An Exploration of Compassion for Others on Suicidality Recovery

by

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Abstract

Suicide is a leading cause of death for young adults. Among undergraduate students, risk factors for suicidality include substance abuse, academic pressure, and identifying as a minority (De Luca et al., 2016; Giordano & Cashwell, 2012; Shadick et al., 2015). Additionally, suicidal students tend to struggle with self-esteem, and commonly experience social isolation, hopelessness, emotional dysregulation, and mental illness (Chang, 2017; Joiner et al., 2009; Norouzi et al., 2016; Zafar et al., 2012). Compassion for others, on the other hand, may increase hopefulness, social connectedness, and self-esteem (Gilbert, 2014; Mongrain et al., 2011). Thus, the potential benefits of compassion toward others appear to align with the targets of suicidality recovery. However, there has been a lack of research on the potential role of compassion for others in undergraduate students' suicidality recovery. The purpose of this study was to explore the experience and meaning of compassion toward others, as it relates to undergraduate students' recovery from suicidal thinking and behaviours. I interviewed six undergraduate students about their experiences with compassion for others and its impact on participants' recovery from suicidality. Using data analyses methods from interpretative phenomenological analysis (IPA; Smith et al., 2009), six superordinate themes emerged, including: sense of purpose through making a difference in others' lives, reciprocity, positive self-concept, non-judgement and acceptance, social connection, and the cost of compassion. These findings suggest that compassion for others may be an important factor in suicidality recovery for undergraduate students. Limitations and future directions for research in the areas of compassion for others and suicidality are discussed.

Keywords. undergraduate students, compassion, suicidality, suicidality recovery, interpretative phenomenological analysis

Preface

This thesis is an original work by Hailey Allegro. The research project, of which this thesis is a part, received research ethics approval from the University of Alberta Research Ethics Board, "The place of compassion for others in undergraduate students' recovery from suicidality", Pro#00098126, June 2nd, 2020.

Dedication

This thesis is dedicated to my Auntie, Cheryl Capek, the kindest and funniest person I know.

Thank you for inspiring me to pursue a career in psychology.

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Thank you to my participants for their time, openness, and vulnerability. Without them, this study would not have been possible.

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An Exploration of Compassion for Others on Suicidality Recovery

Chapter 1: Introduction

Each year, almost one million people worldwide die by suicide, nearing one hundred individuals per hour [World Health Organization (WHO), 2016]. Amidst suicide deaths, adolescents and young adults are at an increased risk compared to other age groups, as suicide is the second leading cause of death for young people (Mortier et al., 2018). In a recent study conducted by Mortier and colleagues (2018), 75% of undergraduate students had experienced suicidal ideation. Furthermore, undergraduate students are almost twice as likely to report suicidal thoughts and behaviours compared to the general adult population (Kaniuka et al., 2019).

The definition of *suicide* is the deliberate and completed act of ending one's own life (Gvion & Apter, 2012). Several terms that are related to the word suicide, however, do not indicate that a deliberate death has occurred. The terms *suicidality* and *suicidal thoughts and behaviours* imply the desire for and potential act of death. Individuals may have thoughts of suicide, which can range from brief, irregular thoughts, to a fixation on death (Borders, 2020). Suicidal thoughts may also include making a suicide plan (Borders, 2020). The term *suicidal behaviours* refers to intentional acts that may cause harm to the person performing the act (Goodfellow et al., 2019). Some individuals may deliberately hurt themselves (e.g., cutting), without the desire for death, an act known as *non-suicidal self-injury*. Further suicidal behaviours include *suicide attempts*, which occur when a person purposely tries to end their life (Goodfellow et al., 2019). An attempted suicide often indicates that the attempter did not die (Gvion & Apter, 2012). Lastly, a *completed suicide* refers to death by suicide (Goodfellow et al., 2019).

All terms associated with suicide, including thoughts, behaviours, attempts, and death can afflict undergraduate students. Undergraduate students are individuals who are typically in their late teens to early twenties and who are undertaking postsecondary education (Han et al., 2016; Mortier et al., 2018). University is often an opportunity where students can meet new people, become more independent, and experience new learning. However, during university, students might also experience extreme and unique stress, potentially increasing suicide risk (Horwitz et al., 2020). Risk factors might include academic pressure, substance abuse, relationships issues, and financial stress (Seeman et al., 2017). Given such risk factors, it is vital to understand sources of resiliency and recovery for undergraduate students.

For individuals suffering from suicidality, experiencing compassion may contribute to the desire for recovery (Cole-King et al., 2013). Compassion is recognizing hardships in either ourselves or others, while being motivated to diminish suffering (Gilbert, 2014). Gilbert (2009b) conceptualized compassion as a connected triad, where compassion can be from others, toward others, and toward oneself (i.e., self-compassion). Recent evidence suggests an association between self-compassion and decreased suicidality in undergraduates (Kelliher-Rabon et al., 2018). Kelliher-Rabon et al. (2018) indicated that self-compassion may serve as a protective factor against suicidality by increasing undergraduate students' healthy coping mechanisms. Additionally, self-compassion might decrease suicidal thoughts in other adult populations (LoParo et al., 2018). Some individuals, however, may fear self-compassion and have difficulty extending compassion toward themselves in times of distress (Kirby et al., 2019).

While studies exist on self-compassion in connection to suicidality recovery, the exploration between compassion for others and suicide is limited. This holds especially true for undergraduates, with no known studies focusing specifically on the student population.

Moreover, no researchers have studied the personal experience of compassion from the perspective of undergraduate students who are or were suicidal. Thus, there is a need for research on how other forms of compassion, such as compassion for others, might decrease suicidality in undergraduate students.

Although it is unclear how compassion toward others might reduce suicidal thoughts and behaviours, the potential benefits of compassion appear to be inversely related to the psychological correlates of suicidality. Specifically, compassion toward others may help improve well-being and decrease issues such as depression and low self-esteem (Gilbert, 2014; Mongrain et al., 2011). Additionally, compassion for others may positively influence connection with others, hopefulness, and emotion regulation (Cosley et al., 2010; Hsiao et al., 2020; Jazaieri et al., 2014). Typically, suicidal individuals struggle with mental illness, diminished self-esteem, social isolation, emotion dysregulation, and hopelessness (Chatard et al., 2009; Jaiswal et al., 2016; Joiner et al., 2009; Law et al., 2015; Plancke et al., 2020). Practicing compassion toward others may, therefore, be particularly helpful in recovery from suicidality.

Little research addresses the linkage between compassion for others and protective factors against suicidality in the undergraduate population. Furthermore, no known studies have focused on compassion for others and its relationship to suicidality recovery from the perspective of participants. Giving participants the opportunity to share their perspectives on significant events and to make sense of such experiences is crucial, especially when studying novel topics (Smith et al., 2009). Rather than defining personal experience based upon previously established conclusions and theory, participants can convey the meaning of such events in accordance with their own beliefs and truths.

Purpose of Study

The purpose of this qualitative thesis study was to explore compassion toward others in relation to undergraduate students' recovery from suicidality, from the perspective of undergraduates themselves. My main research question was: What is the experience and meaning of compassion toward others, from the perspective of undergraduate students who have recovered from suicidality? This study contributes to knowledge and understanding of compassion and suicidality in young adults and aims to bridge the literature in these two areas. My findings may help inform compassion-based interventions for helping youth who are struggling with suicidal thoughts and behaviours. Furthermore, my study may open up new avenues for researchers interested in exploring the relationship between compassion and recovery from suicidality.

To address the research question above, I utilized interpretative phenomenological analysis (IPA), which is an approach used to study meaning and lived experience in the context of psychological and social phenomena (Smith et al., 2009). In using IPA, I derived pertinent themes within each individual case as well as common themes across all cases.

Researcher's Positionality

Before pursuing my master's degree, I volunteered with the Distress Centre Calgary for several years. While serving on the Distress Centre phone lines, I often spoke with suicidal individuals. On such high-risk calls, I was required to assess the caller's risk of attempting suicide, while simultaneously providing empathy, support, and resources. When I began taking calls on my own, I feared I would pick up the phone and the caller would be suicidal. Fortunately, my coordinators, supervisors, mentors, and fellow volunteers helped me navigate such high-risk calls, ensuring that I felt supported. As I spoke with more callers who were suicidal, and helped them handle their situation, my confidence increased.

Speaking with suicidal callers, something that once scared me, was not as frightening as I had originally thought. As my comfort levels grew surrounding conversations about suicide, I realized that I held faulty assumptions about suicidal people. I assumed that discussing suicide would encourage a suicide attempt. Furthermore, I was concerned that these conversations would be especially upsetting to me. To the contrary, the Distress Centre taught me that open conversations about suicide are necessary; suicidal individuals learn that their feelings are valid, that the thoughts will not last forever, and that help is available. I also realized that these crucial conversations were much more important than my discomfort, leading me to face my fears. These conversations also sparked an interest in me: I wanted to learn more about suicide and what inspires individuals to overcome suicidality. Therefore, in my master's thesis research, I chose to develop this understanding through meaningful conversations with individuals who had recovered from suicidality.

Although mindful of others' opinions and beliefs in terms of personal experience, I am not without bias. I am a white, cisgender, heterosexual, middle class, well-educated adult. I am privileged in our society, and by virtue, my experiences reflect my privileges. My experiences are more than likely different than those who do not share my background. Furthermore, I will likely never fully understand the experiences of others who do not share the same intersectionalities as me. Therefore, I must recognize my personal lens and reflect how it influences my views. Continued reflection is especially important as I attempt to interpret participants' personal experience with a history presumably unlike mine.

Overview of Remaining Chapters

The next chapter provides an in-depth literature review on suicidality and compassion for others. I discuss specific reasons and factors that help explain why undergraduate students are at

an increased risk of suicide. I then review the relevant literature on compassion, including conceptualizations and definitions of compassion. I follow with a review of compassion for others, including its benefits and potential relationship to suicidality recovery. In the third chapter, methodology, I provide a description of IPA (Smith et al., 2009) and its relevance to my study's design. I then discuss the participant characteristics in detail, including the recruitment process. Lastly, I describe the data collection and analysis methods I utilized, as well as the criteria used to establish trustworthiness. The fourth chapter consists of my findings, including themes within each individual case as well as themes across participant cases. In my final chapter, I summarize and discuss my findings in the context of the literature. The chapter also covers the implications and contributions of my study, as well as its limitations. Finally, I suggest directions for future research.

Chapter 2: Literature Review

I begin this chapter by reviewing suicidality and suicide risk factors in the general population before describing risk factors for undergraduate students. I then focus on interventions used to treat suicidal individuals, including undergraduates. Next, I present conceptualizations of compassion, followed by a review of the relevant research on compassion. I then turn to the literature on compassion and suicidality, specifically focusing on the importance of compassion for others in suicidality recovery. Lastly, I consider compassion-focused interventions and their potential impact on suicidal thoughts and behaviours.

Suicidality

Suicide Risk Factors

Risk Factors in the General Population. An adolescent who identifies as male, is a member of the LGBTQ+ community, and/or has a family history of suicide is more likely than an individual without these characteristics to die by suicide (Brent et al., 1999; Liu & Mustanski, 2012; Steele et al., 2018). Additionally, previous suicide attempts, and non-suicidal self-injury may increase an adolescent's risk (Brent et al., 1999). Bullying and substance abuse are also risk factors for adolescent suicide (Peng et al., 2019; Spirito & Esposito-Smythers, 2006). Adult suicide risk factors are similar to those of adolescents, including identifying as male; having a family member die of suicide; non-suicidal self-injury; and previous suicide attempts (Bolton et al., 2010; Steele et al., 2018). Other factors include being White and experiencing financial difficulties (Overholser et al., 2012; Steele et al., 2018). Chronic pain is another risk factor associated with suicidality, regardless of sex, age, or cultural background (Hooley et al., 2014). In Canada, Indigenous peoples are also at an increased risk of suicide (Clifford et al., 2013). The above factors, although frequently present in individuals who have died by suicide, do not paint a

full picture of the experience of suicidality. Therefore, it is important to consider internal psychological factors that increase the risk of suicide.

