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Hunting to Feel Human, the Process of Women's Help-Seeking for Suicidality After Intimate Partner Violence: A Feminist Grounded Theory and Photovoice Study

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Abstract

Women reach out to health care providers for a multitude of health problems in the aftermath of intimate partner violence, including suicidality; however, little is known about how they seek help. The purpose of this study was to explore how women seek help for suicidality after intimate partner violence using a feminist grounded theory and photovoice multiple qualitative research design. Interviews were conducted with 32 women from New Brunswick, Canada, and seven from this sample also participated in five photovoice meetings where they critically reflected on self-generated photos of their help-seeking experiences. Data were analyzed using the constant comparative analysis of grounded theory. *Hunting to Feel Human* involves fighting for a sense of belonging and personal value by perceiving validation from health care providers. Women battled *System Entrapment*, a feeling of being dehumanized, by *Gauging for Validation* and *Taking the Path of Least Entrapment*. Implications for health care providers include prioritizing validating interactions and adopting a relational approach to practice.

Keywords

suicide, intimate partner violence, grounded theory, photovoice, multiple qualitative methods, women's mental health, feminist ethical theory, trauma and violence informed care

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Introduction

Intimate partner violence (IPV) is associated with negative health effects for women including depression (Smagur et al., 2018; Spencer et al., 2019), posttraumatic stress disorder (Aupperle et al., 2016; Spencer et al., 2019), and substance use problems (Cafferky et al., 2018; Dichter et al., 2017). The stress of IPV can become so great that women think about or attempt suicide (Munro & Aitken, 2019; Rahmani et al., 2019; Wolford-Clevenger et al., 2018). Despite their efforts to get help with the negative health effects of IPV, women are confronted with access barriers to services, interfering with their capacity to promote their health (Costa et al., 2019; Fay-Hillier, 2017). Difficulty accessing help is confounded by abuser's attempts to isolate women from loved ones and other support providers (Arnault & O'Halloran, 2016; Ragusa, 2017). Isolated and overwhelmed with the stress of having been abused, women think that they are undeserving of help and a burden to others, beliefs that are strongly linked to suicide (Joiner, 2005; Monteith et al., 2017). Feeling guilty for needing help, women who have experienced IPV may believe that others would be better off if they were to die by suicide. Mental health problems like those associated with IPV can lead to unbearable psychological pain, another factor linked to suicide (Campos et al., 2018; Montemarano et al., 2018). Women may believe that the only way to end the pain is to end their lives. Despite the urgency of this health problem, how women get help for suicidality within the context of IPV is relatively unknown.

In the feminist grounded theory and photovoice study described here, I explored how women who have experienced IPV seek help for suicidality, a concept defined as thinking about or attempting to kill oneself. Previously I reported the basic psychosocial problem facing women as *System*

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Entrapment, a sense of dehumanization or low belongingness and loss of agency from invalidation or not being taken seriously by health care providers (HCPs) (Taylor, 2020). Dehumanization is intensified by *Trauma Entrapment*, the state of wanting to end one's life due to being controlled by unbearable psychological pain (Taylor, 2020). *Trauma Entrapment* is intensified by *Abuser Entrapment*, the feeling of being stuck within an IPV relationship (Taylor, 2020). IPV disproportionality affects women (World Health Organization [WHO], 2010) and *Abuser Entrapment* is a representation of this intersection between gender and violence. Intersecting factors contribute to a feeling of being controlled and hopelessness; however, women persist to seek help despite these difficulties.

System Entrapment is managed by the basic psychosocial process of women help-seeking, *Hunting to Feel Human*. Here, I delineate this basic psychosocial process through an exploration of (a) *Feeling Human* and (b) the core strategies of the *Hunting* process, *Gauging for Validation* and *Taking the Path of Least Entrapment*. These strategies guide women's help-seeking journey toward *Feeling Human*. The findings offer important new insights regarding women's agency in help-seeking for suicidality in the wake of IPV that will inform HCPs, administrators, and policy makers on creating more responsive services to women's needs in this context.

Gaps in the Literature

Literature on help-seeking for suicidality in women who have experienced IPV is lacking. Services providing care to women are ill-informed on how to help as suicidality and IPV are usually studied separately; therefore, little is known about the unique impact on women's health when the two intersect (Wilson et al., 2017). Nonetheless, difficulties accessing help for both suicidality and IPV are documented in the literature. The bulk of research on help-seeking for suicidality relates to variations in service use frequency. For example, stigma has been found to prevent help-seeking for suicidality altogether (Fulginiti & Frey, 2018; Han & Oliffe, 2015); however, most people who died of suicide had seen a mental health professional or other HCP within the last few months before their death (Fontanella et al., 2017; Leavey et al., 2016). It is well documented that getting help for suicidality is difficult. Psychiatric institutions and services designed to help people with suicidality have been criticized throughout history as being unethical due to coercive treatment and power imbalances between patients and HCPs (Foucault, 1965; Ladrido-Ignacio et al., 2017). Patients perceive HCPs' efforts to prevent suicide in psychiatric units as being controlling, reducing their sense of dignity and security (Brophy et al., 2016; Frey et al., 2016).

