Crisis, Stress, and Human Resilience: An International Journal

Volume 5, Number. 1
September 2023

MULTIPLE-ATTEMPT SUICIDE SURVIVORS: A CONSTANT COMPARATIVE ANALYSIS

Brittany Stahnke
stahnkejoy@etsu.edu
719 675-7007
East Tennessee State University
ORCID ID: 0000-0003-0287-3369

Chase Gaumond
crgaumond@outlook.com

Abstract: *Suicide is the most serious mental health crisis, being the second leading cause of death after accidents in those under the age of 34. As a secondary analysis of a grounded theory study, unlike studies previous, this constant comparative analysis seeks to assess differences in those who attempt suicide multiple times versus those who merely consider suicide and/or attempt once. Using interviews with 15 participants, authors assess demographic and experiential differences in participants, finding that those who attempt multiple times are more likely to have had serious childhood trauma, overwhelming feelings of anger, and less educational attainment. Further, those who attempted suicide multiple times had more risk factors than those who did not attempt or attempted only once. Suggestions for future research and practice are reviewed.*

Keywords: *suicide, suicide attempt, multiple-attempter, abuse, anger*

INTRODUCTION

The rate of those who successfully attempt suicide is on the rise; specifically, there are two and half times more suicides than homicides in the U.S. each year (NIMH, n.d.). Suicide is the most serious mental health crisis, being the second leading cause of death after accidents in those under the age of 34. In 2020, 45,900 people died of suicide (NIMH, n.d.). Not only is the rate of completed suicides on the rise, but the rate of those who attempt is climbing (Hedegaard et al., 2021). While 12.2 million adults considered suicide this same year, at least 1.2 million attempted (NIMH, n.d.). While 90% of attempters do not go on to complete suicide, there is a higher chance of suicide once an attempt has been made. Five to eleven percent of attempters will eventually die by suicide, with about 23% reattempting without completing and 70% having no further attempts (Owens et al., 2002).

CURRENT KNOWLEDGE

Core factors that are considered in the study of suicide are reasons for dying and reasons for living. The more reasons people have to live, the less likely they are to attempt suicide, especially when comparing those with suicidal ideation versus those who have acted on the suicidal ideation through suicide attempt (Christensen et al., 2021). However, reasons for dying may be more predictive of suicidal behavior than reasons for living or

lack thereof (Brüdern et al., 2018). Looking into reasons for suicide, 80% of older adults who commit suicide are unemployed (Bai et al., 2021). Further, having a partner is associated with increased suicidal ideation while having children is associated with decreased suicidal ideation (Brüdern et al., 2018). A frequent reasoning for suicide attempt is relationships (Akotia et al., 2019). Reasons for living and dying are factors that can rapidly change in a person's life, however, making a person's risk of suicide widely variable across a lifespan.

While one's history of suicide attempts can predict future attempts, studies show that six months after a suicide attempt the previous attempt is no longer predictive of later attempts (Brüdern et al., 2018). On the other hand, suicidal ideation is the only thing predictive of ideation after six months, though not after two years. What has not been studied recently is if there are differences between those who consider but do not attempt and those who choose to attempt suicide (Klonsky & May, 2015). Further, are there qualitative differences between those who attempt suicide once in their lives and those who have multiple suicide attempts? One study looked at the differences in suicidal behavior of single-attempters, multiple-attempters, those who have ideation but do not attempt, and those without any suicidal behaviors, finding that multiple-attempters were more likely to be divorced/widowed and to have more lethal attempts (Berardelli et al., 2020). Yet, other differences may exist that can only be found by looking at a smaller number of cases more deeply. While it has been found that multiple-attempters are more likely to have more serious mental illness than single-attempters, both studies look at inpatient populations soon after suicide attempts, which does not leave room for the insight, reflection, and retrospection that is necessary to understand one's own suicidal behaviors. This study will focus on those who have considered or attempted suicide at least six months past the event.