Internal Risk Factors. Adults who have suicidal ideations and have made suicide attempts are more likely to report low self-esteem (typically defined as a person's appraisal of their own worth; Chatard et al., 2009). In the past, researchers have attempted to explain the relationship between self-esteem and suicidality. For example, Rasmussen et al. (2018) interviewed 61 participants closely associated with 10 young men who died by suicide. From the perspective of the participants, prior to suicide, the young men had suffered from feelings of failure, loneliness, and unworthiness. Additionally, the participants indicated that the young men displayed a significant discrepancy between their actual self and their ideal self. According to the authors, these factors may have contributed to low self-esteem, and in turn, provoked suicide.

In addition to low self-esteem, social isolation may heighten suicide risk, a relationship consistent across all age groups (Joiner et al., 2009). Whereas aloneness and a perceived lack of belonging increase suicide risk, social connection decreases the risk (Joiner et al., 2009). As Joiner et al. (2009) indicate, instances of suicide decline when people join together, even if the occasion is mournful in nature (e.g., a funeral). Often accompanying low belongingness is high burdensomeness (Hames et al., 2018). Individuals who perceive themselves as a burden often believe their death would be a relief to others (Joiner et al., 2009). Joiner et al. (2009) found that adults with low belongingness, high perceived burdensomeness, and possession of lethal means were at highest risk of attempting suicide. The link between social isolation and suicide might be partially explained by mental illness, most notably depression (Yur'yev et al., 2011). Ahmadpanah et al. (2017) found that major depressive disorder (MDD) sufferers who had

recently attempted suicide reported that they felt alienated, believed they were a burden to others, and perceived others as being apathetic toward them.

Another suicide risk factor not to be overlooked is hopelessness (Jaiswal et al., 2016). Hopelessness is defined as persistent despair paired with the belief that one's life will not improve in the future despite efforts to change one's situation (Chang, 2017; Wang et al., 2015). In a study conducted in rural China, Niu et al. (2020) used a psychological autopsy method to compare data from a sample of adults who died by suicide with data from a sample of living adults, based on demographic characteristics (i.e., age, gender, and community) shared by the two groups. The latter group completed self-report measures on depression, social isolation, and hopelessness. Hopelessness and social isolation were found to significantly increase the risk of suicide. In explaining how hopelessness predicts suicidality, Lew et al. (2019) suggested that individuals who feel hopeless might exhibit inflexible coping when facing stressful situations. Additionally, with hopelessness being linked to both depression and suicide (Murphy et al., 2000), researchers have speculated that hopeless beliefs can contribute to depression, which, together with hopelessness, increase the risk of suicide (Alloy et al., 1988).

Commonly accompanying suicidality is emotion dysregulation (Law et al., 2015). Emotion dysregulation refers to difficulties accepting distressing emotions, such as anxiety, anger, and sadness, while at the same time struggling to use healthy coping methods in the presence of such emotions (Pisani et al., 2012). A person's ability to cope with difficult emotions appears to be a better predictor of suicide than is the experience of negative emotions themselves (Law et al., 2015). In a study by Anestis et al. (2014), adult participants who had previously attempted suicide were more likely to report distress intolerance, adjustment problems, and challenges in solving interpersonal issues. Additionally, adults with weak emotion regulation

were more likely to use non-suicidal self-injury to cope (Anestis et al., 2014). In discussing their findings, Anestis et al. (2014) suggested that participants used suicidal behaviours as a way to escape the issues associated with emotion dysregulation. Individuals high in emotion dysregulation also appear more likely to suffer from hopelessness, social isolation, and mental illness (Law et al., 2015).

A final factor pertinent to the current study is mental illness. Individuals diagnosed with a mental disorder are more likely to die by suicide compared to those without such illnesses (Plancke et al., 2020). Arsenault-Lapierre and colleagues (2004), in a meta-analysis study that included 3275 adolescents and adults, indicated that as many as 90% of people who completed suicide had a mental illness. The risk of suicide increases when an individual meets the criteria of any mental illness; however, such a risk is greater in individuals with psychotic, depressive, or bipolar disorders (Plancke et al., 2020).

Previous research sheds some light on possible factors related to the increased suicide risk among individuals with a mental illness. Li et al. (2020) collected survey data from a sample of young adults to compare participants who had attempted suicide with those who had not. Participants who had both a mental illness and a previous suicide attempt reported higher levels of stress, along with limited coping strategies to handle such stress (Li et al., 2020). Financial difficulties among participants with a mental disorder also appeared to contribute to suicide risk (Li et al., 2020). In a study conducted by Wastler and colleagues (2020), veterans previously diagnosed with a mental disorder and who also reported low levels of belonging were more likely to experience suicidal ideation. Wastler et al. (2020) suggested that the relationship between mental illness, low belongingness, and suicidality was strongest when the participants

also experienced internalized stigma (explained as believing and relating stereotypes about a mental illness to the self).

Risk Factors in the Undergraduate Student Population. In addition to risk factors in the general population (Steele et al., 2015), unique factors exist specific to undergraduate students. As Shadick et al. (2015) have indicated, university students who identify as a minority are at higher risk of suicide compared to non-minority students. For example, students self-identifying as LGBTQ+, especially if they also identify as a person of colour, report suicidal thoughts and behaviours more often than students who are not a part of a minority group (Shadick et al., 2015). Isolation and discrimination, frequently occurring in minority groups, may increase mental health issues and, thus, suicidality (Shadick et al., 2015).

Some studies report less suicidality among racial minority students compared to White students, which may potentially be a consequence of cultural factors like supportive social networks (e.g., see Perez-Rodriguez et al., 2008 and Shadick et al., 2015). However, a lower risk of suicide does not appear to be the case for Indigenous students (Hop Wo et al., 2020). The increased suicide risk in Indigenous undergraduate students might be explained by racism, lack of community in the university setting, and previous mental health issues (Hop Wo et al., 2020). International students might also experience suicidality at an increased rate, perhaps because of cultural differences, marginalization, and homesickness (Wong, 2013).

Concerning gender differences, evidence suggests that female students experience suicidality and attempt suicide more often than males (Lamis & Lester, 2013). Lamis and Lester (2013) indicated that these gender differences may be explained by the higher rates of depression in women. Nonbinary and transgender students also appear to be at higher risk of suicide compared to cisgender students (Lefevor et al., 2019). Lefevor et al. (2019) found that in a

sample of almost 300,000 undergraduate students who had sought counselling, nonbinary and transgender individuals were more likely to engage in suicidality, with close to 70% experiencing suicidal thoughts, and almost 50% attempting suicide.

Academic pressure and perfectionistic attitudes toward academics might increase a student's wish to die (Eells, 2017). Although high-achieving students typically achieve high grades, they potentially hold themselves up to an unrealistic standard (Eells, 2017). These standards might be in accordance with personal and/or familial expectations (Eells, 2017). Such pressure can lead to extreme stress and possibly suicidality (Eells, 2017). Low grades, on the other hand, may also predict a students' suicide risk (De Luca et al., 2016; Seeman et al., 2017). Suicidal undergraduates usually have lower grades compared to non-suicidal students (De Luca et al., 2016). De Luca and colleagues (2016) argued that the relationship between low grades and suicidality is mediated by mental illness, social isolation, and substance use. Other studies have also explored students' substance use in relation to suicidality (Giordano & Cashwell, 2012). College students may use substances to conform with peers or to cope with stress or mental illness (Assari, 2018; Giordano & Cashwell, 2012). However, some research links substance use with increased emotional suffering, as well as life disruption, such as failing classes or strained relationships (Pompili et al., 2012). Financial difficulties might also influence suicidal ideation and behaviours in university students. Considering the substantial cost of university, undergraduates may experience stress based upon such reasons as concerns about debt and the reliance on student loans (Kruisselbrink Flatt, 2013). As with the general population, internal risk factors may perpetuate suicidality in undergraduates, especially when combined with external factors.

Internal Risk Factors. The transition into university (and into adulthood) is a period of major change, such that undergraduate students gain more independence and must determine a career path (Zafar et al., 2012). However, low self-esteem often accompanies this transition, perhaps due to difficulties with navigating change, falling short of goals, and struggling with social connection (Zafar et al., 2012). The relationship between undergraduate suicidality and self-esteem is multifaceted. For instance, self-esteem was significantly lower in a sample of undergraduate students with MDD and high risk of suicide, compared to those with MDD and low suicide risk (Mitsui et al., 2014). Low self-esteem is associated with self-hatred and worthlessness, factors that may perpetuate the relationship between depression and suicidality (Mitsui et al., 2014). Social support might also influence self-esteem and its impact on suicidality (Kleiman & Riskind, 2013). In a sample of 172 undergraduate students, Kleiman and Riskind (2013) found that those students who felt socially supported and engaged with such supports showed higher levels of self-esteem, as evidenced by self-report data.

Social isolation in its own right predicts suicidality in university students (De Luca et al., 2016). For example, in a study of 1,072 participants conducted by Goncalves et al. (2014), students who reported few social connections (e.g., romantic relationships, extracurricular activities, etc.) were more likely to report suicidal thoughts, compared to students with higher levels of social supports. Separation from family and friends as well as difficulty making and maintaining friendships in a large university environment may partially explain why students experience social isolation (Boddy, 2020). As suggested by other research on social isolation and suicide (e.g., Joiner et al., 2009), high perceived burdensomeness and low belongingness is also apparent in suicidal university students (Lamis & Malone, 2011). Furthermore, Lamis and Malone (2011) reported a mediating relationship between alcohol abuse and suicidal tendencies

in college students, suggesting that students may use alcohol as a way to cope with loneliness, in particular, feelings of burdensomeness and estrangement. Which specific types of social interactions reduce suicidality, however, is not currently known.

Hopelessness is yet another risk factor faced by undergraduate students (Lew et al., 2019). Perceived failure to achieve personal goals or live up to expectations might lead an undergraduate to feel hopeless (Chang, 2017). In a study conducted by Gulec Ovekcin and colleagues (2017), over 4,000 undergraduate students completed a mental health survey. The students who reported high levels of depression, anxiety, and hopelessness were more likely to indicate suicidal ideation (Gulec Ovekcin et al., 2017). Gulec Ovekcin et al. (2017) suggested that anxiety and depression were exacerbated by hopelessness, which increased suicide risk. Although such studies give researchers information about hopelessness and suicide risk factors in the undergraduate population, the results do not tap into students' experiences in a comprehensive and contextualized way.

With the constant changes and challenges faced by undergraduate students often come difficulties with emotion regulation (Torrado et al., 2020). Emotion dysregulation in students may occur because of perfectionistic behaviours towards coursework (Aldea & Rice, 2006), impairment due to substance abuse (Leganes-Fonteneau et al., 2020), and mental illness onset (Norouzi et al., 2016). Consistent with research on the general population (e.g., Law et al., 2015), emotionally dysregulated university students may also experience nonacceptance of their internal affective states as well as poor coping skills in the face of negative emotions (Rajappa et al., 2012). According to Rajappa and colleagues (2012), hopelessness may connect emotion dysregulation to suicide. Students who struggle with regulating emotions may believe that negative emotions are permanent and inescapable; and therefore, students might turn to suicide

as a means of escape (Rajappa et al., 2012). Additionally, emotion dysregulation may lead college students to perceive themselves as alone in the world, also contributing to suicidality (Anestis et al., 2011).