Gender is an important factor in women's help-seeking. While gender influences the experience of suicidality and accounts for differences in help-seeking between men and women, these differences are not considered in the delivery of health care (Jaworski, 2016). Gender has an even greater impact on IPV, further complicating health care access. Patriarchal ideology that designates males as superior over women enables gender power imbalances within societal structures and systems (Dobash & Dobash, 1992; Price, 2005). This hierarchal organization contributes to and sustains IPV (Kelly et al., 2011; O'Toole et al., 2007). Despite calls to acknowledge IPV as a gendered form of violence within health care systems (Garcia-Moreno et al., 2005), HCPs fail to recognize the impact of women's oppression within traditional gender roles on their risk for IPV (dos Santos et al., 2018; Rajan et al., 2016). Indeed, many HCPs lack knowledge and skill required to address the needs of women who have experienced IPV, compromising their physical and emotional safety (Olive, 2017; Zijlstra et al., 2017). The gravity of inadequate health care for women who have experienced abuse is even more concerning considering IPV is associated with more frequent help-seeking behaviors in comparison with those who have not experienced abuse (Dichter et al., 2018; Ford-Gilboe, 2015). Although very little literature exists on help-seeking for suicidality in the context of IPV, culturally informed support groups have been demonstrated to decrease depressive symptomatology in African American women with a history of IPV and had recently attempted suicide (Kaslow et al., 2010; Taha et al., 2015). A comprehensive understanding of help-seeking for suicidality including broad factors that influence women's capacity to find and receive effective health care is needed to inform and improve service provision for women.

Theoretical Underpinning

The theoretical underpinning of this study was feminist ethical theory, an approach that seeks to deconstruct the patriarchal ethical framework that ignores societal power imbalances disproportionately affecting women (Tong & Williams, 2016). While the philosophical underpinning allows the researcher to capture the particular perspective *only* if it is present within the data (Wuest, 2000), feminist ethical theory provided a lens through which to understand power imbalances inherent in women's help seeking for suicidality in the context of IPV. Feelings of powerlessness in people who are suicidal (Alessi et al., 2018; Fogarty et al., 2015), being controlled within an IPV relationship (Burelomovaa et al., 2018; Stark, 2013), and the historical oppression of women create a vulnerability to a loss of agency while seeking help. Feminist ethical theory highlights women's everyday realities (Tong & Williams, 2016), taken-for-granted knowledge that is missing in the body of knowledge on suicide.

The status quo bio-physiological paradigm in which the large majority of suicide research is conducted focuses on biology or internal factors while sociopolitical forces and women's perspectives of trauma are devalued (Tseris, 2013). Focusing on symptoms is an individualist approach that

neglects others' role in women's mental health problems, contributing to victim blaming (Morrow, 2017). Feminist ethical theory focuses on attending to others' needs by taking responsibility for oppressive forces that restrict people from reaching their potential (Meyers, 2000). With the objective of challenging dominant ideologies, feminist ethical theory promoted an awareness of overriding social structures and assumptions about suicidality and IPV, illuminating women's realities of help-seeking and the obstacles they overcame in their Hunt to Feel Human.

The purpose of the present study was to develop a substantive theory of how women seek help for suicidality in the context of IPV. This feminist Grounded Theory (GT) and Photovoice (PV) multiple qualitative method research design is a critical approach that enabled the development of theory in the context of broader social structures and power dynamics influencing help-seeking for suicidality in women who have experienced IPV.

Method

Guided by Morse's (2012) framework for integrating multiple qualitative methods, Grounded Theory (GT) and Photovoice (PV) were used to explore women's help-seeking for suicidality after IPV. The primary or complete method was GT and the secondary or supplementary approach was PV. GT represented the complete method due to its defining characteristic to develop substantive theory (Singh & Estefan, 2018; Wuest, 2012), the goal and intended outcome of the present study. GT is an exploratory research approach for the study of relatively unknown areas of interest on human behavior (Holloway & Todres, 2010) that uses a simultaneous data collection and analysis method (Glaser & Strauss, 1967). The supplementary method, PV, is a participatory action research approach that uses self-generated photography to create social change by capturing strengths and challenges of marginalized groups (Wang & Burris, 1994). The *Hunting to Feel Human* theory was discovered through the GT constant comparative analysis of the interview and PV group transcripts. A feminist approach parallels the current study's research design as GT allows for the discovery of women's diverse strengths and explores the social context on health outcomes (Wuest, 1995). In addition, PV involves an acknowledgment of the participants' voice as an indicator of reality (Wang & Redwood-Jones, 2001) and is critical for research involving gender inequalities (Duffy, 2011).

Ethical Considerations

This study adhered to the Tri-Council Policy Statement on Ethical Conduct for Research Involving Humans (TCPS-2; Canadian Institutes of Health Research, 2014), meeting approval of the University of New Brunswick Research Ethics Board and the Horizon Health Network Research Ethics Board. The study was explained and women were given time to ask questions before they signed separate consent forms for the interview and PV meetings. All women in the PV groups signed a confidentiality form to respect each other's privacy. The focus of feminist research on the relationship between the researcher and participant, the nature of the in-depth interviews, and the duration of time that the participants were engaged in the interviews made respecting women's dignity and minimizing power imbalances especially important (Newton, 2017). I created a secure environment by meeting in private spaces of the women's choosing and obtained ongoing consent with the reminder that they could end their participation at any time. All women reported that they did not believe their safety was at risk by participating in the study and I provided resources for community supports for ongoing distress related to their past trauma.

Data Collection

In response to study advertisements in health clinics and physicians' offices, 32 English-speaking participants who identified as women aged 19 to 68 years from both rural and urban centers in New Brunswick, Canada, volunteered for an interview. All women self-identified as having left an abusive partner at least 1 to 25 years prior and some continued to experience ongoing harassment. All women reported that their participation in the study did not increase their risk for danger. The women had experienced thoughts of killing themselves since leaving their abusive partner and reported that they did not have suicidal thoughts while participating in the study. Five participants were employed, 25 were unemployed, and two were students. Nine women had some post-secondary education, 20 had completed high school, and three women had completed some high school. Finally, 24 participants identified as English Canadian, seven as French Canadian, and one woman identified as being both Caucasian and Asian Canadian.

