Experiences and Wisdom Behind the Numbers
Qualitative Analysis of the National Action Alliance for Suicide Prevention's Research Prioritization Task Force Stakeholder Survey

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Background: The Research Prioritization Task Force of the National Action Alliance for Suicide Prevention conducted a stakeholder survey including 716 respondents from 49 U.S. states and 18 foreign countries.

Purpose: To conduct a qualitative analysis on responses from individuals representing four main stakeholder groups: attempt and loss survivors, researchers, providers, and policy/administrators. This article focuses on a qualitative analysis of the early-round, open-ended responses collected in a modified online Delphi process, and, as an illustration of the research method, focuses on analysis of respondents' views of the role of life and emotional skills in suicide prevention.

Methods: Content analysis was performed using both inductive and deductive code and category development and systematic qualitative methods. After the inductive coding was completed, the same data set was re-coded using the 12 Aspirational Goals (AGs) identified by the Delphi process.

Results: Codes and thematic categories produced from the inductive coding process were, in some cases, very similar or identical to the 12 AGs (i.e., those dealing with risk and protective factors, provider training, preventing reattempts, and stigma). Other codes highlighted areas that were not identified as important in the Delphi process (e.g., cultural/social factors of suicide, substance use).

Conclusions: Qualitative and mixed-methods research are essential to the future of suicide prevention work. By design, qualitative research is explorative and appropriate for complex, culturally embedded social issues such as suicide. Such research can be used to generate hypotheses for testing and, as in this analysis, illuminate areas that would be missed in an approach that imposed predetermined categories on data.
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Introduction

This paper presents results from a discourse analysis of the National Action Alliance for Suicide Prevention's Research Prioritization Task Force (RPTF) stakeholder survey. The survey has been described in detail elsewhere[1]; briefly, multiple comments from 716 respondents representing 49 U.S. states and 18 countries[a] were gathered in the initial data-generating round of a modified Delphi process. In this initial round from August 8 to November 11, 2011, an opportunistic sample of individuals from a wide variety of suicide-related organizations and departments were asked to generate ideas ("goals") for a suicide prevention research agenda. These early-round, open-ended responses fed into the modified Delphi process—which involved a more structured and constrained response format as part of an iterative consensus process to identify the 12 Aspirational Goals (AGs) discussed throughout this supplement.

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[a]Australia, Austria, Belgium, Canada, China, Denmark, France, Germany, Hong Kong, Israel, Italy, Mexico, New Zealand, Norway, Pakistan, Sweden, Switzerland, and the United Kingdom.

The goal of this qualitative analysis was to provide additional perspectives for use in the research prioritization process, specifically in-depth analysis of the complex way respondents thought about suicide prevention and suicide prevention research. As will become clear throughout this paper, distinctions are not always made between the two. Individuals would discuss a gap they saw in suicide prevention as an area that needed research, whereas others saw suicide prevention activities and suicide prevention research as completely interconnected. In order to understand such intricacies, the early-round, open-ended responses were qualitatively analyzed and results are presented below. To be clear, the kind of analysis described in this paper is not a substitute for more comprehensive, properly designed and executed qualitative research (e.g., ethnography, proper sampling, and semi-structured interviews). These survey responses do, however, provide a rich source of information about culturally constructed meanings of suicide (e.g., the event itself, what could precipitate it, what it means for the family/society at large).

This study was conducted as part of a Presidential Management Fellowship at the Substance Abuse and Mental Health Services Administration, USDHHS; survey analysis occurred at the National Institute of Mental Health. As a result of the author's participation in the RPTF, a collaborative research team based at the University of North Texas Health Sciences Center provided de-identified data from the RPTF online survey conducted between August and November 2011[1] and requested her qualitative perspective as a linguistic anthropologist.[2,3]

Results analyzed here include the 719 de-identified responses of varying lengths (from a few words to pages) from that online survey. The survey allowed respondents to self-identify as one of four categories: "survivors" (family survivors as well as attempt survivors, 228 respondents); "researchers" (220 respondents); "policy/administrators" (170 respondents); and "providers" (101 respondents).[b] Once the author received this data, each respondent was randomly assigned a number within their self-selected category.

The sections that follow provide background regarding the survey data that form the basis of the analysis; an overview of the qualitative methods employed; a summary of the resultant codes and metacategories extracted in the initial analysis; a more detailed description of a discourse summary for one subcode, "life and emotional skills," that illustrates how qualitative methods reveal things that did not otherwise come to light in the top–down impositional approach and can be used to develop an approach to create testable theories and investigate the nuances of a topic; and discussion of future research directions.