University students may also experience a heightened risk of suicide while in the process of developing a mental illness (Norouzi et al., 2016). Undergraduates are at an age in which many mental disorders first begin to develop, including mood, anxiety, and trauma-related disorders (Kessler et al., 2007). At the same time, significant changes typically experienced by undergraduates are related to increased stress (Liu et al., 2019). In a sample of undergraduate students, Liu et al. (2019) found an association between the presence of a mental illness and high stress levels. The students diagnosed with a mental illness who reported high degrees of stress were also more likely to participate in self-injury and disclose suicidal thoughts (Liu et al., 2019). Furthermore, students in the LGBTQ+ community reported higher stress levels, mental illness, and suicidality compared to students not a part of the community (Liu et al., 2019). The onset and experience of a mental illness and suicidality in university can engender academic failure as well (Keyes et al., 2012).

Undergraduates must adapt to a new lifestyle once in university. With these changes, students may face several external risk factors for suicide, such as academic pressure, substance abuse, and marginalization (Zafar et al., 2012). Simultaneously, undergraduates may also deal with internal risk factors, including low self-esteem, social isolation, hopelessness, emotion dysregulation, and mental illness. As there exist many risk factors, which often overlap, suicide can be difficult to predict as well as prevent (Assari, 2018). However, practitioners must still assess suicide risk in the undergraduate population, as well as treat those suffering from suicidality.

Suicide Assessment

Along with the risk factors described above, the presence of warning signs might be suggestive of suicidality (Perlman et al., 2011). Warning signs may include threats, gestures, discussions of death, planning out suicide, and/or attempting to obtain lethal resources (Perlman et al., 2011). Such warning signs, however, might not fully encapsulate a person's desire for suicide. Additionally, not all people who end their own life show visible signs of suicide (Rodway et al., 2020). Therefore, practitioners often use assessment tools, most commonly self-report measures, to help determine if a person is at risk of harming themselves. Gutierrez et al. (2000) stressed the importance of assessing for both suicide risk and protective factors, as a person high in risk factors who is also high in protective factors might not be as high a risk of suicide as a person with low protective factors. If only one or the other is examined, a person's risk might be inaccurately assessed, possibly leading to the wrong treatment or lack of treatment altogether (Gutierrez et al., 2000). It should be noted, however, that current assessment practices come with limitations. As mentioned by Bryan and Rudd (2006), accurately predicting suicide is difficult, even after conducting a thorough risk assessment. The goal of a risk assessment, therefore, is not as much about anticipating suicide as it is about acknowledging risks of suicide in an individual and reacting to each risk in a suitable manner (Bryan & Rudd, 2006).

If a thorough assessment suggests a high suicide risk, a practitioner should follow evidence-based steps to provide assistance and ensure the safety of the suicidal individual (Perlman et al., 2011). First and foremost, it is essential to establish rapport with the individual (Perlman et al., 2011; Sadek, 2019). Strong rapport helps build a trusting relationship, where the suicidal person may feel supported, and less isolated. Providing clear communication and collaboration whenever possible goes hand in hand with rapport building (Perlman et al., 2011;

Shea, 2009). Collaboration might include speaking with other supportive people in the client's life, such as family and friends. Also important is attending to culture (Perlman et al., 2011). Cultural sensitivity is essential in all aspects of assessment, including suicide. For example, the meaning of suicide in a cultural context might aid an assessor in a stronger understanding of the culture, while simultaneously building rapport (Perlman et al., 2011). The assessor should also use culturally sensitive tools in the assessment process. Furthermore, assessors should discuss cultural values with the suicidal individual and their supports, to minimize faulty assumptions and ensure the appropriateness of the tools (Chu et al., 2013; Perlman et al., 2011). Throughout the assessment process, assessors must provide appropriate and detailed documentation (Perlman et al., 2011). Suicide assessment documentation might include a list of risk and protective factors, assessments conducted, and suggested treatments, including those already received. Although careful action in suicide assessment may decrease suicidality (Perlman et al., 2011), assessment is usually one of the first steps in the recovery process. The next action is often suicide-specific treatment.

Psychotherapeutic Interventions for Suicidality

Evidence suggests that certain psychotherapeutic interventions help reduce suicidality in individuals wishing to die (Brown & Jager-Hyman, 2014). Some evidence-based approaches addressing suicidality include dialectical behaviour therapy (DBT), problem-solving therapy (PST), and cognitive behavioural therapy for suicide prevention (CBT-SP; Brown & Jager-Hyman, 2014). DBT, a type of therapy most commonly used to treat personality disorders, focuses on regulating and accepting emotions (Linehan et al., 2006). In one study, adults undergoing DBT displayed a reduction in suicidality after one year of treatment and sustained this recovery after an additional year (Linehan et al., 2006).

PST is a therapeutic technique in which clients learn to cope with a variety of issues and stressors using problem-solving skills (Eskin et al., 2008). In a study conducted by Eskin et al. (2008), adolescent and young adult participants received six sessions of PST over a 6-week period. Compared to the waitlist control group, the treatment group reported reduced depression and suicidality, along with increased self-esteem.

CBT-SP focuses specifically on lessening suicidality, increasing distress tolerance and coping skills, and preventing suicidal thoughts and behaviours from occurring in the future (Stanley et al., 2009). CBT-SP appears efficacious for suicidal individuals of all ages (Bryan, 2019). Lastly, some evidence exists showing the effectiveness of psychotherapy in addition to psychotropic drugs in reducing suicidal thoughts and behaviours; however, more research is needed to determine if drugs alone can reduce the risk (Zalsman et al., 2016).

Interventions for Suicidality in the Undergraduate Student Population. Previous research shows DBT, PST, and CBT as viable and effective treatments for suicidal college students (Breet et al., 2021; Eskin et al., 2008). CBT and DBT, however, are preferred by most practitioners treating suicidality in university students (Lester & Lamis, 2011). This preference is likely based upon the extensive evidence base pointing to the therapies' effectiveness (Lester & Lamis, 2011). The potential benefits of the above therapies can be explained by the integrative cognitive model of suicide (Lester & Lamis, 2011). According to the model, a suicidal individual pays attention primarily to negative information, which leads to an increased focus on suicidal thinking. A focus on negative information encourages hopeless feelings and reinforces beliefs of burdensomeness, lack of agency, and limited coping ability (Lester & Lamis, 2011). Indeed, hopelessness, lack of control, and social isolation have been shown to influence suicidality in university students (Lester & Lamis, 2011). Cognitively-based therapies may target such issues

through increasing problem-solving and coping skills (Lester & Lamis, 2011). Skill-building techniques may help shift a person's automatic thoughts of hopelessness, lack of control, and suicidality toward thoughts of capability and coping (Lester & Lamis, 2011).

A major criticism of traditional cognitively-based therapies, however, is their focus on changing "irrational" or "distorted" thoughts and behaviours in order to change feelings (Gilbert, 2009a). Although a person may come to understand why their thoughts and behaviours are unreasonable and inaccurate, the new logical thoughts may not necessarily be believable or effective in de-escalating difficult emotions (Gilbert, 2009a). Regarding the effectiveness of DBT, most studies' participants are individuals diagnosed with borderline personality disorder (BPD; Lester & Lamis, 2011). Therefore, the efficacy of DBT for suicidal individuals without BPD is largely unknown (Lester & Lamis, 2011). The above limitations help identify a research gap, particularly for addressing the emotional aspects of suicidality. A possible alternative strategy might be understood through compassion.

Compassion

Conceptualizations of Compassion

Compassion, although only a recent focus of empirical study, has been shown to be beneficial to humanity for hundreds of years (Gilbert, 2009a). Despite compassion being the subject of considerable research and theory, conceptualizations vary. Compassion is central to many belief systems, such as Buddhism (Gilbert, 2014). In Buddhism, compassion draws upon empathy (understanding the pain of another fellow being), as well as the desire to relieve the pain (Makransky, 2012). Paul Gilbert (2014), the creator of compassion-focused therapy (CFT), defined compassion as "a sensitivity to suffering in self and others, with a commitment to try to

alleviate and prevent it" (p. 19). Gilbert's (2014) definition of compassion has Buddhist roots, which to some extent are incorporated into CFT.

Kristin Neff (2003b), another major researcher in the compassion field, also draws from Buddhist thought and practices. Neff's (2003b) research in compassion has primarily centered on self-compassion, which she defines as tending to the self during hardship or perceived incompetence (Neff et al., 2007). Self-compassion is composed of three parts: kindness toward the self instead of self-disparagement; understanding suffering as a common human experience; and separating difficult emotions and cognitions from one's identity (Neff, 2003b).

The meaning of compassion might also differ depending on the individual (Pauley & McPherson, 2010). Studies adopting a qualitative design may help further develop conceptualizations of compassion, based on individuals' interpretations of and experiences with compassion (Pauley & McPherson, 2010). Although definitions and conceptualizations of the term may differ, compassion appears beneficial (Gilbert, 2009a). A useful way of understanding the benefits of compassion, particularly in the context of my study, can be found in Gilbert's (2009b, 2014) emotion regulation theory.

Emotion Regulation Theory. Gilbert (2009a) regards compassion as part of a tripartite emotion regulation system consisting of three sub-systems: (a) threat and protection, (b) resource seeking, and (c) warmth and contentment. The threat/protection system is the seat of emotions such as anger, fear, and disgust (Gilbert, 2014). Most people consider such emotions as unpleasant; however, these feelings help identify threats to allow for an immediate, protective reaction (Gilbert, 2009b). Strong, emotional reactions can save an individual's life when threatened. The same reactions, however, can also be a source of dysfunction in innocuous situations (Gilbert, 2009b). For example, being in a crowd may trigger the treat/protection

system in some people (Gilbert, 2014). However, more often than not, a crowd does not pose a threat; but when fear is consistently triggered in the same situation, it can cause disruptive behaviours such as avoidance or escape (Gilbert, 2014).

The resource-seeking system, in contrast, is geared toward finding and gaining resources, such as food, sex, and territory (Gilbert, 2009a). Through excitement and vigor, the resource-seeking system motivates humans to obtain desired resources (Gilbert, 2009a). However, the resource-seeking system creates short-term good feelings, and a craving for more. In the Western world, many people fixate on these pleasurable feelings, often attempting to experience them as much as possible (Gilbert, 2009a).

The last system in Gilbert's (2009b, 2014) theory is the warmth/contentment system. When content, an individual is not driven to protect or seek. Rather, contentment is associated with affection, resulting in calm, happy feelings, as well as connection to others. The contentment system is also associated with compassion toward others and oneself. Although it is neither possible nor desirable to completely shut off the resource-seeking and threat systems, at times they may become over-activated or over-used (Gilbert, 2009a). Such overuse can result in excessive negative affect (Gilbert, 2009a). The contentment system, in contrast, helps to de-escalate the other two systems. Effective emotion regulation depends upon a balance between all three systems. One way of accessing the contentment system is through compassion (Gilbert, 2014).

Flow of Compassion. Gilbert (2014) conceptualizes compassion as a connected triad, with compassion flowing from others, toward others, and toward oneself (i.e., self-compassion). Compassion from others is accepting warmth and kindness from those around us (Gilbert et al., 2014). Compassion toward others is care and concern for others' welfare, the desire to be kind

and warm toward them, and the wish to alleviate their suffering (Gilbert et al., 2014). Lastly, self-compassion is described by Gilbert (2009b) as "a basic kindness, with a deep awareness of the suffering of oneself and for other living things, coupled with the wish and effort to relieve it" (p. xiii). Neff's (2003b) definition of self-compassion differs slightly; Neff emphasizes acknowledging faults and suffering and responding to such suffering with compassion.

Compassion and Suicidality

Although studies have demonstrated the impact of compassion on suicidality recovery, most existing research has focused on the relationship between suicidality and self-compassion. For example, a recent study found that university students who had high levels of anxiety and depression and who practiced self-compassion were less likely to engage in suicidal behaviours (Kelliher-Rabon et al., 2017). Kelliher-Rabon et al. (2017) suggested that self-compassion reduced suicidality by decreasing depressive symptoms and increasing flexible coping mechanisms (e.g., adapting to hardships through increased efforts of self-care). Additionally, Hasking et al. (2019) found a negative relationship between self-compassion and suicidality. Undergraduate participants who self-reported high levels of self-compassion regularly relied on self-kindness, mindfulness, and common humanity when dealing with hardship. Conversely, participants low in self-compassion were more likely to report suicidal ideation and self-harm in times of difficulty. The researchers suggested that self-compassionate coping skills might help individuals regulate difficult emotions, therefore rendering suicidal behaviours unnecessary.