The interviews were semistructured, allowing participants freedom in their responses to open-ended questions (McIntosh & Morse, 2015), including "How did you seek help when you had thoughts of killing yourself?" Women were given a modest cash honorarium for their time. After their interviews were completed, seven local women from the full sample volunteered to participate in five 2-hour PV meetings. Participants received new digital cameras during the first meeting accompanied by a brief discussion on taking meaningful images and obtaining consent from people captured in the photos. Women were invited to take pictures that represented their help-seeking for suicidality after IPV. During three subsequent meetings, women shared their images, discussed their meaning in their lives, identified missing themes, and assigned themselves to capturing additional images to bring to the next meeting. A more complete discussion of PV in this study is provided elsewhere (Taylor, 2020).

Data Analysis

The primary analysis included a GT constant comparison of the entire data set, including five PV meeting transcripts, 32 interview transcripts, and approximately 30 photos. Glaser (2001) makes it clear that "all is data" (p. 145) including a combination of interviews, documents, and observation, allowing for a seamless integration of PV data into the GT analysis. The PV analysis began during the second meeting where the photos were displayed on a projector for the rest of the group to observe. The creator of each photo explained the meaning of her image, followed by a group analysis guided by critical questions outlined in the mnemonic "SHOWeD": What do we See here? What is really Happening? How does it relate to Our lives? Why is the situation occurring? What we can Do about it? (Wang & Pies, 2004). The women reflected on the context of their help-seeking, allowing for rich evaluations of their needs, validation of the severity of their trauma, and reconciliation of their strengths. The PV group dialogue was transformative, garnering insights that had not been discovered during their preceding interview through a collective sharing where one idea expanded on another. The discussion was elevated to a recognition of societal and systems-level injustices that contributed to their problems, lessening self-blame of their struggles. The PV meetings ended after confirming the PV findings with the women by organizing the data into themes and presenting them on posters for their review and feedback.

The GT analysis is a process that begins with open coding (Glaser, 1978). Data are coded line by line, forming concepts that eventually collapse into categories, and relationships between categories elevate descriptive data to a higher level of abstraction (Strauss & Corbin, 1998; Wuest, 2012). The goal of discovering a basic psychosocial process is achieved by continually asking *what is going on here*? (Wuest, 2012). Initial codes closely corresponded to the participants' language and as they were constantly compared with other pieces of data, they evolved into a more conceptual level. An analysis of one woman's picture of her cat, a pet that gave her unconditional love and a reason to live, evolved into the development of the following codes: *seeking personal value, being taken seriously*, and *seeking unconditional acceptance*. These PV codes were constantly compared with codes that had been simultaneously emerging from the analysis of the interview data. Interview codes including *the essence of me* and *getting to the real deal* or *seeking authentic connections* represented Sarah's needs while help-seeking: "Psychiatry is about the heart of the person . . . the real deal . . . where all your emotions and feelings, and everything . . . the real part of the human spirit." All of the codes mentioned here collapsed into *belonging with others* and *validating my personhood*, categories that would eventually merge and develop into *Feeling Human*. Combining interviews and participants' analysis of their images enhances the validity of the findings as the researcher is able to compare findings between both data collection methods (Cannuscio et al., 2009), decreasing the risk of "misinterpretation" (Duffy, 2010, p. 795). Photos added clarity and a deeper understanding of women's need to be validated.

Theoretical coding raises the data to a higher level of abstraction by finding connections and making relational statements between the concepts and categories (Glaser, 1978). As the concepts related to women's assessment on how to find help or Gauging for Validation began to emerge, including *observing the surroundings, wading through the water, and feeling-it-out*, I sought a contextual understanding of this process. I inquired, "What is the consequence of this?" for each piece of data that had been named with a code related to Gauging for Validation. The answer emerged as a decision-making process that guided help-seeking toward either protecting against invalidation by moving away from a negative health care situation or maximizing validating by moving toward compassionate HCPs. The hypothesis at this point in the analysis was that women would move toward the health care system only if validation was likely to ensue and that they would retreat in the face of invalidation. However, ongoing constant comparative analysis did not confirm this hypothesis. It was discovered that women sometimes reached out for help even when validation opportunities were not evident, a finding that required further analysis to make sense of this variation.

Theoretical sampling, the collection of additional data to check on hypotheses that have been emerging inductively and to further develop the emerging theory (Glaser & Strauss, 1967; Wuest, 2000), was used to make sense of the way women both avoided and did not avoid invalidating interactions with HCPs. I amended the interview questions during subsequent meetings with participants by asking more about help-seeking behaviors in the context of invalidation, yielding data that were constantly compared with help-seeking behaviors in the context of validation. Emerging from this analysis was that help-seeking continued despite feeling invalidated during *higher* suicidality intensity levels, whereas help-seeking abated in the face of invalidating health care situations within the context of *lower* suicidality intensity levels. The rigorous process of continually inquiring about the relationships between the concepts based on new information emerging from the data created additional dimensions to the theory. Once the data had been teased out and no new information emerged or theoretical saturation occurred, the analysis ended (Glaser & Strauss, 1967).