Methods

Responses were loaded into MAXQDA, version 10 (VERBI GmbH, Berlin), a qualitative and mixed-methods data analysis software package for textual and content analysis. The software allows coding of text, images, audio and video files, and other forms of data as well as transcription of audio and video files. The mixed-methods features allow for comparison of code segments, crosstabs, creation of frequency tables, comparison of themes through quote matrix, typology tables, and various visualizations of data (e.g., code relationship maps, matrix browsers, code relations, text comparison, and word frequencies).

After inputting the de-identified responses into MAXQDA 10, the coding process began (Figure 1) using what some researchers call "in vivo coding," labeling a section of text with a label taken from the text itself. The first round of coding was completed using categorizing strategies—coding and thematic analysis.[4,5] Using a grounded theory approach[6–9]—in which theories are developed from gathered data (allowing conclusions to be gathered from what participants actually do, not just what it is believed they should or may do) rather than of gathering data to test a theory or hypothesis—data were analyzed for potential analytical categories (codes) and then relationships between categories.[10] An inductive coding model allowed for meaningful categories to emerge from the data rather than being imposed by the researcher.[11] Some codes and thematic categories produced from the inductive coding process were very similar to the 12 AGs derived from the modified Delphi process such as those dealing with risk and protective factors,
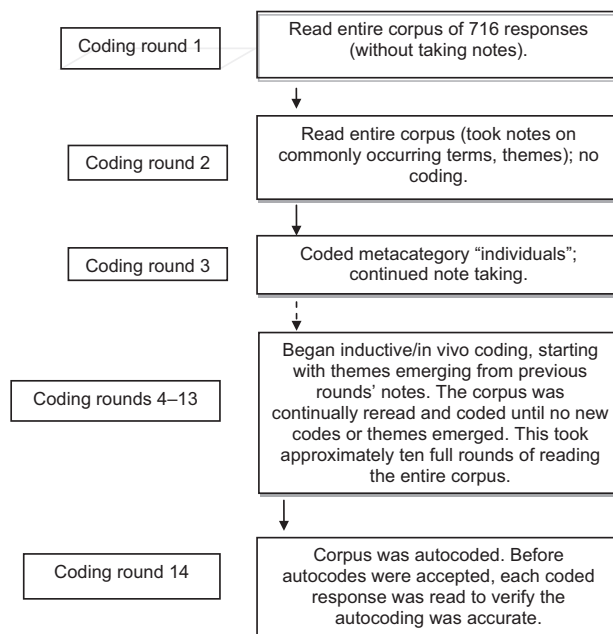

Figure 1. Coding process

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[b]Respondents' categorization came from their self-selection. Some respondents were unhappy that they had been forced to choose only one category because they identified as more than one category. Future efforts in this area should allow individuals to choose more than one category and include an "other" category to allow respondents to write freely. Such a design will allow for more nuanced analysis, if desired, by the researcher.

Table 1. Research codes: "people" metacategory

Code	Subcode	Number of times referenced
Survivors/completers	Attempt survivors	46
	Loss survivors	31
	Reattempt survivors	13
	Completed suicide	9
Community members	Family	62
	Parents	20
	Friends	19
	Managers/employers	8
	Caregivers	7
	Coworkers	4
	Support system	3
	Peers	3
	Church members	2
	Classmates	2
	Society	2
	Spouse	2
	Bully/victim	1
	Boy scouts	1
	Community coalitions	1
	Famous people	1
	Girl scouts	1
	Natural helpers	1
	Neighbors	1
	Parent–teacher association	1
Demographic groups	Suicidal individuals	330
	Teenagers/young adults	130
	Children/youth	74
	Those with mental illnesses	32
	Men	29
	Seniors	25
	Military/veterans	21
	Native American	12
	Trauma survivors	11

(continued)

Table 1. *(continued)*

Code	Subcode	Number of times referenced
	Those with substance use issues	9
	Adults	8
	Rural residents	8
	Those not in treatment	6
	LGBTQ2S	5
	Deaf community	3
	Homeless individuals	2
	Those with physical illness	2
	Urban residents	2
	Women	2
	Latinos/as	2
	African Americans	1
	Babies	1
	Economically distressed	1
	General public	1
	Immigrants	1
	Uninsured/ underinsured	1
	Non-native English speakers	1
Healthcare and service providers	Healthcare professionals	81
	Mental health providers	64
	Educators/school personnel	39
	Policy makers	7
	Researchers	7
	Law enforcement	5
	Gatekeepers	5
	Clergy	4
	Social workers	3
	Alcoholics Anonymous	1
	Bereavement counselors	1