Although most research centres around self-compassion and suicide, some research illustrates how accepting compassion from others may help prevent suicide. In a study that explored participant experiences of self-disclosure of suicidality, Frey et al. (2018) interviewed individuals who survived a suicide attempt. Participants revealed that accepting compassion from

a kind, understanding confidant helped the participant disclose thoughts of suicide to that person (Frey et al., 2018). After disclosure, the confidant could aid the suicidal person in finding appropriate help. The authors suggested that supportive family and friends should strive to take a compassionate stance when a loved one discloses mental health issues or suicidal ideation, so that the suicidal person feels comfortable accepting compassion and help from supportive others (Frey et al., 2018).

Self-compassion and accepting compassion from others show promise in suicide prevention. However, these strategies come with limitations. In particular, some individuals may experience discomfort or anxiety when receiving compassion from others or from oneself (Gilbert et al., 2014; Kirby et al., 2019). For example, a person might fear others will think of them as selfish for engaging in compassion toward oneself (Kirby et al., 2019). Furthermore, individuals might regard their thoughts as shameful, to such an extent that they see themselves as being undeserving of compassion or believe that no one would understand such thoughts (Gilbert et al., 2014). In addition, fears of compassion appear to exist in individuals who have experienced past abuse (Gilbert, 2009b). For example, some abuse survivors may feel triggered when faced with affection, rather than perceiving a caring person as a calming and reassuring source (Gilbert, 2009b). Self-compassion may also bring up adverse feelings for a person who experienced previous abuse, as the survivor might feel they are unworthy of compassion (Kirby et al., 2019).

Although fear may occur when extending compassion toward others, such fears appear less severe compared to fears of self-compassion and accepting compassion from others (Kirby et al., 2019). Kirby et al. (2019) found fears of compassion toward others were weaker in comparison to fears of self-compassion and accepting compassion from others. Self-compassion

and accepting compassion from others might be beneficial in suicide prevention some of the time. However, such strategies are not effective for every suicidal person, especially where fears of self-compassion or fears of accepting compassion from others exist. It is crucial, therefore, to gain an understanding of the other direction of compassion (i.e., compassion for others) and its potential role in decreasing suicidality.

Compassion Toward Others and its Relationship with Suicide Recovery

Compassion for others may not only improve relationships with others but may also increase personal well-being and decrease mental health concerns such as depression (Gilbert et al., 2014). However, studies connecting compassion for others and suicidality are few, making it unclear how the two aspects are related. Nonetheless, compassion for others appears beneficial to some aspects of mental health and well-being. For instance, compassion for others appears to ameliorate difficulties with self-esteem, loneliness, hopelessness, emotion regulation, and mental illness (Cosley et al., 2010; Hsiao et al., 2020; Jazaieri et al., 2013; Khanjani et al., 2019; Mongrain et al., 2011), all of which are risk factors for suicide in undergraduate students (Chatard et al., 2009; Jaiswal et al., 2016; Joiner et al., 2009; Law et al., 2015; Plancke et al., 2020).

Self-Esteem. Self-compassion is typically regarded in the literature as being distinct from self-esteem (Neff, 2011). Whereas self-esteem is a personal assessment of one's own worth (Neff, 2011), self-compassion is about extending kindness toward oneself regardless of perceived self-worth (Gilbert, 2009a; Neff, 2011). Self-compassion may be more important than self-esteem for fostering resilience, since self-compassion encourages self-care when faced with adversities (Leary et al., 2007; Neff, 2011). However, self-compassion and self-esteem are often

related, such that people who have high levels of self-compassion typically also have high self-esteem (Neff & Vonk, 2009).

In addition to self-compassion, practicing compassion toward others, even for as little as 5 minutes per day, may improve self-esteem (Mongrain et al., 2011). In a study conducted by Mongrain and colleagues (2011), undergraduate participants assigned to an experimental group practiced compassion toward another person between 5 and 15 minutes and described the experience in writing. Compared to a control group in which participants solely performed a neutral memory task, the experimental group exhibited a significant increase in self-esteem, even after 6-months post-test (Mongrain et al., 2011). The results suggest that the compassion exercise increased self-esteem by influencing the participants' view of themselves and their perceived value to society (Mongrain et al., 2011).

Previous research has also suggested that a positive relationship exists between compassion for others and self-esteem, and that such a relationship may decrease stress levels (Piferi & Lawler, 2006). For instance, in a sample of 96 undergraduate students who completed a number of personality, behavioural, and health measures, participants who self-reported high levels of socially supportive behaviours were also more likely to have lower levels of stress and lower blood pressure (Piferi & Lawler, 2006). Piferi and Lawler (2006) indicated that compassion for others may lower stress and blood pressure by increasing self-esteem and coping skills. Given that low self-esteem and excessive stress are risk factors for suicide in undergraduate students (Liu et al., 2019; Zafar et al., 2012), compassion for others may protect against suicidality. However, to my knowledge, no studies have explored the connection between compassion for others, self-esteem, and suicidality.

Social Connection. Social support, connection, and isolation have all been researched in relation to compassion for others (Cosley et al., 2010). For example, one study found that individuals who participated in prosocial behaviours, such as volunteering or donating money, expressed increased feelings of belonging (Huang et al., 2016). As suggested by Huang et al. (2016), an individual's desire to escape loneliness might drive them to connect with the community through being of service to others.

Similarly, Hutcherson et al. (2008) found that compassion for others decreased social isolation in a group of adult participants who practiced a brief, compassionate meditation toward a stranger. The participants disclosed increased feelings of connection and well-being, compared to the control condition. Conceivably, such a meditation may assist in regulating emotions and influencing ambition, thus, increasing well-being (Hutcherson et al., 2008).

In another study, 59 participants gave a short talk to two confederate strangers, who were either socially supportive or neutral (Cosley et al., 2010). The participants assigned to the social support condition experienced reduced stress levels and increased compassion toward the strangers (Cosley et al., 2010). It is possible that the experience of social support, even from strangers, may raise a person's compassion for others through perceived closeness (Cosley et al., 2010). Through strong, compassionate relationships, an individual might feel more comfortable reaching out to their supports for help, potentially buffering stressors (Cosley et al., 2010). This study, together with other studies noted above (e.g., Cosley et al., 2010; Huang et al., 2016; Hutcherson et al., 2008), highlight how compassion for others can increase a person's social connection. However, to my knowledge, no studies have considered compassion for others and its impact on social connection as a coping mechanism for suicide, especially for undergraduate students.

Hope. When experiencing compassion either from another, for another, or for oneself, feelings of hope toward one's life and future may emerge (Spandler & Stickley, 2011). Compassion and its positive correlates, including social connection and safety, appear to strengthen one's feelings of hope (Spandler & Stickley, 2011). Through hope, individuals may believe that their lives have greater purpose and meaning (Spanlder & Stickley, 2011). For instance, Guthrie et al. (2014) conducted a study in which teenaged participants mentored younger individuals. When acting compassionately toward their mentee, the teenagers disclosed increased feelings of hope. Specifically, the participants attributed the compassion that they felt toward their mentee to increased feelings of worthiness, purposefulness, and hopes of making a difference in another's life. However, no studies appear to cover the topics of compassion for others, hope, and their combined impact on suicide recovery.

Emotion Regulation. Some studies identify compassion for others as a possible means of regulating difficult emotions (Jazaieri et al., 2013). For example, in a study by Jazairi et al. (2013), adults completed compassion-based meditation classes and daily meditation practices, where the mindfulness meditation training focused on kindness toward the self and others. Post-intervention, participants reported less likelihood of suppressing emotions, as well as greater acceptance of negative emotions, when compared to the waitlist participants. Additionally, the treatment group reported an increased desire to prevent suffering in others. The relationship between compassion for others and emotion regulation may be explained by compassion's promotion of greater acceptance of all emotional states, making difficult situations appear less daunting (Jazaieri et al., 2013).

Engen and Singer (2015) provided evidence on how compassion toward others may increase activity in brain structures related to emotion regulation. In Engen and Singer's (2015)

study, compassionate meditation experts' brains were scanned while they practiced compassion toward a videotaped stranger in distress. The fMRI scans showed increased brain activity in the ventral striatum (a structure related to emotion regulation and positive emotions) in the participants while they practiced compassion (Engen & Singer, 2015). Although the studies conducted by Jazairi et al. (2013) and Engen and Singer (2015) provide evidence for regulating emotions using compassion for others, there is a lack of research on how compassion toward others may encourage suicidality recovery.

Mental Health. Compassion for others is commonly associated with better mental health and well-being (Gilbert, 2014). As evident in a study by McDonald et al. (2021), first responders who self-reported strong feelings of compassion for others were also more likely to report low dissociation and high contentment. The results suggest that compassion could be a possible protective factor, potentially mitigating the risk of burnout among first responders (McDonald et al., 2021). In another example, high levels of compassion for others were associated with lower anxiety and depressive feelings among undergraduate students (Chiesi et al., 2020). However, suicidality is missing from the research on compassion for others and mental health, and thus needs exploring.

Compassion-Based Interventions

Although there is a shortage of research on compassion for others as a protective factor in recovery from suicidality, some studies demonstrate the potential benefits of compassion-based interventions in suicide prevention (Asano & Shimizu, 2018). One such intervention is compassion-focused therapy (CFT; Gilbert, 2009a). CFT is grounded in Gilbert's (2009a) emotion regulation theory, which suggests that the human brain regulates emotions by balancing the threat/protection, resource-seeking, and warmth/contentment systems. However, when the

systems are unbalanced, and more feelings associated with the threat/protection or resource-seeking systems occur compared to warmth/contentment, mental health struggles may ensue (Gilbert, 2009a). A major goal of CFT is to assist clients in accessing their warmth/contentment system; consequently, clients learn to feel safe, calm, and content with others as well as themselves (Gilbert, 2009a). With frequent access to the warmth/contentment system, clients might also feel confident in their rational thinking, when used to combat intrusive thoughts (Gilbert, 2009a).

CFT has been shown to reduce suicidality in some populations (Daneshvar et al., 2020). For example, Daneshvar and colleagues (2020) conducted a study in which women diagnosed with post-traumatic stress disorder (PTSD) due to domestic violence participated in 8 sessions of CFT. After the intervention, the women reported reduced levels of suicidality as well as fewer cognitive distortions (defined as illogical thoughts in response to negative emotions), compared to a control group (Daneshvar et al., 2020). Daneshvar et al. (2020) argued that the participants in the experimental group learned to cope with stressors and difficult emotions using compassion, thus reducing distortions and suicidal thinking.

A CFT intervention was also successfully used to diminish suicidality in a sample of adults (Ogueji & Okoloba, 2020). The participants, who were previously diagnosed with HIV/AIDS, reported decreased levels of shame and suicidal feelings after a 14-week long CFT intervention, when compared to the control group (Ogueji & Okoloba, 2020). Ogueji and Okoloba (2020) suggested that compassion helped reduce the participants' shame levels, and ultimately, suicidality. Additionally, the intervention may have led to greater self-acceptance and self-compassion. Based on these results, Ogueji and Okoloba (2020) concluded that a CFT intervention could be a potential option for suicidal adults.

Some evidence also points to CFT as a feasible treatment option for undergraduate students (Fox et al., 2021). Fox and colleagues (2021) used a compassion-focused group intervention for undergraduate students experiencing self-criticism and shame. After the intervention, the participants showed significantly lower rates of shame, self-criticism, and mental health issues. Fox et al. (2021) attributed the success of the intervention to engagement with compassion (whether to the self, to others, or from others), leading to activation of the brain's warmth/contentment system. However, the use of a comparison group (e.g., a waitlist control) would have strengthened the results of the study. Additionally, the study did not assess if the compassion-focused intervention would be beneficial for undergraduate students experiencing suicidality.