Results

Hunting to Feel Human, the basic psychosocial process of help-seeking in women who have experienced IPV is a nonlinear, dynamic journey that helps women to continue living during thoughts of suicide. *Hunting* encompasses a pattern of behaviors in search of *Feeling Human*, a sense of value and belonging. *Feeling Human* is contingent on perceiving

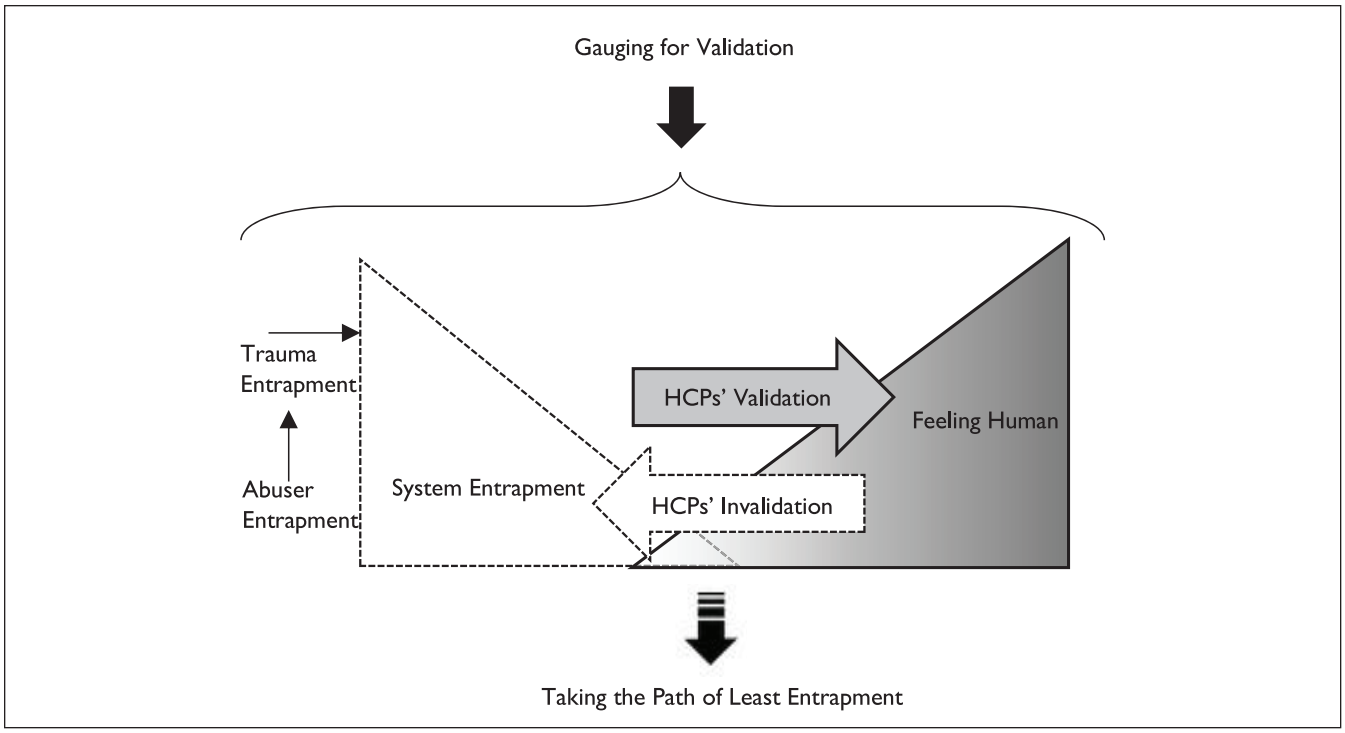

Figure 1. Main components of the Hunting to Feel Human process.

validation, a sense of being heard and understood by HCPs as indicated by the gray triangle and arrow in Figure 1. The Hunting process seeks to reduce the dehumanization of being invalidated or experiencing *System Entrapment* as indicated by the white triangle and arrow in Figure 1. This basic problem is intensified by *Trauma Entrapment*, the feeling of being stuck in suicidality (Taylor, 2020). *Abuser Entrapment*, the feeling of being controlled in an IPV relationship, is the greatest contributor to *Trauma Entrapment* as shown on the left hand side of Figure 1. The *Hunting* process is a vigorous struggle of overcoming access barriers by assessing the risks for invalidation and maximizing validation in hopes of *Feeling Human*. To begin, *Feeling Human* and its condition, validation, will be explored. Finally, I describe an overview of core *Hunting* strategies, *Gauging for Validation* and *Taking the Path of Least Entrapment*, shown at the top and bottom, respectively, in Figure 1.

Feeling Human

The goal of the *Hunt* is to *Feel Human*, a sense of having personal value and a connection to the world by perceiving validation or being accepted and taken seriously. While *System Entrapment* arises with *in*validation, *Feeling Human* arises with validation. *Feeling Human* is required to avoid a suicide attempt; however, physical safety and the act of killing oneself is not the primary focus of the *Hunt*. The purpose of *Feeling Human* rather is a justification for one's existence by strengthening a sense of belonging to others and the world and counteracting the dehumanization that leads away from living. *Feeling Human* is sought in every interaction with an HCP by sharing past traumas, distressing emotions, and suicidal thoughts. *Feeling Human* signifies a movement toward freedom from *System Entrapment*, providing a sense of relief and hopefulness about the future. *Feeling Human* is demonstrated in one participant's account of connecting with an HCP, helping her to find meaning in life by understanding her problems in relation to others:

> I don't know what I would do without [my HCP] . . . I just know there is more meaning to life . . . You don't need to go and end your life just because you are having problems in life . . . I don't know if I would [have made it if I] hadn't met her . . . Every day I talk to her, when I leave I feel better about myself.

Feeling Human was not limited to ending suicidality for this participant. Her self-concept increased by realizing that she was not alone in having life struggles, that her problems were a part of the human condition. *Feeling Human* does not guarantee complete freedom from *Trauma Entrapment*, but rather it is a sense of being deserving of help for one's suicidality.