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Table 1. Research codes: "people" metacategory (continued)

Code	Subcode	Number of times referenced
	Funeral directors	1
	Government or public worker	1
	Suicide prevention task force members	1
	Suicide hotline staff	1
	Telephone/reception staff at hospitals and primary care offices	1

LGBTQ2S, lesbian, gay, bisexual, transgender, queer, two spirit.

provider training, preventing reattempts, help-seeking, and stigma; other codes highlighted areas not identified as important in the later rounds of the Delphi process, including life and emotional skills, importance of a holistic approach to suicide, role of spirituality in recovery.

During the coding process, some sub-subcodes were identified (e.g., postvention, research on risk, and protective factors) that, as coding rounds continued, were clearly part of an overarching code of "research," meaning respondents were explicitly calling for research on these topics or what was being described was clearly a research pathway. At that point, the author would go back and nest those under overarching subcodes. Other times, a subcode was identified first (e.g., life and emotional skills). Subsequent coding rounds showed that a substantial number of these responses directly referenced help-seeking (a new sub-subcode) rather than general life and emotional skills.

Two metacategories emerged from the qualitative analysis; the first related to all individuals or groups named in the data. These codes included all individual groups mentioned in the text, including populations, subpopulations, community members, and all other groups of people (e.g., attempt survivors, demographic groups, and healthcare and service providers). Table 1 provides an example of how actual language and terms used by respondents can be nested within themes. Such attention to the way people actually talk about suicide is critical to help researchers, and the field more broadly, understand the complex relationships and webs of meaning that exist for individuals. It is also helpful to understand the different ways individuals and groups conceptualize these ideas. The second metacategory was the "strategy" codes, which included all suggestions for research pathways, suicide prevention practices, policies, and interventions (Table 2). Both metacategories represent areas that were clearly important to respondents and collectively presented a holistic and nuanced vision of suicide and suicide prevention. To illustrate a "strategy" code, this paper will report on the secondary analysis of one subcode: "life and emotional skills."

The survey responses were also deductively coded using the RPTF's 12 AGs.[12] Future papers will explore qualitative analysis of both deductively derived codes based on the 12 AGs as well as the many other inductively derived codes.

Results

Results reported in this paper illustrate the qualitative approach by focusing on a subcategory from the strategies/research pathways metacategory. They are from a discourse analysis performed on all responses coded as "life and emotional skills."[c] This type of contextualizing strategy[4,5] allowed for a holistic analysis of an individual response (as part of a larger analytical category or "code") and a closer exploration of their assumptions about the nature of suicide, argumentation, the role(s) of research in suicide prevention, and so on. Using both strategies provides richer results and enables attention to both macrolevel trends and microlevel responses.

Control, Communication, and Not Being Understood

An attempt survivor responded to the survey by describing the difficulty of being able to adequately express pain to others. This individual noted that "there is a [g]ap of understanding between the individual going through the pain"[d] and those around them:

> When you're at the end of your rope and others are looking at you like you are over exaggerating, complaining[,] or unrealistic, it's devastating….It is important for others to understand that suicide is [merely] one of the symptoms[,] like lack of [appetite] or interruption in sleep[,] [but] it is just the most serious one. Suicidal thoughts are not just crying [wolf]. It becomes a [physical] and medical problem[,] not [necessarily] the individual[']s psychological profile. Suicide becomes the last ditch effort to stop the pain…. Your mind formulates a cost-[benefit] analysis of [whether] or not you can withstand the pain or not…. They may in fact [exercise] their only weapon and that is to [relieve] the pain through [suicide] (Survivor).[e]

For this attempt survivor, suicide was considered a way to reclaim control—control over both their pain and

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[c]Codes were not mutually exclusive and many passages were coded for more than one category/subcategory.

[d]All quotes are attributed to the self-identified group in which they belonged and are reproduced as written by respondents; an attempt to make responses more readable can be found in brackets [ ]. Those changes include spelling—when the original is difficult to understand—and grammatical additions to facilitate readability. No substantive changes were made.