Lastly, in one published case study, an adult with mental health issues reported decreased levels of depression and suicidal thoughts after thirteen sessions of CFT (Asano & Shimizu, 2018). Through techniques used to activate the warmth/contentment system, the client learned to approach their difficult emotions with compassion instead of criticism and shame, thus potentially making CFT a viable treatment for individuals with mental health issues (Asano & Shimizu, 2018). Asano and Shimizu (2018) also suggested that receiving compassion and directing compassion to others might lead to eventual self-compassion, which could also aid in reducing high levels of self-criticism.

The Present Study

Undergraduate students are individuals who commonly struggle with diminished self-esteem, social isolation, hopelessness, emotion dysregulation, and mental illness, all of which may contribute to the high suicide rate in this population (Chatard et al., 2009; Hames et al., 2018; Jaiswal et al., 2016; Law et al., 2015; Plancke et al., 2020). Given the high rate of suicidal

ideation and behaviours among undergraduates, researchers must strive to understand protective factors in preventing suicide. Compassion holds promise as a possible source of recovery for individuals experiencing suicidality (Cole-King et al., 2013; Gilbert, 2009a). Two directions of compassion flow, namely self-compassion and compassion from others, have been shown to reduce suicidality in some individuals (Cole-King et al., 2013; Kelliher-Rabon et al., 2017). However, fears of these directions of compassion are commonplace, making it difficult for some individuals to grasp and use to their benefit (Kirby et al., 2019). At present, little is known about the phenomenon of compassion toward others in relation to suicidality. Additionally, there is a lack of research on undergraduate students' experiences of compassion toward others, as an important aspect of students' suicidality recovery. However, the benefits of compassion for others appear to be inversely related to the psychological correlates of suicidality. Therefore, the purpose of the current research study is to explore the meaning and experience of compassion for others as it relates to recovery from suicidal ideations and behaviours in undergraduate students. I selected the qualitative approach of interpretative phenomenological analysis (IPA) to address this research gap and to develop an understanding of the phenomenon from the perspective of individuals who have experienced it. In the next chapter, I describe interpretative phenomenological analysis, as well as the methods I used to achieve my research aims.

Chapter 3: Methodology

Design

To accomplish my research aims, I used interpretative phenomenological analysis (IPA), as described by Smith et al. (2009). IPA is a qualitative methodology used to study meaning and lived experience in the context of psychological and social phenomena (Smith et al., 2009). IPA is built upon the theoretical assumptions of phenomenology, hermeneutics, and idiography. To help the reader gain a deeper understanding of IPA, I explain its philosophical foundations and their relevance to my study.

Phenomenology

Simply stated, phenomenology is the study of human experience (Smith et al., 2009). According to Smith et al. (2009), phenomenology focuses on significant personal experiences and how a person makes sense of experience on their own terms. Using phenomenology, researchers seek to understand the meaning of a specific experience of a specific participant.

Several philosophers have helped shape phenomenology. Often considered the father of phenomenology, Husserl's philosophy is based upon the deep understanding of one's own experience of a specific phenomenon, and what makes the experience particularly salient (Smith et al., 2009). In contrast to scientific approaches that attempt to explain phenomena in terms of previously established theory, Husserl encouraged *reflexivity* (Smith et al., 2009). Reflexivity is a method in which phenomenological researchers analyze their personal biases and attitudes, and how these beliefs may impact their understanding of another person's experience (Clancy, 2013). Using a *phenomenological attitude*, researchers endeavor to view the phenomenon from the perspectives of their participants (Allen-Collinson, 2011). Husserl suggested that phenomenologists practice *bracketing/epochē*, which involves setting aside one's knowledge on

a specific topic and attempting to understand the phenomenon solely through the eyes of the participant (Allen-Collinson, 2011).

Although opposing the emphasis on experimentalism in scientific research, Husserl asserted that phenomenology should still be considered scientific (Jennings, 1992). According to Husserl, a researcher should not perform an experiment on a phenomenon without first understanding its fundamental components (Jennings, 1992). Husserl insisted that researchers begin by studying an area of interest using a phenomenological approach before conducting a scientific experiment (Jennings, 1992).

Heidegger, on the other hand, moved away from an emphasis on bracketing toward a focus on interpretation (Smith et al., 2009). Heidegger's philosophical stance is based upon what he deemed as *being-in-the-world*, where each person interprets different aspects of the world based upon their personal views (McConnell-Henry et al., 2009). He asserted that objectivity and subjectivity cannot be separated, as each person understands each piece of the world from their unique position in the world (McConnell-Henry et al., 2009). In his stance on being-in-the-world, Heidegger differed from Husserl, insisting that researchers cannot fully disconnect from their world when attempting to understand another person's world (McConnell-Henry et al., 2009). Therefore, the researcher brings their perspectives and understanding of the world when engaging with participants' data, making the researcher a vital part of data analysis (McConnell-Henry et al., 2009).

Merleau-Ponty built upon Heidegger's philosophy of the individualized experience, whilst focusing on the importance of perception (Carman, 1999). Merleau-Ponty asserted that the body is the medium in which the world is understood (Carman, 1999). Therefore, perception

connects the world to the body, allowing humans to experience all aspects of their surroundings (Carman, 1999).

Sartre, another phenomenological philosopher, wrote on existentialism and the reality of the world (Jones, 2001). Specifically, Sartre hypothesized that ordinary objects and concepts become meaningless once all assumptions about the phenomenon are removed (Wardman, 1987). With his existential ideologies, Sartre believed humans to have a great deal more freedom than is often accepted by everyone (Jones, 2001). Without the barriers of societal rules and expectations, human beings have the freedom and opportunity to do, think, act, etc. in almost any way they wish (Jones, 2001).

Taken together, the works of phenomenological philosophers influence the work of an IPA researcher. Phenomenology allows the participant and the researcher to think about concepts in a way that goes beyond predefined theory and societal assumptions; rather, IPA researchers focus on meaning of experience, however the meaning is perceived by the individual (Jones, 2001; Smith et al., 2009). In attempting to view and interpret individuals' significant experiences in a way that matches the person's beliefs, researchers also attempt to give a backseat to other influences such as scientific categorization (Smith et al., 2009).

Hermeneutics

Hermeneutics, the next theoretical foundation of IPA, is where the methodology acquires its interpretative stance (Smith et al., 2009). Originally, hermeneutics was used to interpret classical writings, such as biblical texts (Kinsella, 2006). To properly understand a text, one cannot simply translate and read the text to comprehend its meaning. Rather, the reader must attempt to understand the author, the original audience, the use of language, and the historical context in which the text was written (Kinsella, 2006). Historically, a specific hermeneutic

technique would need to be applied depending on which type of text a reader was interpreting (Huang, 1996). In the 1800's, Schleiermacher created a universal hermeneutic technique applicable to any piece of writing (Huang, 1996). In his hermeneutic technique, Schleiermacher insisted upon grammatical and psychological interpretations, meaning the reader interprets the objective language while simultaneously interpreting the subjective thoughts of the writer (Huang, 1996). Therefore, using Schleiermacher's hermeneutics, the reader attempts to uncover the author's state of mind through their writing (Huang, 1996).

Heidegger also contributed to the hermeneutic methodology, in part through his elaboration on the concept of the *hermeneutic circle* (Gyollai, 2019). The hermeneutic circle is an interpretative technique in which the researcher constantly shifts between small and large meaning units to understand the meaning of all units (Gyollai, 2019). Small meaning units (e.g., a word) can only have meaning when applied to a large meaning unit (e.g., a sentence; Gyollai, 2019). However, the large meaning unit only has meaning because of its small meaning units that make up the large unit. Heidegger also insisted that human beings interpret meaning units within the context in which they exist (Gyollai, 2019). Therefore, in keeping with Heidegger's notion of the hermeneutic circle, the researcher circulates between the parts, the whole, and the context to interpret the phenomena of interest (Gyollai, 2019). In IPA, for example, the researcher reads through the entire text several times while searching for specific meaning units; next, the researcher codes small units of data, while also ensuring the codes fit with the whole text (Smith et al., 2009).

Gadamer expanded on Heidegger's hermeneutical philosophy, indicating that a text can withstand several different interpretations; however, each interpretation holds a truth (Dobrosavljev, 2002). Gadamer did not believe in absolute knowledge; instead, interpretation is

based upon the individual (Dobrosavljev, 2002). For example, a text, translated into a new language by a specific individual sustains an interpretation not the same as if it were translated into a different language by a different individual (Dobrosavljev, 2002). Nonetheless, the interpretation is valid.

These philosophical underpinnings join to create a vital aspect of IPA research: the *double hermeneutic* (Smith et al., 2009). A concept originally developed by sociologist Anthony Giddens (1984), the double hermeneutic is described as a dual interpretation, where a person interprets their perception of the world, while at the same time, researchers attempt to interpret a person's attitudes and perception of the world. The double hermeneutic occurs in social sciences, as opposed to natural sciences (McKemmish et al., 2012). Natural scientists try to understand a natural phenomenon (e.g., a chemical reaction), whereas the phenomenon cannot develop an understanding of the scientist (McKemmish et al., 2012). In contrast, social scientists often study people, whose understanding of their environment make up the research area of interest (McKemmish et al., 2012). Whilst using IPA and engaging with participant data, the researcher attempts to understand what the participant is attempting to understand of a significant event (Smith et al., 2009). In practice, the researcher might offer an interpretation of a participant's experience not achievable without access to other participants' data, previous research, and the participant's own interpretation of the experience (Smith et al., 2009).

Idiography

According to Smith et al. (2009), "idiography is concerned with the particular'' (p. 31). This is in contrast to a nomothetic approach, which is defined as an inclination to provide generalizations about a given phenomenon (Beltz et al., 2016). Beltz et al. (2016) stated that idiographic approaches tend toward subjectivity, whereas nomothetic approaches tend toward

objectivity. Idiography is central to IPA, as researchers seek to understand how a specific experience is perceived by a specific individual or group of individuals (Smith et al., 2009). This approach allows researchers to learn detailed accounts of specific experiences, which are usually not captured when using a nomothetic approach (Noon, 2018). Through idiography, IPA goes beyond categorical understandings of phenomena; researchers potentially grasp an understanding of the experience of a specific phenomenon (Noon, 2018).

Using an idiographic approach, each case is studied in detail, resulting in rich, thick interpretations of participants' experiences (Smith et al., 2009). To achieve these detailed descriptions of the phenomena of interest, researchers use a purposeful sampling approach (Smith et al., 2009). In addition, an IPA researcher often chooses a small sample so the researcher can spend time with each individual case, gaining a deep understanding of each participant's experience with the phenomena (Smith et al., 2009). Although IPA eventually moves from a specific case to patterns across all cases, these subtleties of each individual are still vital and considered in the findings (Smith et al., 2009).

Participant Characteristics

Six individuals participated in my study. I chose a small sample size in accordance with typical IPA procedures, so that I could focus on thoroughly understanding each participant's experience, as well as gaining an in-depth understanding of common patterns across participants (Smith et al., 2009). All of the participants were current undergraduate students; one was a first-year student, one was in their second year, three were third-year students, and one was in the fourth year of their undergraduate program. The participants were between the ages of 18 years and 25 years (mean age = 20 years). Two participants self-identified as male, and four self-identified as female. The self-identified ethnic/cultural backgrounds of participants were

Mexican, West Asian, Hispanic, Jewish, East Indian, and Middle Eastern. One participant was an international student, while the remaining 5 participants were from Canada.