Feeling Human is influenced by conceptualizations of humanity within Western society. Its meaning has been created through power inequities, excluding women and other oppressed groups from receiving or achieving humaneness (Antony, 1997; Walker, 2002). The concept of humanity traditionally represents morality or how one ought to behave (Gert & Gert, 2002; Simon, 1986), a meaning distinct from

women's help-seeking in this study as the notion of right or wrong and good or bad is not characteristic of *Feeling Human*. Within the feminist literature, it is recognized that marginalized people who do not fit within the dominant moral framework due to factors beyond their control are viewed as less humane or less valuable (Antony, 1997; Weitzel, 2003). Ableism, a form of social oppression toward groups of people who are perceived within society as having a disability including psychiatric conditions (Bogart & Dunn, 2019), intersected with gender in this study. The pressure to be normal and the stigma of having a mental health problem elevated women's sense of worthlessness. Ableism was a form of prejudice that disrupted the help-seeking journey as it involves expectations to be a productive member of society, leaving those with mental health problems feeling shame for having difficulty functioning. For example, mothers in this study using drugs to manage psychological pain from past trauma were dehumanized by perceiving that HCPs judged them as being immoral or bad parents. These attitudes were particularly distressing as women perceived HCPs to be authority figures with the power to restrict access to health services if HCPs judged them to be undeserving of help. In contrast, the language within the *Hunting* theory conveys that being human is sufficient to garner validation and to be deserving of *Feeling Human*. Regardless of mental health struggles or difficulty functioning, there is no expectation to be *more* human.

Validation. Indicators of *Feeling Human* are a sense of self-worth and deservingness, characteristics achieved through validation or an acknowledgment of one's unbearable pain and value as a human being. Accustomed to feeling invisible, acknowledgment of women's existence increased their self-value. Validation is most forthcoming in the context of physical danger, for example, being granted access to emergency services after a near lethal suicide attempt. While interventions aimed at survival promote a sense of physical security, feeling validated on an emotional level yields an even greater sense of self-worth and *Feeling Human*. Being heard by a compassionate HCP promotes the highest level of validation, an interaction that overrides the dehumanizing effect of being simultaneously invalidated by another HCP or health service. One woman in the study felt invalidated when HCPs were not able to secure adequate housing; yet, she felt valued and empowered while working with one of her HCPs: "If it wasn't for [HCP] I would've never made it . . . when I need somebody to talk to, [HCP] didn't refuse to talk to me. [HCP] was there to listen. Even if it was good or bad [HCP] was there." Depending on consistent validation from a HCP was the most important resource for her healing. Accepting the participant's need for support regardless of the frequency or nature of the request allowed her to *Feel Human*. Carl Rogers (1951), a psychologist who had a significant impact on the study of human behavior during the 20th century (Witty & Adomaitis, 2014), strongly supports *Feeling Human* with his theory that providing unconditional positive regard toward the client is the most effective way to help the person heal (Martin, 2017; Rogers, 1962).

A contingency to *Feeling Human* is being taken seriously and believed. Feeling suicidal is not as visible as a physical emergency; therefore, it is more easily minimized and ignored. Alternatively, HCPs believing women's psychological pain and taking their suicide risk seriously offset the shame of needing help. Validation also entails acceptance, that is, remaining open to and nonjudgmental about repeated non-lethal suicide attempts, expression of intense emotions, and IPV. Acceptance of disturbing thoughts, feelings, and behaviors that evoke shame within society, including expression of anger in women and self-mutilation, fuels *Feeling Human*. Whereas suicidality is isolating and dehumanizing, validation and the search to *Feel Human* occur within an interpersonal context. The freedom from social isolation and stigma that occurs with *Feeling Human* is strengthened by Rogers's idea that achieving self-worth in the context of relational power dynamics is a goal of humanity (Kass, 2015; Rogers, 1962).

Acceptance also embodies the absence of predetermined expectations to change women's suicidality and other difficulties related to having been abused. Whereas *System Entrapment* includes pressure to feel, think, and behave differently by ending self-harm or to leave an abusive partner, HCPs' acceptance of suicidality and trauma experiences helped women to explore their situations and to determine how to regain control of their lives. Acceptance and validation is demonstrated through HCPs' empathy, conveying an appreciation and understanding of women's difficult situations. Acceptance contributes to *Feeling Human* through HCPs recognition that being in an abusive relationship or a having mental health problem is not women's fault and that there are valid reasons for needing help. Without being pressured to change and given space to work on their problems on their own terms, women's suicidality decreased. Ultimately, HCPs' acceptance of suicidality helped women manage suicidality. The feeling of being accepted increases when HCPs interact in ways that extend beyond an objective professionalism, a stance that women perceived to be removed from the human experience, to acknowledge their own vulnerabilities regardless of their status as *experts*. One woman described her treatment needs during periods of suicidality: "someone to listen, someone to talk to, non-judgmental, there's to be no therapy, no professional intervention." Personal connections and mutual sharing fostered a sense of belongingness and deservingness.

Feeling Human is supported by growing literature on the importance of a therapeutic relationship with an "empathetic human being" in the recovery of suicidality (Michel, 2011, p. 19), specifically the healing impact of HCPs' conveying a nonjudgmental attitude (Chi et al., 2014; Hagen et al., 2018). The critical impact of therapeutic interactions with HCPs was demonstrated through suicidal participants' reported

need for interactive support online (Harris et al., 2014). Furthermore, help-seeking behaviors (King et al., 2015) and a sense of belonging (Baker & Fortune, 2008) increased after accessing HCPs' support online during periods of suicidality. These studies support the importance of interpersonal care and being taken seriously in the effort to *Feel Human* while managing suicidality.

The power of *Feeling Human* is reflected in the coherence of this concept across the entire sample. Regardless of diversity among women's socioeconomic status, the intensity of dehumanization remained constant. The urgent need to *Feel Human* threaded throughout women's help-seeking journeys regardless of differing levels of employment, education, housing security, family support, and mental health functioning. Furthermore, the impact of validation consistently promoted the desire to remain alive.

