that by obtaining the experiences of previous volunteers that have now discontinued their involvement with the charity, alternate views may be provided. Moreover, although literature supports many of the limitations that were identified in relation to the medical model, no medical professionals participated within this investigation and were therefore not able to offer contributions from a biomedical perspective.

Further exploration into the impact of non-medically based practices that exist to support those who are suicidal (such as MayTree) is recommended.

Conclusion

This research demonstrates the necessity of an integrative understanding of suicidality, in order to establish a more comprehensive approach to supporting

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those who suffer because of it. The limitations and advantages of both MayTree – which incorporates a psychosocial and humanistic perspective – and the medical model – which conforms to a biological perspective – were identified. Moreover, it was highlighted that the limitations of each perspective could be complemented by the strength of the other, and the apparent advantages could also be further strengthened through collaborative efforts. However, an argument can be made that the biomedical model, in particular, would benefit from widening its perspective to incorporate psychosocial risk and protective factors into its practice. MayTree, from both the perspective of volunteers, as well as in the limited associated literature available, appears to provide effective support for its service users and recognizes the necessity for professionalized care in biologically complex cases of suicidality.

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