Recruitment

Prior to recruitment, this study was reviewed and approved by the Research Ethics Board at the University of Alberta. Recruitment took place between June 17th, 2020, and August 19th, 2020. All participants were recruited from the University of Alberta. I recruited participants using the University of Alberta's undergraduate Listserv and the University's Undergraduate Research Initiative Facebook page. Individuals who were interested in participating in the study were invited to contact me via email (see advertisement in Appendices A, B, and C). I replied to interested participants via email with the study information and consent form (See Appendices D and E) and a description of the participation inclusion criteria. For participants who indicated that they met the inclusion criteria and who confirmed their interest in participating in the study, I asked them to sign the consent form and send it back to me electronically. After obtaining consent, we arranged a date and time to conduct the interview. I received 17 more requests from undergraduate students interested in participating in the study than I was able to interview, given the need to maintain a small sample.

Procedure

Individual semi-structured interviews took place between June 23rd, 2020, and August 31st, 2020. Due to the COVID-19 pandemic, all interviews were conducted remotely, either via telephone, or the video conferencing website doxy.me. Doxy.me is a platform designed for health practitioners to connect with their patients and clients securely and privately. I conducted the interviews from home in a quiet, private location where confidentiality could be protected. For online interviews, I emailed participants a link to doxy.me ahead of the interview.

Alternatively, if the participant opted to meet via telephone, I called the participant on the agreed-upon date and time.

I began the interview by introducing myself to the participant. I then asked all participants if I could audio-record the interview; all participants consented to being recorded. Before I began asking the interview questions, I briefly re-explained the purpose of my study to the participant, including the estimated length of the interview. Additionally, I assured the participant that they were not obligated to participate in the interview and could withdraw from the study at any time without penalty. Lastly, I explained that all information would remain confidential, the participant's name would be replaced with a pseudonym, and any identifying or potentially identifying information will be excluded from the interview transcript. I then gave the participants an opportunity to ask questions before I began asking the interview questions.

The interview consisted of five main questions and seven sub-questions. The questions were primarily open-ended questions in which I asked each participant to describe their experience of compassion for others and the impact it had on their recovery from suicidality (see Appendix F). To gain as much detail as possible, I probed the participants throughout the interview, using questions such as, "Can you explain what you mean by that?", "Can you discuss more about this?", "Is there anything else you can say about that?", etc. (Smith et al., 2009). The main interview lasted between 20 minutes and 81 minutes (M = 42 minutes).

Immediately following the interview, I sent the participant a demographics form to fill out and send back to me electronically (see Appendix G), a list of counselling referrals (if the participant was interested; see Appendix H), and an electronic $25.00 gift card to either Starbucks or Tim Horton's. Next, I transcribed each interview, ensuring I excluded or changed any identifying or potentially identifying information. Simultaneously, I created a list of follow-

up questions so I could understand the participant's experience in more detail. I completed the transcription within one week of the interview. I then emailed the participant a copy of their transcript to review for accuracy and completeness. The participant and I also scheduled a follow-up interview within a two-week timeframe and met again either via doxy.me or telephone. The participant had the opportunity to discuss any information they deemed necessary and ask any questions, and I asked my follow-up questions. Finally, I thanked the participant for their time and willingness to share their experiences. The follow up interview lasted between 12 minutes and 35 minutes (M = 20 minutes).

Data Analysis

Throughout data analysis, I relied on IPA guidelines as suggested by Smith and colleagues (Pietkiewicz & Smith, 2014; Smith et al., 2009; Smith & Shinebourne, 2007), and Larkin et al. (2006). In accordance with the theoretical underpinnings and methodology of IPA, I strove to uncover themes both within cases and across cases, while still incorporating the nuances specific to each individual. To achieve this aim, I began by transcribing each interview verbatim. Simultaneously, I captured subtleties such as pauses, emphases, and laughter. I then listened to the audio-recording of the interview while reading and rereading each interview transcript one at a time. Rereading the interviews allowed me to understand each participant's individuality, moving from general tones to nuances. Whilst listening to the interview and rereading the transcript, I wrote memos. Smith et al. (2009) encourage IPA researchers write memos in different ways, suggesting three focal points: descriptive, linguistic, and conceptual. Descriptive memos are recordings of significant words, expressions, or remarks, and are usually considered basic level memos. Therefore, during my first pass through the transcripts, I captured descriptions of the participant's experience without great depth. During the next readthrough, I

wrote linguistic memos, which Smith et al. (2009) consider to be comments focused on the way the participant uses language. I paid attention to language use such as figures of speech, laughter, tone and expressiveness of voice, and so on. Linguistic comments helped connect my descriptive memos to my conceptual memos. Conceptual memos, which I wrote during the following readthrough, are especially interpretative (Smith et al., 2009). These memos allowed me to comment on how I understood the participant's understanding of the phenomena, which led me to the process of coding. This entailed coding the transcript at a low level of abstraction, ensuring that I kept my research question at the forefront of my consciousness while taking heed of each participant's individual interpretation of the phenomena. During this process, I meticulously read through the transcript again, and assigned codes to meaningful excerpts. Some codes were also used for other pieces of data if they fit, while some code stood alone. To help organize coding, I used the qualitative data analysis software Atlas.ti, version 8.4.4 (Scientific Software, 2019). After coding the transcript, I engaged in peer review sessions with my supervisor, in which we ensured the codes were aptly named and fit with the data.

Once I established the codes for the transcript, and they were approved by my supervisor, I began clustering the codes into initial themes. A code was grouped into a theme if it was conceptually comparable or related to other codes. During this stage, a small number of codes were excluded if they did not appear to be part of a specific pattern or theme. After I completed clustering the codes into themes, I again participated in peer review sessions with my supervisor who helped me develop strong, well-founded themes.

I repeated the same process (i.e., memos, codes, and initial themes) for the remainder of the interviews. Once I established the initial themes for all six transcripts, I progressed to searching for thematic patterns across all cases. I took all initial themes from the participants,

and clustered similar themes together to become superordinate themes. A theme only became superordinate if it appeared in at least half of the interviews. While creating the themes, I wrote conceptual memos about the participants' experiences related to each theme, as well as the phenomena in general.

Lastly, I wrote my findings, which is a key aspect of IPA data analysis (Pietkiewicz & Smith, 2014). I began by writing vignettes for each participant, explaining their individual experience with the phenomenon. I then wrote detailed accounts of each superordinate theme, ensuring to incorporate individual interpretations of the experienced phenomena. I included quotations from the participants as evidence for the patterns. After completing my writeup, I engaged in peer review with my supervisor again to help ensure that the themes fit the participant data and answered my research question.

Establishment of Trustworthiness

Trustworthiness, defined as the extent to which investigators can assure quality of their research, must be established throughout data collection and analysis (Creswell & Poth, 2018). To maximize trustworthiness, I used several methods, including reflexivity, bracketing, memoing, member checking, peer review, audit trails, and thick descriptions (Chan et al., 2013; Creswell & Poth, 2018; Larkin & Thompson, 2011; Smith et al., 2009) as described below.

In accordance with the phenomenological philosophy of IPA, I attempted to minimize the impact of my prior assumptions on my interpretation of the data through bracketing. I practiced reflexivity and bracketing using multiple strategies. These strategies included staying consciously awareness of my biases, beliefs, and previous exposure to the literature while engaging with the participants and their data. If at any time my focus shifted away from the participant and toward my own experiences and interests, I would step away from the data, only

returning once I was ready to engage hermeneutically with the data again (see Chan et al., 2013 and Larkin & Thompson, 2011). In addition, I kept memos of my interpretations of the participants' experiences, so I could reflect on how my biases might be appearing in the interpretations. Lastly, I conducted a peer review in which my supervisor assisted me in refining my codes and themes and helped ensure that my interpretations fit the data.

In addition to reflexivity, qualitative research often stresses the importance of *member checking*, which involves asking for participant feedback throughout data collection and analysis to ensure accuracy (Creswell & Poth, 2018). As mentioned above, I engaged in member checking by first sending the participants their transcripts for their review. In addition, I conducted follow-up interviews with each participant, to clarify my understanding from the first interview. To maximize transferability, or the level to which the findings can be applied to other populations, I also wrote thick, rich explanations of each theme, including excerpts from participant transcripts.

Finally, I kept an audit trail of my work and decisions throughout the process, such as keeping track of all versions of memos, codes, and preliminary themes in the order I created them. I also kept a log of all changes I made during and after peer review (Carcary, 2009). Additionally, I continually reflected on my decision making, while keeping track of how I refined my thinking throughout the research process.

Ethical Considerations

Several efforts were made to ensure that my study was ethical in nature and protected participants from harm. Before I recruited participants, I considered the possibility of short-term distress when recalling and discussing previous suicidality. Therefore, one of the inclusion criteria for my study was based on ethical considerations, as participants had to be free of

suicidal thoughts and behaviours for at least one year (Baiden & Fuller-Thomson, 2016). Before I began interviewing the participants, I reiterated that their participation was voluntary and withdrawal from the study was possible at any time without penalty. Throughout the interview, I watched for any signs of distress from the participants. Additionally, my supervisor, who is a Registered Psychologist, was available for consultation when necessary. I also offered the participants a list of counselling referrals. When transcribing the interviews, I changed any identifying or potentially identifying information and used pseudonyms in place of participants' real names. I also assigned each participant a number for their consent form, which was kept separately from their interview transcripts. Lastly, I kept all documents on a password-protected, encrypted computer.

Chapter 4: Findings

I begin this chapter by introducing each participant through a brief vignette. These individual vignettes help capture the idiographic nature of each participant's experience. In the subsequent section, I describe the six superordinate themes that surfaced from data analysis across participants. The descriptions of each theme are accompanied by excerpts from the interviews, as evidence of the pattern (Smith et al., 2009). I have used pseudonyms for each participant and have masked all identifying information.

Participant Vignettes

Jane

Jane was a cisgender female in her late teens, and from a West Asian background. A few years prior to our interview, Jane was hospitalized due to suicidality. During her short stay at the hospital, she realized just how important compassion for others was to her well-being. When she was hospitalized, Jane began a friendship with a woman who was also a patient in the same unit. Jane explained that she and her friend "kept each other in check" regarding suicidality: "We were more focused on recovering together." Once discharged from the hospital, the women agreed to text each other any time they felt suicidal, and they would "ditch [their] friends and hang out and fix it." Jane appreciated her mutually compassionate relationship with her friend, describing the pair as having "unspoken boundaries and trust." They knew what could and could not be said or done within the bounds of their relationship. For instance, they were aware of what not to talk about and what not to share with others.

Although Jane originally used her friendship as a distraction from suicidal thoughts, she eventually felt responsible for her friend's well-being. Jane's sense of responsibility then motivated her to model healthy coping strategies for her friend. From Jane's perspective, serving

as a role model was important because she felt accountable for her friend's safety. Jane worried that her unhealthy behaviours would give her friend permission to imitate them. Therefore, when tempted to engage in suicidal behaviours, Jane chose healthy coping mechanisms instead. Inadvertently, the habits Jane exhibited to her friend became habits of her own. Speaking about her experience, Jane felt pleasantly surprised by her recovery: "I'm actually quite happy…that it ended up like that because if I wasn't inclined to be a role model, then I'm not sure if I would've recovered the same way that I did. And I recovered pretty well."

Jane eventually started extending compassion toward other people in addition to her friend. However, Jane explained that compassion was easier to give to those who, like herself, had also experienced suicidality. Furthermore, compassion *from* others felt more sincere from people with similar experiences. Jane described her experience discussing suicidality with people who did not understand what it meant to be suicidal:

> With a lot of other people, you can't just talk about it, because they're like, '*gasp*! Oh my god, are you okay? I'm sorry if I did something'…It feels fake…They also don't know what to do and they've never dealt with it before so they're just like, surprised.

With such reactions, Jane felt more comfortable with friends who had previously dealt with suicidality. Accordingly, Jane defined compassion as caring for someone who has "similar experiences or seeing something of yourself in them."