PURPOSE

This paper is a secondary analysis of a previous grounded theory study that looked at causes of suicide in those who have considered suicide, whether an attempt was made or not (Stahnke et al., 2022). During this analysis, it was observed that there may be differences in those who attempt suicide and those who do not. Why do some people with very challenging situations choose not to commit suicide while others do? Are there inherent or environmental differences? While many research efforts surrounding suicide involve looking at reasons why people do commit suicide, perhaps there may be additional insight gained by also talking to people who have not committed, despite the risk factors, consideration, and even attempt. In exploring differences between these two groups, a secondary goal and purpose emerged: is there a difference between those who attempt multiple times and those who do not attempt or attempt only once?

METHODS

This study used secondary data to form analysis. First, authors used data from previous qualitative interviews to assess differences between people who consider and attempt suicide and those who do not attempt, despite suicide consideration. One year prior to the current paper, the first author interviewed individuals who had seriously considered and/or attempted suicide regarding their consideration process. Participants were selected via purposive sampling and snowball sampling; the first author sent out emails to university students, professors, and staff advertising the purpose and methods of the study with advisement to reach out to the first author. Since major findings are found within the first 10 (Francis

et al., 2010) or 12 (Guest et al., 2006) interviews (Crouch & McKenzie, 2006), the researchers attained IRB permission for 15 participants. All interviews took place either via zoom or in-person in a university office at the discretion of participants. Interviews were audio-recorded to ensure precision while optimizing confidentiality.

Demographic information was collected, and semi-structured interviews were performed with participants by the first author (see Appendix A). After five interviews, audio recordings were transcribed to look for patterns within and across interviews, and the previous three authors met for initial analysis. Subsequently, ten more participants were interviewed. At this point, the two authors met again to use open coding, axial coding, and selective coding to develop conceptual categories.

Change in Comparison Groups

When initially working to analyze data, questions regarding differences in attempt history of participants presented, and the two authors chose to look at attempter vs. non-attempter differences using constant comparative analysis. During this analysis, authors discovered differences more so between two other groups—those who had attempted once or not at all, and those who had attempted suicide multiple times.

The constant comparative method involves "generating and plausibly suggesting many properties and hypotheses about a general phenomenon" (Glaser, 1965, p.438). Put simply, "the analyst merely inspects his data for new properties of his theoretical categories and writes memos on these properties" (p.437). Authors used the comparative method to find differences between the interviews and demographic characteristics of those who have desired suicide and attempted and those who have considered suicide and not attempted, by defining an "attempt" as having full intent to kill oneself and the means in one's hands (driving in a car at 180 mph, gun to head, pills in hand/mouth, etc.). Later, authors made this same comparison between the five who attempted suicide multiple times and the other ten participants. The four stages of the constant comparative method of grounded theory are:

1. comparing incidents applicable to each category
2. integrating categories and their properties
3. delimiting the theory
4. writing the theory

The focus of the constant comparative method is the generation of many theories (Glaser, 1965). There are plenty of reasons why some people may not attempt suicide, despite consideration and even incessant suicidal thoughts, and the initial aim of this study was to provide space for this understanding inside those who experience suicidality whether they do or do not attempt. Each author took half of the interviews and re-analyzed them with the goal of comparing attempters and non-attempters and later, multiple attempts and the rest of participants.

RESULTS

The two kinds of themes that appear using this method are themes that are constructed by the authors and those found through the language in the interviews (Glaser & Strauss, 2017). The differences found between attempters and non-attempters were based on the construction of the authors, but the findings based on the wording of the participants who had attempted multiple times, and later in comparison to those who had not, were found based on the words of the participants. As authors "came across case[s] where [high risk factors, an absent or abusive dad, and feelings of anger/impulsivity before attempt] did not appear to be the baseline"

(p.111), authors followed the data in comparing two different groups.

Demographics

The participants who identified not having a religion attempted suicide while all who identified as Christian had not attempted. Further, all three non-heterosexual participants had attempted. Further, this study had a higher rate of African Americans in comparison to the general population (20%); (Anglin et al., 2005). While African Americans have lower suicide rates than White Americans, African American teenagers who commit suicide are increasing at rates higher than other groups of teenagers.

Risk and Protective Factors

Tables 1 and 2 compare risk and protective factors of attempters and non-attempters while Tables 3 and 4 compare risk and protective factors of multiple-attempters and 0-1 attempts. It was found that while the attempter and non-attempter groups did not display any differences in how many risk factors were present in their lives, attempters were actually more likely to have a higher number of protective factors. This finding is ruled to be arbitrary, given the likeness between the protective factors of Tables 3 and 4 and the insignificant rate of differences. The full list of factors per participant is present in Table 5 Appendix B.