Hunting

Whereas *Feeling Human* represents *what* women seek during suicidality after having experienced IPV, *Hunting* represents *how* women seek help, represented in Figure 1. *Hunting* is a grueling search for a sense of security and confidence about remaining alive and comprises various ways of fighting against dehumanization. *Hunting* does not imply an attack, but rather an unrelenting expenditure of energy and skill in finding relief from their distress so that they can continue living. In this way, *Hunting* demonstrates the depth and intensity of women's journey. *Hunting* is an isolating and persistent attempt to regain control in the midst of *System Entrapment* until a compassionate HCP is found. Unable to access services for her suicide attempts for several months, one woman defended her need for services when she encountered a HCP at a community clinic:

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

Like a "starving wolf," her survival reflex was to *Hunt* for a sense of worthiness by conveying her urgent need for validation to the HCP. Whereas the conceptualization of suicide within society implies incompetence and incapacitation, *Hunting* is a novel way of understanding suicide as it depicts women as active agents in determining their health outcomes. Studies demonstrating women's capacity to protect themselves from the negative mental health effects of violence (Wong et al., 2016; Wuest et al., 2003) substantiate the agency implicit in the *Hunting* process.

Gauging for validation. *Hunting to Feel Human* is informed by *Gauging for Validation*, found at the top of Figure 1 depicting a strategy used to determine *Hunting* actions. *Gauging for Validation* is an intuitive assessment of the potential to encounter *System Entrapment* or to *Feel Human* through HCPs' validation and empathy. This assessment is an automatic response to environmental cues that provide information on whether validation or invalidation is forthcoming. *Gauging for Validation* provides a plan on how to minimize *System Entrapment* and maximize *Feeling Human*. The purpose of *Gauging for Validation* is to generate a judgment on the safest way to reach out for help. Gingerly wading into the *System* with distrust, women vigilantly assess the environment for power imbalances, generating clues on how to proceed with the *Hunt* while protecting against further distress or loss of control. In every direction and with each opportunity, intricate details of the *System* and the services provided are observed and processed. *Gauging for Validation* resulted in several *Hunting* responses; however, two core pathways of seeking help are to: (a) avoid the *System* or invalidating HCPs and manage the dehumanization of suicidality alone or (b) reach out for help while risking being dehumanized by HCPs' invalidation. Both pathways risk *Entrapment*; however, one is always *Gauged* to be less dehumanizing than the other. *Gauging for Validation* guides the *Hunt* in the least dehumanizing direction by *Taking the Path of Least Entrapment*.

Taking the path of least entrapment. The *Hunt* assumes a harm reduction approach by *Taking the Path of Least Entrapment* or choosing a pathway of help-seeking that reduces the exposure of invalidation. For example, when the prospect of validation is hopeless within the *System*, dealing with *Trauma Entrapment* alone and avoiding HCPs is *Gauged* to be the least dehumanizing option because the dehumanization within the *System* feels worse than managing suicidality without professional help. Conversely, when the degree of harm from the dehumanization of *System Entrapment* is *Gauged* to be lower than the dehumanization and pain of *Trauma Entrapment*, taking any *Path* within the *System* or reaching out for help becomes the better option. In other words, women experiencing the highest levels of psychological pain and suicidality endured a certain amount of *System Entrapment* in hopes of eventually *Feeling Human* by encountering a validating HCP.

A woman in the study took the *Path of Least Entrapment* by persisting in her wait for the emergency department (ED) doctor despite hearing the ED nurses talk negatively about her; this path was judged to lead to less *Entrapment* than going home without medical treatment. She explained her decision by recounting her stance toward the ED nurses:

> [In reference to the ED nurses], "So if you are not going to listen to me anyway and I'm going to sit here and wait for the goddamn doctor to see me, I don't give a rat's ass if you don't believe me

> or if you were judging me as long as I end up getting [the psychiatrist] to help me." So I think my will to live and my will to survive is craziness and that's what it was; craziness . . . The will to get better was stronger than . . . having to put up with how people judge me in the hospital.

The least dehumanizing choice was *Gauged* to be waiting for the psychiatrist in the ED while feeling invalidated by the ED nurses. She was willing to sacrifice feeling disrespected for a chance to *Feel Human*. This woman identified as a person with low socioeconomic status, contributing to her desperation to get help. While *Hunting* patterns were consistent among all women despite their diversity of social location, low economic status contributed to an increased urgency to seek help. For example, being without financial means to attend private counseling, travel to doctor's appointments, and pay for medications, women *Hunted* with greater intensity and rigor as demonstrated by the woman's persistence to wait in the emergency room for many hours and days to see a doctor. A higher urgency for help related to lower socioeconomic status lead to a greater tolerance of *System Entrapment* in hopes to *Feel Human*. The IPV literature supports the concept of *Gauging* as mothers were found to weigh the risks and benefits in making health decisions for their families in the aftermath of IPV (Bentley, 2017), including contemplating the risk of being seen as an incapable parent for needing mental health help (Ford-Gilboe et al., 2005). In all, *Gauging for Validation* opportunities is a continuous complex process of measuring a variety of risks and opportunities.

Summary

Hunting to Feel Human is a process of battling for validation during *Trauma Entrapment*, the sense of dehumanization related to suicidality. *Feeling Human*, the goal of the *Hunt*, is a sense of belonging and self-value that justifies continuing to live. *Hunting to Feel Human* is the basic psychosocial process of managing *System Entrapment*, the basic psychosocial problem that represents a sense of dehumanization as a result of HCPs' invalidation. *Gauging for Validation* or assessing for opportunities to *Feel Human* in each help-seeking situation yields a judgment that informs on how the *Hunt* will unfold. Measuring the levels of *Trauma Entrapment* in comparison with *System Entrapment* determines whether reaching out for help or avoiding the *System* is the best pathway to reducing dehumanization. *Taking the Path of Least Entrapment* is a harm reduction approach to help-seeking that has important practice and policy implications for helping women with suicidality who have experienced IPV.