Skye

Skye was a cisgender woman in her late teens, from an East Indian background. Compassion for others became meaningful to her when her brother was experiencing mental health issues that Skye deemed "were a lot worse than" hers. While helping her brother, she put his needs above her own "even if [she] wasn't feeling well." Her compassionate acts ranged from

what Skye called “small,” such as making her brother breakfast or buying him his favourite food, to more substantial acts, like listening to her brother’s worries, despite them being “toxic” to her. Over time, Skye observed her brother’s mental health gradually improve. Based on her compassionate behaviour toward her brother, Skye believed she had made a difference in his life. Skye began to feel greater self-worth, as she saw her life as being valuable and meaningful to others.

During her struggles with suicidality, Skye had a pessimistic view of herself and others. She believed that her actions were inconsequential and that others had ulterior motives for being her friend. However, as she began to increasingly extend compassion toward others, Skye’s views became more optimistic. She had a newfound appreciation and gratitude for her life. As her suicidality became to subside when helping her brother, Skye decided to expand her compassion to others in her life, such as her boyfriend and parents. Over time, Skye’s compassion broadened to friends, acquaintances, and even strangers. Skye believed that compassion toward others had the greatest effect on her mental health, compared to medication and counselling. Compassion also helped Skye become more mindful and emotionally regulated, with her realizing that “not everything’s about me and not everything’s such a big deal.”

Throughout her recovery, Skye learned when she needed to limit her compassion for others in order to care for herself. For example, she experienced times when she wanted to “keep myself distracted and happy about things, [but] had to listen [to others] being depressed like over and over.” Although Skye did believe these experiences were neither positive nor negative, “it didn’t help [in my recovery], that’s for sure.”

Holleigh

Holleigh was a cisgender female student of Hispanic descent and who was in her late teens at the time of the interview. For Holleigh, family always came first. Therefore, before her recovery from suicidality, Holleigh was motivated to help her family members in any way possible. For example, when her family first moved to Canada, Holleigh would stay awake into the early hours of the night listening to her sister's problems. Additionally, Holleigh spent time with her mother, helping her learn English. Holleigh stated that such actions made her feel "useful" and helped her recognize how she could positively contribute to others' lives.

Practicing compassion for others helped Holleigh feel worthy, especially since Holleigh struggled with her own self-worth: "I felt that nothing I did mattered. You could cut out the part of the room I was in, and nobody would notice or care. It wouldn't even mean anything." Given the positive impact of compassion on her feelings of worthiness, Holleigh looked for other opportunities to express compassion. For example, in addition to showing compassion to members of her family, she extended compassion to friends and also to strangers. She also found a love for volunteering and chose a major in university she could use to help individuals in her community.

As her compassion grew, Holleigh noticed her relationships strengthen. However, she observed that her strongest relationships were those where compassion was mutual, or at the very least, where the other person showed appreciation to her: "It feels better to help someone that actually…is thankful…They don't even have to do anything back…They just have to be thankful or show their appreciation."

Although compassion facilitated Holleigh's recovery from suicidality, she struggled to accept compassion from others. While Holleigh was happy to help other people, she did not necessarily believe that she deserved the same kindness, as her issues might cause others pain:

"If it's going to burden them… [I do] not want to say something that…could be harmful, because I would be hurting them." Despite feeling apprehensive about speaking with others about her issues, she recognized that talking to others would likely help her, while staying quiet was "detrimental" to her mental health.

Jessie

Jessie was a cisgender female in her early twenties, who self-identified as Mexican. Throughout Jessie's adolescent and adult life, she maintained a close group of friends. Jessie and her friends shared in common mental health issues and experiences with suicidality. When one of her friends experienced a crisis, Jessie did everything she could to help them, including "setting up alarms to check on them throughout the night." Jessie would also show her friends compassion in situations not specific to mental health, such as helping friends with schoolwork. Jessie appreciated others' expressions of gratitude toward her, especially when her friends acknowledged her compassion. She saw gratitude as a sign that her efforts were helpful to others, whether Jessie was assisting in a crisis or not. With her growing awareness of how she could make a difference in others' lives, she began viewing her life as having purpose.

Throughout her recovery, Jessie's suicidality lessened with multiple small acts of compassion. Small acts included purchasing items from small businesses, donating money, picking up someone's dropped belonging, and so on. In one example, Jessie spoke with a customer who came into her workplace "under the influence." Despite the stranger's state, Jessie acted compassionately toward him, helping him feel heard and understood. She explained she was glad the customer chose to approach her, because "maybe…if they had gone to a different place, they wouldn't have been treated the same. So, I tried to have like, even if it's very, very

small, a positive impact, and just be kind." Although Jessie described the event as small, it nonetheless positively impacted her, and stuck out in her mind as meaningful:

> It feels nice,.…I guess a rewarding feeling, knowing that you don't know this person, but you were able to help even if it's in a really small way. And maybe they won't remember you, but you remember them, and you remember the situation.

Although expressing compassion for others was helpful to Jessie in many ways, she experienced some difficulties, including emotional exhaustion. Jessie described having compassion for others as "hard" at times, especially when she could not take a break from her friend's mental health issues. When speaking about the impact of her emotional exhaustion, Jessie stated it "brought down my mood…listening to someone feel like that and being so hopeless; it affected me in a way like, they're always gonna feel like this like, I can't do anything."

Flynn

Flynn was a cisgender male in his early twenties. He was an international student from a Middle Eastern background. Thinking back to darker times, Flynn recalled a life-changing event. Late one night, he ran into an acquaintance who seemed unusually despondent. Flynn decided to ask her if she needed help. Upon asking, she informed him that she was experiencing something similar to his own issues: she was struggling academically due to suicidal thoughts. Flynn felt compelled to help her and assisted her in getting back on track with her coursework. For example, Flynn woke up early on numerous occasions to ensure that she attended her morning classes. As the relationship deepened into a friendship, Flynn experienced several feelings that he believed were helpful in his recovery. First, helping his friend made Flynn "feel good," as he watched her succeed and understood that he was a part of her success. He also felt responsible to

stay alive, as his friend relied on him. Lastly, he felt influenced by her: "It…made me start thinking…she had it worse and she's also still hanging in there."

The friendship was one of the first opportunities where Flynn felt he could be open about his mental health struggles. Flynn described how he was previously hesitant to discuss his issues because of the influence of gender stereotypes: "I never felt like I should talk about it because I remember the first time I tried,…it's the whole response like, man up, you're a *guy*, you need to be *better* at this." Through compassion for others, Flynn recognized such clichés as untrue. Additionally, he acknowledged that by being open about his past suicidality, he could assist others in their mental health journeys. Flynn no longer felt ashamed about his previous mental health issues. Instead, he voiced his experience with pride, in hopes that his friends would feel comfortable discussing their problems with him. As compassion for others helped Flynn move past his shame, he also noticed a shift in his relationships with others. For example, compassion gave Flynn "an opportunity to meet new people, make new friends," and "strengthen [current] relationships."

Flynn's perspectives also shifted while recovering from suicidality. He realized that difficult emotions were inevitable in life, and he understood that they would not last forever. He also continued to recognize pain in others and offered them support where possible. Additionally, Flynn's compassion journey helped him discover a passion for volunteering, as well as finding a new university major more in line with his values.

Compassion for others, for the most part, helped Flynn recover from depression and suicidality. However, Flynn recalled a time when compassion had the opposite effect on his mental health. Speaking about a relationship with a "toxic" ex-partner, Flynn believed that his compassion had been taken advantage of: "I think one of the main reasons why I [became

suicidal] was because I was being compassionate for someone, and it turned out that person was just…manipulative." Although compassion had a negative impact on Flynn's life at one point, it did not stop him from expressing compassion to others during and after his recovery. Fortunately for Flynn, compassion had a positive impact on his mental health when directed at appreciative and kind people.

Todd

Todd was a cisgender male in his mid-twenties, who self-identified as Jewish. From Todd's perspective, compassion had a "surprisingly" helpful impact on his suicidality recovery. During a period of suicidality in his life, Todd offered to drive his partner's father to a surgical appointment. What was originally meant as a favor became a turning point for Todd. Throughout the car ride, Todd witnessed his partner's father being in "excruciating" pain. Todd then realized that he was not the only person enduring adversities. As he became more acquainted with his partner's father, Todd's feelings toward the favor also began to shift. Driving his partner's father to the appointment may have been a burden to Todd initially; however, the favor transpired into an "enjoyable experience." Instead of feeling inconvenienced by the favor, Todd felt joyful, a feeling he had lacked for some time. Todd described the event as "a nice break from my own emotional turmoil and just being able to help someone else, just kind of lifted my mood."

Because Todd's depression and suicidality lessened after expressing compassion in one situation, he decided to "[make] more of an effort to reach out to other people." Such efforts further solidified the effectiveness of compassion for others on his recovery. He learned about his preference for being around friends, especially when he could help them with their issues. Through compassion, Todd also learned that many of his friends were facing difficulties, just as he was.

As Todd's compassion for others became more consistent, he observed several social benefits. For example, Todd noticed an increase in his social engagements with others, pulling him out of isolation. Additionally, compassion helped him attend more to others. With his new lens, Todd focused less on his own issues:

> It's made me more receptive to want to help people, not just focusing on my needs only, so whether that is cooking my family meals in the morning or just doing a chore for them if they have something else that's more pressing. So just being more mindful of what other people need.

Lastly, compassion helped Todd realize that there was strength in vulnerability. Although frightening, Todd stepped out of his comfort zone and felt proud for doing so: "[It's] very empowering and eye opening because I think it takes a certain level of maturity to kind of look at yourself and realize that what you're doing isn't the best option and you can do something better." Whereas shame had previously held back his recovery, Todd no longer felt ashamed of his struggles.

Common Themes

Across the participants, six superordinate themes emerged: sense of purpose through making a difference in others' lives; reciprocity; positive self-concept; non-judgement and acceptance; social connection; and the cost of compassion. Although some themes relate to each other, each theme represents a distinct aspect of participants' experiences. Table 1 illustrates the occurrence of each central theme across all participants.

Sense of Purpose Through Making a Different in Others' Lives

Table 1

Superordinate Themes

Participant	Sense of purpose through making a difference in others' lives	Reciprocity	Positive self-concept	Non-judgement and acceptance	Social connection	The cost of compassion
Jane	•	•	•	•		
Skye	•		•	•	•	•
Holleigh	•	•		•	•	•
Jessie	•	•	•		•	•
Flynn	•	•	•		•	•
Todd		•		•	•	

According to most participants, having compassion for others helped participants find a sense of purpose, thus reducing their desire for suicide. For most participants, a sense of purpose manifested through reflecting on how their potential death through suicide would affect people that they cared about. In other words, if the participants ended their lives, the individuals left behind would be negatively impacted. In most cases, the participants gained a sense of purpose after experiencing how their support improved others' lives. For example, when Skye, Flynn, and Jessie began expressing compassion for other people, they recognized their own importance in the lives of others. As Skye stated, in describing the impact of helping her brother,

> I was able to do something for somebody, and…what I did meant something to somebody else, or like, there was some point of being alive. At that point what I thought [was] that somebody would care if I wasn't.

In Flynn's case, a reason for staying alive developed while helping his friend with her depression and academic difficulties. Being one of the only people who knew of his friend's situation, Flynn felt "very responsible" to help her overcome her issues. His increased feelings of compassion and responsibility for his friend helped him establish a reason to stay alive.

When Jessie was suicidal, she imagined others thought of her presence as a burden: "When you're…not in a good place…you just think, 'oh, people are better off without me, you don't need me,' that type of thing… 'Why am I doing this…I'm making their lives worse.'" With compassion, however, Jessie saw past her suicidal thoughts. When she experienced the effects that her compassion had on other people, she realized her importance in others' lives: "Helping others and [being] actually able to help them in a way, it just helps you realize, oh, maybe I'm making a positive impact on their life." As evidenced by the above, having compassion for others helped many participants understand their value in the lives of others, which led to feelings of purpose.