Table 1. *Descriptives of Suicide Risk Factors*

	Attempters Mean *(SD)*	**Non-Attempters Mean *(SD)***
Individual	4 *(1.6)*	4 *(1.7)*
Relational	2.8 (*1.5*)	2.8 (*1.2*)
Community	.33 *(.5)*	.33 *(.5)*
Societal	1.7 (*.87*)	1.7 (*.87*)
Overall	8.8 *(3.5)*	8.8 *(2.6)*

Table 2. *Descriptives of Suicide Protective Factors*

	Attempters Mean *(SD)*	**Non-Attempters Mean *(SD)***
	4.1 *(1.5)*	3.8 *(1.2)*

While there was not a quantitative difference found in risk factors of attempters versus non-attempters, when looking at those who attempted suicide multiple times versus those who considered or only attempted once, differences were found.

Table 3. *Descriptives of Suicide Risk Factors*

	Multiple Attempts Mean *(SD)*	**0-1 Attempts Mean *(SD)***
Individual	4.8*(.8)*	3.6*(1.5)*
Relational	3.8*(.8)*	2.3*(1.5)*
Community	.4*(.5)*	.4*(.5)*
Societal	2*(.7)*	1.4*(.7)*
Overall	11*(1.9)*	7.7 *(3.1)*

Table 4. *Descriptives of Suicide Protective Factors*

Multiple Attempts Mean *(SD)*	**0-1 Attempts Mean *(SD)***
4 *(1.4)*	4 *(1.4)*

Interviews

The authors recognized various "feeling" words that were used frequently by participants. Anger, loneliness, impulsivity, fear, and guilt were all identified frequently by the participants. Specifically, the participants who had experienced multiple attempts used, on average, these words 9.5 times in their interview while those who did not make multiple attempts used them 7.2 times. Below are instances in which participants used these words to describe their suicide attempts:

Anger.

> **"**So that created a lot of guilt and created more anger and almost contempt for myself for feeling that way." (9)
>
> **"**I worked really hard in my life to get out of the cycle that I was in in my childhood. and then instead of feeling empty, I'm kind of angry about it." (10)
>
> **"**At the time I was diagnosed with MDD at that time and it was also outbursts of anger." (11)
>
> **"**I guess I did have more anger issues…" (11)
>
> "Yeah, I guess more frustration." (15)

Isolation.

> "Alone." (1)
>
> "…Talk about the abuse that had happened and to also talk about how I felt so bad and felt so isolated despite having friends and family." (9)
>
> "So, I never really fit in really well socially and that might have contributed to the isolation. And not caring. Yea I might have had some friends, good friends but I was isolated because I was not fully into that social life." (9)
>
> "I feel like I could lose pretty much everyone in my life and not kill myself but then again I can live that isolated introverted life." (9)
>
> "Around that time I was getting overwhelmed and feeling kind of isolated because she would lock me in my room a lot." (10)
>
> "I was completely isolated and I thought that that is how it will always be." (10)

"And I guess it was the isolation." (11)

"So initially, even though I was trying and work towards it, I would drink a lot. And I hated being alone." (15)

Impulsivity.

"The ADD treatment resolved some of the remaining symptoms of inattentiveness and a little bit of impulsiveness." (9)

"I think it had something to do with it. Just the impulsivity. At least that's how it was explained to me." (15)

"It was impulsive." (15)

Fear.

"You could see that he wasn't ready yet and you could see his pain and fear" (1).

"I wanted to end the fear that someone would find out and yes. and then in a dark way, I also wanted to end my life to prevent the social revolution that would happen from my friends and family." (9)

"Probably just the fear of it going wrong is what has kept me from doing anything." (10)

"Yeah, I was afraid of what could happen." (15)

Guilt.

"Last thing I want to do is have somebody jump in front of my car and me hit them and kill them and then the rest of my life I have that guilt." (1)

"I felt really guilty." (9)

"So that created a lot of guilt and created more anger and almost contempt for myself for feeling that way." (9)

Missing Parent(s).