Discussion and Implications

Hunting to Feel Human offers substantial insights to helping women who are suicidal after IPV through a unique in-depth analysis of their help-seeking patterns and offers a critical lens that challenges the dominant medical model of the health care system. The status quo provision of services for suicide prevention and intervention is based on a hierarchal structure where patients have little agency in their treatment (Fitzpatrick & River, 2018). The medical model falls short of helping people with suicidality due to the emphasis on the bio-physiological (Koning et al., 2017). The Hunting theory is distinguished from the majority of suicide literature that comprises of correlational studies and epidemiologic data which have limited application for intervention (Franklin et al., 2017). A large portion of suicide research does not inform on underlying processes and contextual factors that decrease suicidality. Understanding help-seeking from women's standpoint of their every-day actions informs a pragmatic approach that translates into clinical interventions and policies that have meaning to women. The need to strengthen HCPs' capacity to promote *Feeling Human* by developing stronger connections with women is supported by one study that found nurses helped their suicidal patients by "reconnecting the person with humanity" (Cutcliffe et al., 2006) through a caring relationship (p. 791).

Successful application of the *Hunting to Feel Human* theory is contingent on changing the fundamental approach through which suicidality is conceptualized and treated. A dominant ethical principle within the medical model, beneficence or *to do good* (Audi, 2014), is sometimes used as justification for paternalistic medical practices (Proctor & Keys, 2013). The common use of coercive practices within psychiatric institutions (Steinert, 2017) is enabled by the assumption that HCPs have the authority to dictate what is in the patients' best interests. For example, some women in this study were placed in a locked seclusion room during periods of suicidality in order to prevent self-harm; however, being contained in isolation removed them from meaningful engagement with others. *Feeling Human* informs HCPs that self-harm prevention does not imply controlling the physical body through restraint-orientated interventions, but rather offering opportunities for psychological safety through validating interactions. Administrators and clinicians can work to deconstruct institutional structures that are built upon the value of physical safety at the expense of psychological safety.

One way of deconstructing institutional structures is to examine the intent and health outcomes of custodial interventions for patients on *suicide watch* within psychiatric units in which patients are kept within viewing distance of a HCP or are constantly observed through a camera. Observation practices operate under the assumption that suicide prevention equates controlling patients' bodies by secluding them in a locked room or observing their physical status at regular intervals. Simply checking if the patient is alive is dehumanizing. Alternatively, a treatment culture in which psychological health is prioritized involves taking time to understand patients' suicidal experiences, informing HCPs how to respond to their emotional needs. Collaborating with patients to design a safety plan may help increase their

sense of security. Scheduling frequent visits to connect meaningfully with patients or helping them identify comfort measures to reduce their suicidal thoughts are noncoercive ways to promote *Feeling Human*. Furthermore, dismantling infrastructure by re-designing psychiatric units without seclusion rooms may create a less intimidating environment and reduce *System Entrapment*. Promoting visibility of and greater access to HCPs through open concept nursing stations and areas for patients to socialize with HCPs, such as a shared coffee station, may enhance patients' sense of belonging.

Relational Practice Considerations

Clinical practice and policies that align with help-seeking needs for suicidality in women who have experienced IPV ought to be relational, an approach that recognizes how people and the environment are continually influencing the other (Varcoe & Einboden, 2011). Recognizing power imbalances within medical systems is important in understanding how interconnections between HCPs and patients impact the help-seeking experience. The way women relate to HCPs is of greatest importance in *Feeling Human*; therefore, a framework for creating secure environments and validating interactions with HCPs are recommended. Critical to the needs of women who have experienced IPV, a trauma and violence informed (TVI) approach is sensitive to relational influences within health care (Ponic et al., 2016). TVI is an approach to care provision that recognizes the impact of violent trauma on health and provides culturally safe services within the health care environment (Browne et al., 2018). Similar to trauma-informed care (TIC) (Elliott et al., 2005), the goal of trauma- and violence-informed care (TVIC) is to prevent retraumatization while receiving services (Ponic et al., 2016). Whereas TIC may narrow the scope of trauma to individual instances or single events, TVIC accounts for the ongoing and insidious nature of violence embedded within interpersonal relationships and institutional structures (Browne et al., 2016), including *System Entrapment*.

A relational approach to helping women by acknowledging the impact of trauma and violence is vital to *Feeling Human*. Treatment for suicidality is currently limited to a narrow focus on the individual, ignoring power dynamics and broader social factors that sustain violence and intensify the health impacts of trauma. Women in this study reached out for help after they exhausted their personal coping skills during a suicidal crisis only to be met with pressure from HCPs to continue using these skills without being offered other forms of support. Women felt that having independent coping skills was prioritized over their need to connect with and to be comforted by others, neglecting women's dignity and humanity. Feeling pressured to change the way they think, feel, and behave and struggling to manage their problems on their own, women felt inadequate and over powered by the HCPs' expectations to change.

In contrast, Carl Rogers's (1951) psychological ideology of providing unconditional positive regard (Martin, 2017) is a treatment guide that reinforces patients' self-worth through equalizing power differentials or harmonizing differences between the counselor and the client (Witty & Adomaitis, 2014). Educating and nurturing HCPs' capacity to provide unconditional positive regard requires removing barriers to understanding women's experiences by challenging underlying assumptions that influence taken-for-granted practices and promote power imbalances. A relational approach rejects the idolization of independence or self-sufficiency in Western society (Potter, 2015) and that reliance on or attachment to others is synonymous with femininity and weakness (Cunniff, 2016; Gilligan, 1982). Challenging the idea that people are autonomous beings detached from one another and acknowledging social interdependence is critical to avoiding shaming people for relying on others during periods of psychological crises. Embracing the limitations of people seeking help for psychological difficulties by providing opportunities for supportive connections (Rogers, 1977) is important for accepting women's needs in the context of IPV and other trauma experiences.