[e]On the first page of the online survey (before the actual survey began), the following disclaimer was printed: "Your participation is completely voluntary. In order to protect your confidentiality, all responses and comments you submit will be deidentified before review. *Please note that by participating in this survey you will be giving the Task Force permission to use your ideas as it develops its suicide prevention agenda*" (emphasis in original). The quotes reproduced anonymously here were also used as input in the RPTF agenda development process, which is why they appear here as well.

Table 2. Research codes: "strategy" metacategory

Code	Subcode	Sub-subcode	Sub-sub-subcode	Number of times referenced
Individual	Emotional/life skills			109
		Help-seeking		106
Infrastructure/legal/policy				47
		Data/surveillance		23
Medical/research	Medication			7
		Pro-medication		75
		Anti-medication		5
	Research	Treatment/intervention/ prevention		189
		General/miscellaneous		106
		Cultural/social factors		105
		Protective/risk factors		95
		Dissemination/outreach		76
		Suicidality		75
		Genetic/structure/ biology		73
		Assessment/screening		61
		Mental health and mental illness		45
		Attempt/reattempt		30
		Definitions/models		25
		Substance use		8
		Postvention		4
			Distinguish between those who attempt and those who do not	84
			Protect from self/from acting on ideation	48
	Testing	Genetic/structure/ biology		35
		Mental illness/ suicidality		28
Social/collective	Education			184
	Messaging/dissemination/ outreach			184
	Stigma			99
	Community			63
	Communication			30
	Culture change			14

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Table 2. Research codes: "strategy" metacategory *(continued)*

Code	Subcode	Sub-subcode	Sub-sub-subcode	Number of times referenced
Treatment/services/care	Accessibility and acceptability			98
	Services/interventions/ treatment			92
	Screening/assessment			78
	Means safety/restriction			65
	Prevention programs			52
	Systems and systems integration			49
	Follow-up			27

a situation on which they appear to have little control. Suicide is a "weapon," and one used by someone with no other ways of addressing a hopeless situation. Survey respondents believed suicide rates would drop if we could teach suicidal individuals and young people life and emotional skills to deal with the feelings described above. Respondents also noted that more research is needed to discover if such life and emotional skills trainings would, in fact, have an impact.

Communication was, in general, highlighted as being important for both communities and suicidal individuals. It is important to note that this category only emerged from the survivors (survivors of loss and survivors of attempts) group. It was clear that survivors of suicide loss and attempt believed that they could get the help they needed, if only they could find the right way to communicate with those around them. According to the same survivor quoted at the beginning of this section:

> The feeling of this misunderstanding is like being awake for an operation and under anesthesia, while the doctor operates on you. You are aware of what's going on, you can feel the pain, but you can't [get] through to anyone about it. No one hears your cry.

Some, but not all, respondents believe that reducing stigma would "allow depressed people or people with suicidal thoughts to be more open to discussing their depression or suicidal thoughts" (Survivor) and "decrease 'codes of silence'" (Survivor) among communities more generally.

Life Skills

Respondents highlighted six types of life skills that they believed would be crucial to reduce suicides: (1) dealing with stress and coping strategies for that stress; (2) emotional regulation, tolerance, and acceptance; (3) communication; (4) interpersonal skills and connectedness; (5) decision making; and (6) general life skills. Responses about these six categories of life skills fell into two overlapping, but distinct, groupings. In the first, respondents argued that we need to train suicidal individuals about life skills that we already know would reduce suicides. Respondents assumed that these areas would be effective; as the corpus only includes anonymous survey data, we have no way to know whether their assumption of efficacy was based on research, personal experience, or assumed to work because of some general cultural knowledge (assumptions and folk theories) about the way mental health, suicide, and the brain "work." This first group emerged primarily from the survivor group (with 27 of 40 total responses), although 9 of 40 responses in this category came from providers and 4 of 40 from policy/administrators.[f] No researchers advocated this position.

The second grouping focused on those same six categories of life skills, but explicitly advocated for research into whether teaching such life skills is effective. Unlike the first grouping, this group included respondents from all self-designated categories: providers (11 of 32 responses); researchers (10 of 32); survivors (6 of 32); and policy/administrators (5 of 32).

The next six sections of the paper will delve into the six categories of life skills, exploring how respondents connected them, what they thought about them, and how they may help us discover novel research pathways to reduce deaths by suicide.

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[f]It is important to note that testing for statistical significance is not appropriate when analyzing code frequencies within qualitative research projects (Draper and Swift, 2010; Fade and Swift, 2010; Pope et al., 2000). These numbers are used here for illustrative purposes only.