Further, those who attempted multiple times were more likely to have grown up with both an absent and/or abusive parent:

"I had a step-dad that was very abusive, and he would say and do certain things that would make me feel a certain way…later, [the friend] began to expose himself to me. My mom made me feel like it was my fault." (1)

"She would lock me in this really scary greenhouse shed and we lived in Washington at the time because we moved around a lot. She would lock me in there in the freezing winter." (10)

"My dad was very verbally abusive [towards my older sister] … he did hit me with a belt and the marks lasted a good 6 months and sorta never went away. It was bad." (11)

"It was more neglect when my mom would go looking for my dad, there was moments when I would wake up in the middle of the night and my parents would be gone and I'd have to take care of my brothers, without my mom telling me what was happening." (15)

While most participants suffered negative or traumatic childhood events, these participants' stories, as a whole, stood out in the frequency, degree, or particularly horrific details involved.

Another noted difference is that all the attempts for these participants, outside of one case, were prior to therapy or working on one's trauma. For the one participant who did not get help healing from the trauma, this was also the only one of the five participants whose suicide attempts had been recent and in later adulthood (40s); the other participants' attempts were all in their teens or 20s. Overall, trauma and externalized anger were the qualitative differences noted in reviewing interviews between multiple-attempters and those who attempted once or not at all. Relational reasons, such as feelings of loneliness and lack of intimate

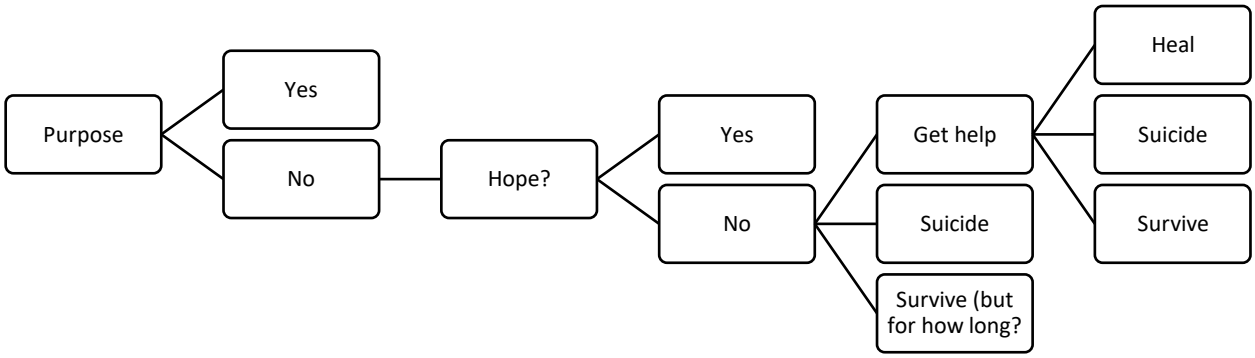
relationships, were also noted in these interviews, which aligns with the higher relational risk factors found.

DISCUSSION

Risk and Protective Factors

Consistent with the finding that protective factors are largely equitable between those who have attempted multiple times and those who have not, studies have found protective factors to be less indicative of future attempt than risk factors (Brüdern et al., 2018). Any quantifying difference in the attempter vs. non-attempter groups was found to be arbitrary. It is possible that arbitrary difference between attempters and those who do not is the element of choice. To build on the figure below, which attempts to understand choice within suicidality, these authors added a factor to the last aspect of the diagram in the previous study—not only can people choose to die or get help, but perhaps there is a third option: to merely survive (Figure 1). Further, given the significant differences between the two groups on relational and individual risk factors of suicide, but the lack of such differences in community factors, this may indicate that the decision to repeatedly attempt suicide is more a product of individual rather than systemic factors.

Figure 1.



Interviews

Anger.

Attempts were more likely to involve feelings of overwhelming anger whereas plans and considerations more often did not. The more attempts, the more likely participants were to identify anger as part of their attempt pattern. These authors do not believe the difference is in those who attempt and those who do not, but that there is a spectrum in that the more attempts, the more issues with experiencing and coping effectively with intense feelings such as anger. Anger is an activating emotion that makes us "want to do something" and has been found to be partly hereditary (Brown, 2022). It is a state in which we feel that something should be very different than it is. Behind feelings of anger are grief, injustice, vulnerability, shame, and betrayal, to name a few. The expression of anger is a cover for other emotions that are not easily processed, and it can fuel negative action, such as a suicide attempt. Most of the feelings of anger involved past victimization and trauma from the far past—feelings that were never healed and were present at the time of attempt.