A relational approach also supports *Feeling Human* by acknowledging the influence of broader contextual factors with suicidality treatment. An awareness of gender, socioeconomic status, racism, discrimination, and cultural factors related to power inequities may be integrated within traditional therapies (Maier, 2016), assisting women to manage negative health outcomes within the context of connections with others (Tseris, 2013) and reducing self-blame. Mindfulness, a strategy that promotes awareness of one's situation and promotes individual accountability for one's problems, can decrease suffering by learning to tolerate distress and build inner strength (Linehan, 1993, 2015); however, risks blaming the victim. Accordingly, mindfulness can be adapted by embedding a relational approach, enhancing women's need for emotional connectedness (Ogden et al., 2015). Mindfulness within a feminist lens draws awareness to social influences within the practice, allowing people to understand how their subjugation may have affected their health (Crowder, 2016).

Although attention to social and interpersonal factors is most important in promoting *Feeling Human*, this does not imply ignoring the individual. Working one-on-one with a trusted counselor to identify broader factors that have contributed to their suicidality may increase women's personal sense of worth. Cripe et al. (2015) writes that a multipronged approach consisting of individual therapy in conjunction with acknowledging social factors that influence health outcomes provides the most comprehensive care related to women's experiences with IPV. Addressing systemic power imbalances that disadvantage people seeking help are vital to removing access barriers, including offering affordable counseling, accessible transportation, and free childcare services.

Scope and Limitations

Implications of the Hunting to Feel Human theory may have reach beyond women seeking help specifically for suicidality in the context of IPV. The GT approach yields dense descriptions of the data and captures variations within the theory, strengthening generalizability of the findings (Lincoln & Guba, 1985). The abstract and contextual nature of the Hunting process allows readers to compare properties and relationships of the theory to those of other women seeking help for trauma and mental health–related conditions. Hunting processes occurred for participants when seeking help for anxiety, depression, posttraumatic stress disorder, and addiction during periods of time when they did not feel suicidal. This theory might also be applicable to seeking help for mental health problems in the wake of various forms of violence aside from IPV, including sexual abuse outside of an intimate relationship, childhood abuse, or workplace harassment. The need for a sense of belonging and self-worth characterized within the Hunt to Feel Human is documented throughout the suicide literature, elevating the applicability of this theory to various groups of people seeking help for suicidality.

Understanding how to help women who have experienced IPV and are seeking help for suicidality has international relevance. IPV is a global health problem (WHO, 2013) and was found to be a risk factor for suicidality in the WHO Multi-Country Study on Women's Health and Domestic Violence Against Women (Garcia-Moreno et al., 2005). The findings presented in this article have potential relevance beyond a North American context as the Western ideology of individualization is challenged in the Hunting to Feel Human theory. Feeling Human is contingent on a relational approach in which suicidality is understood in the context of interpersonal and social factors that influence women's help-seeking. Moreover, in a literature review of psychiatric unit HCPs' treatment of suicidal patients within Canada, the United Kingdom, Portugal, Switzerland, Germany, and Australia, patients consistently had negative perceptions of the care they received (Cutcliffe et al., 2015). The need to improve care for suicidality internationally highlights the applicability of the Hunting to Feel Human theory beyond a Canadian context.

Despite the potential impacts of this study, a limitation is that a convenience sampling may have excluded marginalized women who did not have access to the health services where the study advertisements were posted. Collaborating with Indigenous communities in the research process is critical considering Indigenous women are far more likely to experience suicidality (Health Canada, 2014) and IPV (Conroy, 2018) in comparison with non-Indigenous women. Due to the disproportionality higher risk for suicide in the Lesbian, Gay, Transgender, and Bisexual (LGTB) youth in comparison with non-LGTB youth (Ream, 2019), people from this community ought to be included in studies about help-seeking. Furthermore, including those from the LGTBQ2+ community may change the myth that IPV is a heterosexual issue and broaden knowledge of gender roles in violent relationships. In all, samples of women who have experienced multiple levels of power imbalances in the study of suicidality and IPV may enhance efforts to dismantle taken-for-granted practices in the health care system that ignore women's diverse needs.

Conclusion

Hunting to Feel Human is a substantive theory of how women seek help for suicidality after IPV that was developed using a feminist GT and PV multiple method design. Rich descriptions from interviews and self-generated images contributed to the emergence of Hunting to Feel Human. Hunting to Feel Human is the basic social process that manages System Entrapment, being dehumanized while interacting with HCPs. Feeling Human is a sense of belonging, personal value, and deservingness as a result of HCPs' validation that lessens suicidality and helps women to continue living. Opportunities to Feel Human within the health care system are sought by Gauging for Validation, a strategy women used to assess the risk for encountering System Entrapment. Gauging for Validation generates a judgment on how to proceed with the Hunt by Taking the Path of Least Entrapment, a help-seeking strategy that reduces exposure to invalidation. Interactions with HCPs yield the highest levels of validation, thereby have the greatest implications for Feeling Human. Educators, policy makers, administrations, and clinicians are urged to create more equitable relationship opportunities that promote acceptance and empathy. HCPs' acknowledgment of women's realities in the context of IPV and the difficulties accessing help for suicidality is an important part of creating therapeutic relationships. A health delivery system grounded in a relational approach through a TVI framework maximizes Feeling Human. Drawing awareness of contextual factors that shape ongoing health effects of trauma, taking the blame off the individual, and understanding suicidality in a relational context strengthen women's capacity to remain alive while seeking help for suicidality in the aftermath of IPV.

Author's Note

Any underlying research materials related to this article can be accessed by contacting the author at petrea.taylor@unb.ca.

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