Train Coping Strategies

Responses about teaching ways of dealing with stress and general coping strategies often connected this skill with school and youth. Training teens and young adults how to deal with stress in positive ways was the most common response. Some argued that programs could be based in schools to "develop the coping skills they will need to handle any adversity that they may face throughout their lifetime[,] and thus eliminate the option of suicide for everyone" (Provider). Respondents hoped these coping skills would teach youth more about emotional regulation, tolerance, and acceptance (described below) so that they "become comfortable with negative thoughts and emotions" and show them that such feelings are "temporary and workable instead of something that needs to be changed immediately" (Provider).

As far as research into dealing with stress and coping skills, respondents advocated for both the development of universal prevention interventions that teach coping skills to youth and research into the best way to implement such interventions. One researcher noted that research into postvention programs and their ability to "decrease the suicidal ideation and behavior of survivors and the ability of the postvention to facilitate adaptive coping with this loss" would be crucial. Others focused on promoting and developing coping skills among a diverse list of populations and focusing on identifying transitional periods in the lives of individuals or groups such as divorce, return from combat, or death of a family member. Most, however, promoted research to develop and analyze the effectiveness of universal prevention interventions to be deployed in schools.

Emotional Regulation, Tolerance, and Acceptance

Mindfulness programs and dialectical behavioral therapy (DBT) were advocated by respondents to teach emotional regulation and "interpersonal effectiveness" (Survivor). Such "emotional stability" and suicide prevention trainings, respondents argued, should be "free or inexpensive to all individuals, making it a mandatory training for people who work in public arena[s] such as educators and [politicians, and] to include training for increase in rank and position of authority in the military and corporate business" (Provider).

Another area of focus for respondents was tolerance and acceptance of oneself and of others. As one survivor argued, "[a]t pre-teen and teen years, their focus is what others think about them.… Children aren't raised with confidence in themselves and believe others if they say they are ugly, fat, whatever. Hormones and body changes

are occurring and can lead to devastating comments from others." Such acceptance extends to mental illness and, some respondents argued, could be accomplished by teaching people about how bodies and minds work at different stages of development so they can "manage their thoughts" (Provider) and expectations. Teens, in particular, "don't want to feel that they are the only ones feeling this way" (Survivor), and teaching acceptance and compassion—respondents argued—would help solve many of these issues.

Those advocating for research pushed for "prevention research (universal and targeted) addressing evidence-based mechanisms to counter helplessness and hopelessness states contributing to suicidality (increase divergent thinking, identify advocates when powerless, reduce social isolation)" (Researcher). Others argued that universal preventive interventions should be developed to teach "emotional regulation skills, beginning in early childhood" (Researcher) and find "which therapy techniques work best with teens who have expressed suicidal ideation or which skill building activities have the biggest success with emotional regulation" (Provider).

Interpersonal Skills and Connectedness

This category was, in some ways, related to communication. Respondents argued that teaching interpersonal skills would increase the "connectedness of individuals to others and their community in order to cut through the pain and isolation" felt by suicidal individuals (Provider). These individuals "often feel no personal connection. Nobody cares about them. They have no reason to live and nothing to live for" (Provider). One respondent noted that this was particularly important for older white men; others argued that these skills would be most useful for young people, helping them interact with their peers and address issues of bullying and hopelessness.

Interpersonal skills were also an area of significant interest for those advocating research. Respondents wanted to know how to foster connectedness: from how to "induce in the high[-]risk person a sense of connectedness to the would-be therapist" (Researcher) to "identify[ing] effective strategies for helping isolated and lonely people feel more connected" to the communities in which they live (Provider). Such research, another argued, would help in understanding how to effectively create and strengthen support networks. Others focused on the importance of the connectedness of care and community as part of continuing support after a suicide attempt. As one survivor argued, this might be an online experience that would "allow the survivor to feel less alon[e] and stigmatized."

Problem-Solving and Decision-Making Skills

This category specifically relates to decision making about the act of suicide:

> I believe the best way to reach those individuals at risk of suicidal behavior is to be proactive by educating young people of the dangers and consequences of suicidal decisions by implementing better understood decision [making]. (Survivor)

Respondents argued that young people live "life in a very limited frame of reference" (Survivor) and may not understand the ramifications of this "irreversible" decision.

For those who advocated research in this area, determining if "problem solving, impulse control, and personal empowerment in children" (Survivor) would be effective deterrents to suicide could provide an important area of knowledge. However, most respondents argued that research in this area should focus on barriers to treatment and on the most "effective motivational techniques toward treatment" (Provider) to "increase the likelihood that a suicidal patient…will follow through with offered treatment" (Provider).