Trauma.

Part of the reason the rate of risk factors was higher for those who had attempted multiple times was the presence of childhood or young trauma which included rape, abuse,

and unstable living situations. Two of the five multiple-attempt participants had absent fathers throughout childhood, and two more had fathers who were abusive. Further, abuse was sustained or witnessed in four of the five interviews. In the fifth interview, despite the absence of a father, the participants sustained years of horrific abuse unknown to inconsistent parents, thus sustaining long periods of not being safe and longstanding feelings of guilt and shame. While feelings of anger can be seen as an individual factor, those feelings of anger may be more likely to be present in anyone who has sustained such a difficult childhood, thus still stemming from relational experiences rather than individual factors. This does suggest the possibility that one of the most, if not the most, causal factors in later attempts of suicide is long periods of sustained childhood abuse, though neglect also appears to provide differing feelings of isolation and loneliness—other reasons for suicidality that are present in this study. Perhaps working through trauma, as four of these five participants had done and thus far eliminated attempts afterward, diminishes actual suicide attempts as well as inclinations toward it; otherwise, the memories and feelings attached do not go away, such as in the participant who still identified with suicidal inclination and had not gotten help to heal from his trauma.

The Choice Toward Suicide.

Those who stopped considering suicide did so by first seeking help. Further, of the five multiple-attempters, only one did not seek higher education that involved self-development and helping others; effort toward healing appears to be a vital part of ending patterns of attempts, though ending the action may not end the inclination toward suicide, as some participants indicated still exists for them. Once they stopped considering suicide an option, their urge to attempt it mostly—though not completely and always—bypassed. There was a pattern of individuals who had "healed" coming away from suicidal consideration no longer making suicide an option. In essence, they saw a large degree of choice in the consideration of suicide.

The Life Project was the largest human development study ever undertaken, looking at five generations of people over a 50-year span (Pearson, 2017). The two most harmful things to human health were determined to be poverty and poor parenting. In line with this study, all of the five multiple-attempters in this study had inconsistent, under-participating (1 participant) or abusive parents (4 participants).

CONCLUSION

Given that there were no quantitative or qualitative differences found between those who attempt and those who seriously consider, perhaps the actual differences in these groups—in the choice to attempt suicide—is choice-based and impulsive. Perhaps a suicide attempt, given the right state of emotion and happenings in one's environment, is something that could happen to almost anyone. Further, the main differences found in those who attempted multiple times were childhood trauma and intense feelings of anger during the attempt. In particular, abuse was sustained over long periods of time and later was directly linked to feelings of anger when one chose to attempt suicide. Further, adult traumas become more nega-tively impactful when they seemed to trigger feelings and memories of past traumas.

Practice and Research Implications

The most quantifiable difference found in this study between those who had considered and/or attempted suicide once and those who had attempted more than once was the seeking of professional and personal help. Of

the one participant who had recently had suicide attempts and also did not deny that it may happen again, this was also the only multiple-attempter who did not have higher education and did not seek help for his suicidality. Further, there seemed to be fewer human connections in this participant's life that kept him committed to surviving; one of the suicide attempts was stopped by the thought of his cats who needed him, indicating, along with other interviews, that connections can keep one living.

Future research can explore whether there lies a connection between suicide attempt and educational advancement as well as receiving professional help. Further, schools may consider focusing programs on the development of skills to cope with strong emotions such as depression and anger so as to better equip children as they grow into adults on coping with such difficult, intolerable feelings in appropriate, benign ways.

If qualitative, meaning-based reasons for suicide and suicidality continue to be explored and considered, mental health practitioners and policymakers alike would be better able to develop and implement targeted suicide prevention and suicidality treatments to those in need. Given the current dimensions and impact of suicide, such an approach and its associated benefits cannot be overstated.

REFERENCES

Akotia, C. S., Knizek, B. L., Hjelmeland, H., Kinyanda, E., & Osafo, J. (2019). Reasons for attempting suicide: An exploratory study in Ghana. *Transcultural Psychiatry*, *56*(1), 233–249. https://doi.org/10.1177/1363461518802966

Anglin, D. M., Gabriel, K. O., & Kaslow, N. J. (2005). Suicide acceptability and religious well-being: A comparative analysis in African American suicide attempters and non-attempters. *Journal of Psychology and Theology*, *33*(2), 140–150. https://doi.org/10.1177/009164710503300207

Bai, X., Zhou, L., Mo, Q., Jia, C., & Ma, Z. (2021). Understanding the reasons for suicide among older adults in rural China using in-depth interviews. *Crisis*, *43*/(5). https://doi.org/10.1027/0227-5910/a000799

Berardelli, I., Forte, A., Innamorati, M., Imbastaro, B., Montalbani, B., Sarubbi, S., De Luca, G. P., Mastrangelo, M., Anibaldi, G., Rogante, E., Lester, D., Erbuto, D., Serafini, G., Amore, M., & Pompili, M. (2020). Clinical differences between single and multiple suicide attempters, suicide ideators, and non-suicidal inpatients. *Frontiers in Psychiatry*, *11*. https://doi.org/10.3389/fpsyt.2020.605140

Brown, B. (2022). *Atlas of the heart: Mapping meaningful connection and the language of human experience*. Random House Large Print.

Brüdern, J., Stähli, A., Gysin-Maillart, A., Michel, K., Reisch, T., Jobes, D. A., & Brodbeck, J. (2018). Reasons for living and dying in suicide attempters: A two-year prospective study. *BMC Psychiatry*, *18*(1). https://doi.org/10.1186/s12888-018-1814-8

Christensen, K., Hom, M. A., Stanley, I. H., & Joiner, T. E. (2021). Reasons for living and suicide attempts among young adults with Lifetime Suicide Ideation. *Crisis*, *42*(3), 179–185. https://doi.org/10.1027/0227-5910/a000705

Crouch, M. & McKenzie, H. (2006) The logic of small samples in interview-based

qualitative research. *Social Science Information, 45*, 18. https://doi.org/10.1177/05390184060695 84

Francis, J. J., Johnston, M., Robertson, C., Glidewell, L., Entwistle, V., Eccles, M. P., & Grimshaw, J. M. (2010) What is an adequate sample size? Operationalising data saturation for theory-based interview studies. *Psychology & Health, 25*(10), 1229-1245. https://doi.org/10.1080/08870440903194 015

Glaser, B. G. (1965). The constant comparative method of qualitative analysis. *Social Problems*, *12*(4), 436–445. https://doi.org/10.1525/sp.1965.12.4.03a 00070

Glaser, B. G., & Strauss, A. L. (2017). *The discovery of Grounded Theory: Strategies for qualitative research*. Routledge.

Guest, G., Bunce, A., & Johnson, L. (2006). How many interviews are enough?: An experiment with data saturation and variability. *Field Methods, 18*(1), 59-82. https://doi.org/10.1177/1525822X05279 903

Hedegaard, H., Curtin, S. C., & Warner, M. (2021). Suicide mortality in the United States, 1999–2019 (NCHS no. 398) [data brief]. CDC.

Klonsky, E. D., & May, A. M. (2015). The three-step theory (3ST): A new theory of suicide rooted in the "Ideation-to-Action" framework. *International Journal of Cognitive Therapy*, *8*(2), 114–129. https://doi.org/10.1521/ijct.2015.8.2.114

Owens, D., Horrocks, J., & House, A. (2002). Fatal and non-fatal repetition of self-harm: Systematic review. *British Journal of Psychiatry, 181*, 193-199. https://doi.org/10.1192/bjp.181.3.193

Pearson, H. (2017). *The Life Project: The extraordinary story of our ordinary lives*. Penguin Books.

Stahnke, B., Gaumond, C., & Davis, R. (2022). Experienced causes of suicidal intent: A grounded theory analysis. *Crisis, Stress, and Human Resilience: An International Journal*, *4*(1), 32-52.

U.S. Department of Health and Human Services. (n.d.). *Suicide*. National Institute of Mental Health. https://www.nimh.nih.gov/health/statistics/suicide

Appendix A

Interview Questions

Describe your family of origin.