General Life Skills

Other skills for which respondents advocated were those emerging "from positive psychology and from various religious teaching[s]" (policy/administrators). Cultural knowledge also was mentioned, as were education in values and beliefs. Such education, one survivor argued, requires "agencies (healthcare providers, clinicians, clergy) to…form an alliance of care, including medical (med[icine]s if necessary, nutrition, exercise labs), clinical (behavioral modification, coping skills, necessary therapy), and to address spiritual concerns as well (core values, beliefs, heart issues)."

Respondents also believed that certain life skill areas need further research, including finding "effective methods to help suicidal individuals find purpose and meaning to their lives" (Provider) and focusing our prevention efforts on "increasing prevention and self-care, not simply screening and mental health treatment" (Provider).

Discussion

Future Directions

The first research pathway forward indicated by the stakeholder survey data is, as mentioned above, a holistic understanding of suicide. Much of the work on suicide has been macrolevel, epidemiologic analyses that separate biological, cultural/social, and environmental contexts. Aggregate data are critical but erase the rich, detailed information so vitally needed. More needs to be known about the qualitative experience(s) of suicide—how suicidal individuals and their families understand the experience of suicidality and the care received, holes in care, what "adequate" care actually means to suicidal individuals, what triggers crises, how resiliency helps them survive, what do they see as barriers, and what heterogeneity might exist within what we call "suicidal ideation" or "suicidality." More research is needed that tells us the why and how, not just the what. We not only need to know whether a risk factor exists or if X works, but also the nature of X. During a 2000 presentation at the Northeast Injury Prevention Network Invitational Conference for Suicide Prevention Planning, DeQuincy Lezine, PhD, said,

> I am your data and you are not talking to me, not working with me, not including me, not listening to me. Only when I am dead do you ask questions of me —"Why did you do it? What could I have done to help you?" You call me [as someone who has attempted suicide] a different population from "suicide completers" and then talk about me being the highest risk group for suicide. You said it is essential to include those I will leave [behind] once I am dead, but not talk to me before I die. Am I only worth something to you once I have altered my label one final time?
> I am your data but you wait until I am static and unchanging to ask questions of me, questions you should be asking while I am still a dynamic, changing, living individual. I am the attempts you can only estimate right now because only two out of five involved a hospitalization. I am your target. It is my death you are trying to prevent, and you are not talking to me. I am what you go to these conferences for, who you publish brochures for, and pass out cards for, and who you refer to in your presentations—I am your data —current and future…but you have not invited me to your table. (D Lezine, President and CEO, Prevention Communities, personal communication, 2013)

Dr. Lezine is absolutely correct; we researchers—as part of a broader research agenda that includes quantitative and qualitative research, social as well as biological research—must suspend our preconceived notions about suicide and work to understand it as having a web of meanings embedded within complex cultural systems. We must include the various voices of the community of suicidal individuals and value their contribution.

The second research pathway focuses on collaborative research. Not just collaborations among and between various disciplines, but the kind of collaborative research that brings communities in earlier in the process. Lab conditions rarely exist in the natural world and researchers must make the conditions, constraints,

and participants more explicit not just for research but to help communities and clinicians understand the elements that will affect the applicability and efficacy in their contexts. For example, if an intervention requires infrastructure, reliable transportation, access, and ability to pay for well-trained clinicians, child/elder care, or financial or time investment, this must be made clear. These are not just anecdotally important; such factors impact the validity and applicability of what is done to save lives.

All available tools should be used to save lives. Survivors, researchers, clinicians, and others are much closer than they appear on what they want (e.g., a reliable way to "diagnose" suicidality, a series of effective treatments—both biological and psychological/behavioral). Each have their own way of approaching and describing suicide, and more opportunities to collaborate between and among these groups will only succeed when they understand each other. There are ways of communicating that bridge the often difficult divide. Each group brings strengths and experience that are critical in moving our field forward.

Conclusions

Qualitative and mixed-methods research are essential to the future of suicide prevention work.[13] By design, qualitative research is explorative and appropriate for complex, culturally embedded social issues such as suicide.[2,3] It can be used to generate hypotheses for testing and, as in the case of this analysis, illuminate areas that would be missed in a top-down, impositional approach. Finally, qualitative research chooses as its site naturalistic environments—the same contexts in which suicidal people live. Only by combining qualitative and quantitative methods will we finally understand the complex phenomenon we call "suicide."

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