Have you experienced abuse or neglect as a child?

During the time of your [first or only] attempt, tell me about how you were feeling.
If no attempt, talk about time(s) you considered.

During the time of your [first or only] attempt, tell me about your family life.
If no attempt, talk about time(s) you considered.

During the time of your [first or only] attempt, what did you want to end?
If no attempt, talk about time(s) you considered.

After your attempt, what did you feel? What changed?
If no attempt, talk about time(s) you considered.
*Repeat questions in red for each attempt

At that time, what is ONE thing that if it changed, you would NOT have wanted to kill yourself?

Ie, what did you LACK or what did you need GONE?

What has changed since that makes you **not** consider it now?

What were your reasons for living THEN? (List of life factors such as friends, school, etc.)

What were your reasons for dying THEN? (no family, pain, etc.)

Do you think suicide can be prevented? Could something external have prevented you?

How would you best express the cause of your attempt(s)?

"The suicidal mode is an out-of-the-ordinary state of mind which has a time-limited nature of activation [24]. When the mode is activated, the person is cognitively and affectively restricted to suicidal thoughts and feelings of hopelessness and helplessness. In most cases the suicide attempt leads to a reduction of inner tension and the deactivation of cognitive restriction—a cathartic effect. Afterwards, individuals often feel relief and again have access to life-oriented goals" (Ruud et al., 2001 & Brudern et al., 2016, as cited in Brudern et al., 2018).

Do you relate to this mode, is it true of your experience, and how?

Appendix B

Table 5. *Self-Reported Risk Factors of Participants*

Individual	1*	2	3	4	5	6	7	8	9*	10*	11*	12	13	14	15*	Total
Previous suicide attempt							X	X		X	X				X	= 4
Mental illness	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	= 11
Social isolation	X	X	X		X	X	X	X	X		X		X		X	= 10
Criminal problems													X			= 0
Financial problems	X	X		X				X					X	X		= 5
Impulsive/aggressive tendencies			X	X	X			X	X	X	X		X		X	= 7
Job/employment problems	X	X		X	X				X							= 5
Legal problems	X	X														= 1
Serious illness									X	X						= 1
Substance use disorder	X					X		X							X	= 4
Relationship																
Adverse childhood experiences	X	X	X	X	X	X		X	X	X	X		X	X	X	= 11
Bullying	X		X		X		X		X	X	X		X	X	X	= 8
Family history of suicide		X								X				X	X	= 3
Relationship problems	X	X	X					X			X	X	X	X	X	= 8
Sexual violence	X							X	X		X		X		X	= 5
Community																
Barriers to health care				X	X								X			= 2
Cultural/religious view of suicide nobility		X														= 1
Community suicide cluster											X				X	= 2
Societal																
Stigma associated with mental illness	X	X		X			X	X	X	X	X		X		X	= 8
Easy access to lethal means			X		X			X	X	X	X		X	X	X	= 7
Unsafe media portrayals of suicide		X	X			X	X								X	= 5

Individual	1*	2	3	4	5	6	7	8	9*	10*	11*	12	13	14	15*	Total
Protective factors																
Coping and problem-solving skills	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	= 13
Culture/religion discourage suicide		X		X	X				X		X	X			X	= 7
Connections to friends, family, community	X	X	X	X	X		X	X	X		X	X	X	X	X	= 12
Supportive relationships with care providers	X		X	X	X	X		X	X		X	X		X	X	= 11
Availability of physical and mental health care			X	X	X			X	X	X	X	X	X	X	X	= 9
Limited access to lethal means		X		X								X				= 3

*Multiple-attempters

MULTIPLE-ATTEMPT SUICIDE SURVIVORS: A CONSTANT COMPARATIVE ANALYSIS

Author Note

Brittany Stahnke, College of Clinical and Rehabilitative Health Services, East Tennessee State University.

Correspondence concerning this article should be addressed to Brittany Stahnke, College of Clinical and Rehabilitative Health Services, East Tennessee State University, 1276 Gilbreath Dr. Johnson City, TN 37614. Email: stahnkejoy@etsu.edu. ORCID ID 0000-0003-0287-3369

The authors report there are no competing interests, funding sources, to declare.