Holleigh experienced similar realizations, which manifested as hope. When she was suicidal, Holleigh considered what her absence would mean to others. After recognizing that she made a difference in her family's lives, she began considering her life as having purpose. Even when Holleigh was not actively compassionate, she still held onto her purpose, which helped her find hope:

> The way I rationalize that is maybe you're not doing anything for anyone right now, but just because you're not doing that right now doesn't mean that you will not in the future…Like, if you choose to just disappear and then five years down the road there's someone that you could have helped if you had stuck around…You don't know what the future has in store.

Thinking retrospectively, Holleigh wished someone would have acted compassionately toward her when she was suicidal. Instead of succumbing to suicide, Holleigh instead accepted the responsibility of being a helpful person to those people struggling. Through her newfound hope, Holleigh found her reason for "stick[ing] around": to help others.

Jane, on the other hand, felt grateful for her past suicidality. Using compassion and her experience with suicidal thoughts and behaviours, she found a role for herself as a helper in her group of friends. She continually used a kind and compassionate approach when her friends struggled with mental health issues. Jane recognized that had she not been suicidal in the past, she might not have known how to approach a person experiencing suicidality, or how best to help them in their situation. However, with her experience, she knew to approach such situations with compassion and warmth. In doing so, Jane helped saved the lives of others, allowing her to gain a purpose.

Reciprocity

All participants described events in which they first initiated compassion for another while also experiencing suicidality. However, most participants also received compassion back, which further facilitated their recovery. For some participants, giving and receiving compassion happened simultaneously in their relationships. That is, the participants built relationships based upon mutual compassion. Not only did mutual compassion strengthen the participants' relationships, but it also reduced their desire for suicide. For example, Jane and her friend both wanted the best for each other, meaning they would attempt to mitigate each other's suffering in any way they could. According to Jane, she and her friend "were both really invested in each other's lives,…we…made decisions based on each other. I would do something for the sake of her, and she would do something for the sake of me." In Jane's opinion, mutual compassion and kindness helped "push aside intrusive suicidal thoughts" for both women.

Jessie recalled a similar experience with her friends. Given her reputation of being a compassionate person, Jessie's friends relied on her to assist them with their personal distress. At the same time, Jessie was drawn to her friends due to their compassionate natures. The mutual

compassion between Jessie and her friends helped establish trusting relationships, where all parties felt "supported." Regarding her recovery, Jessie described increased feelings of contentment, especially knowing that others relied on her and she could rely on them: "It feels nice…, reassuring like, you have people that you want to be in your life… forever…These are my people…who I want to share my life with." For both Jessie and Jane, reciprocity of compassion enhanced feelings of support and warmth, thus lessening suicidality. Knowing that others stood behind them made the future less daunting.

In some cases, participants' expressions of compassion toward others were met with unexpected compassion back from these individuals. For example, Flynn supported his friend through a mental health crisis, including helping her get back on track academically. Flynn recognized that his friend's issues were "worse" than his, and he helped her in the best way he saw fit. Despite her struggles, Flynn's friend offered compassion back through listening, encouragement, and giving useful advice. Once Flynn experienced compassion from his friend, he recognized the necessity of having caring individuals in his corner, especially while enduring mental health issues. Throughout the development of his friendship, Flynn benefitted from the mutual give and take of compassion.

Likewise, Todd experienced benefits from mutual compassion after first expressing compassion to his friends. After helping his partner's father, Todd decided to revive some neglected friendships by offering his friends kindness and support. Although difficult to step outside of his comfort zone and be the first to initiate such conversations, Todd experienced benefits beyond his expectations. While rekindling his friendships, Todd also received support and encouragement from his friends:

> Through talking with other people, they're kind of reiterating how like, what I'm going through is transitory, and once I find the program that I really enjoy…I'm going to enjoy school better, I'm going see life in a better way.

Whether the participants experienced mutual compassion from the beginning, or reciprocity of compassion came later and unexpectedly, it helped the participants overcome suicidality. Knowing other people cared enough about them to express genuine compassion gave the participants a reason to stay alive.

Positive Self-Concept

Along with experiencing a heightened sense of purpose while acting compassionately for others, participants also saw a shift in their self-concept and identity. For example, some participants expressed being a helper as a core part of their identity. In Flynn's case, he saw a change in his beliefs about himself when he was acting compassionately toward others. When Flynn first experienced mental health issues, he felt much shame. Through compassion for others, however, Flynn discovered that some of his friends also struggled with depression and suicidality; and he began to self-identify as someone who could help. Often, just speaking openly about his suicidality was enough to make Flynn's friends feel safe around him. Gradually, through acts of compassion toward his friends, Flynn's shame began to subside and was replaced by a sense of pride because he could help others in such a profound way. Having the ability to help others through their mental health issues became a part of who Flynn was as a person: "If you need help…if something happens, you know, I'm that guy, and I feel like I always take pride in that."

When Skye was suicidal, she often blamed herself for the suffering she experienced. In many instances, any unpleasant event and the self-blame that ensued would push Skye into

feeling suicidal. When Skye began practicing compassion for others, however, she started noticing the positive qualities that she possessed. For example, she recognized qualities of kindness in herself, and how she could use kindness to make a difference in others' lives. In one instance, Skye explained how her kindness impacted her relationships with individuals at her work: "When I saw [children at her workplace] who were having a bad day… start smiling and talking to me or start connecting with me…and next time they would come to me for help,…it just seemed like they trusted me more." In addition to self-identifying as a kind person, Skye found she had more tolerance for hardship, with misfortunes no longer shaking her beliefs about herself:

> Before, if I had a fight with one of my friends or something then I'd just be like, oh I'm not a likeable person…Now it's just like, okay, we're just different, it's not gonna work out or whatever. Like I don't really care as much.

Similar to Skye, Jessie also found a part of her identity in compassion. When practicing compassion, Jessie began noticing others' reactions to her kindness and support. For example, Jessie's friends and acquaintances "open[ed] up" when around her and would express their gratitude toward her. As individuals in Jessie's life viewed her as kind-hearted, Jessie began believing that she was indeed a kind person. Additionally, Jessie's self-esteem improved, knowing she was a person who could positively impact the lives of others.

Non-Judgement and Acceptance

Several participants discussed how compassion for others helped them find a path of non-judgement and acceptance of others. Jane, for example, noticed a shift in herself, where she went from being a "very judgmental person" to approaching others with empathy. As Jane became more compassionate, she also developed a sense of openness toward others. Instead of judging

someone based on a previous opinion held by her, Jane tended to give them the benefit of the doubt and offer kindness instead.

Jane discussed how compassion helped her tune into others' emotions. Because Jane had also struggled with psychological distress, she could sense when others were "masking their mental health." Jane's awareness of others' feelings allowed her to let go of preconceived opinions; and instead, she approached everyone without judgement. Her acceptance not only improved Jane's relationships with others, but also helped her find a sense of inner peace.

Skye had a similar journey when it came to non-judgement of others. When Skye was suicidal, she had a negative view of other people's' motives and intentions. Once Skye began practicing more compassion toward others, she learned that her judgements were often misguided. For example, Skye learned firsthand how a mental health crisis negatively impacted her brother's well-being. Although her brother's crisis was emotionally difficult on her, Skye chose to act compassionately toward him instead of judging him. In doing so, she helped in his process of recovery. Subsequently, Skye decided to start approaching each person with kindness, to positively impact their lives as well. As a result, Skye's automatic judgements of others started to diminish. Instead of thinking negatively of others, Skye enjoyed being around people. For example, she enjoyed going to work, where she could offer assistance, or even just a smile. In Skye's opinion, "if saying a few words can make someone's day better, why not?"

In the case of Holleigh, compassion for others generated greater self-acceptance. When Holleigh was suicidal, she was quite judgmental toward herself. Once she became more compassionate, she noticed that she acted kindly toward people in her life, regardless of their experience. Holleigh's compassion helped her recognize a dissonance: she did not judge others, but consistently judged herself. Through the dissonance, Holleigh described feeling able to

"accept [herself] a little" since she could accept others. Speaking about her recent feelings toward herself, Holleigh explained, "There are some things I don't like about myself still, and there will always be, and that's okay. But I think for the majority of it I am happy with who I am."

Todd also noticed a reduction in judgement toward himself while practicing compassion for others. Throughout his suicidality, Todd constantly compared himself to others, especially when using social media. He assumed everyone was flourishing and judged himself for experiencing mental health issues. However, as part of his experience of compassion toward others, Todd learned about the personal struggles of his friends and family. Like Holleigh, Todd approached the people in his life with kindness and non-judgement. At the same time, Todd also eased his judgements of himself. Todd began recognizing that everyone struggles in life, however, "they're just not posting [it] on Instagram."

Social Connection

Several participants attributed part of their recovery to increased social connection after practicing compassion. The participants commonly felt isolated during their suicidality. However, the act of giving compassion to others was inherently social in nature, thus giving participants the opportunity to break away from isolation. For example, Todd described being a naturally introverted person who appreciated solitude. While suicidal, Todd entered a prolonged state of social isolation. Although he felt comfortable in his isolation, he fell deeper into his despair. It was through compassion that Todd realized how social isolation was hindering his mental health:

> You get comfortable in a habit that you do, and you don't really want to change. So, I didn't really notice it. But then after that experience [with compassion], I realized that it wasn't helping. So, I had to, I wanted to change it.

Although not easy, Todd stepped out of his safe space and showed compassion to his friends. Through compassion, he experienced social connection by contacting friends and socializing over coffee. While reconnecting, Todd learned that his friends faced similar issues to his own. His friends also offered him a plethora of helpful advice. Todd continually focused on social connection, especially through face-to-face contact, as a way of maintaining his mental health.

Like Todd, Jessie contributed part of her recovery to increased social connection. When suicidal, Jessie also fell into the depths of solitude, believing herself "a burden." Through compassion, Jessie connected with friends, acquaintances, and strangers, coaxing her out of isolation. Throughout the experience, Jessie realized she was not a burden; others needed her, and she needed others. However, Jessie still appreciated and required some alone time to best care for herself. Ultimately, Jessie strove to strike a balance between her social connection and solitude and tried to not tip the scale too far on either side.

Flynn, on the other hand, was naturally extroverted before he experienced suicidality. Once suicidal, he began feeling and acting in an opposite way: "I wasn't really in the mood to study or socialize or attend any events or what not. [I] wasn't in the mood to talk to people, wasn't in the mood to meet new people." Compassion toward others helped Flynn rediscover the importance of social connection in his life: "Over time…it got better, just socializing at school got better, my performance, increase in grades, it just changed, knowing what I wanted to do…I would say everything changed." Speaking about social connection, Flynn identified the importance of "just talking to someone, instead of just bottling everything up."

Holleigh described how she had struggled to connect with others socially when she was suicidal. After having just moved to a new country where she had no friends, Holleigh explained that "there was not a whole lot of social interaction going on." Therefore, Holleigh chose to connect with her family. The connection with family members helped Holleigh understand the importance of socialization in her life. As Holleigh began extending her compassion from immediate family to other individuals, she noticed even more connection. With compassion, Holleigh went from knowing few people to making more connections, both in her personal and professional life. Because social connection was so impactful to Holleigh, she also decided to create a mobile application that helped individuals connect socially in their communities.

The Cost of Compassion

All participants perceived compassion toward others as being predominantly beneficial for suicidality recovery. However, some also reported experiencing distress or even burnout after expressing compassion for a significant amount of time. Notably, a couple of participants discovered a need to balance their compassion for others with their personal self-care. For example, compassion was primarily a positive experience for Skye; however, compassion toward others did come with some drawbacks. Though compassion benefitted the mental health of both her brother and herself, she struggled to strike a balance with self-care. For instance, Skye described how listening to her brother at times caused her distress: "[It] wasn't like showing compassion…was negative; it was just…some of the things that I had to listen to, they weren't helpful for me." Rather than attending to her own needs and ending conversations where she felt triggered, Skye continued to listen. Although Skye was proud of her selflessness, she began understanding the necessity of self-care when feeling overwhelmed.

Jessie quickly understood the disadvantages of compassion, recognizing burnout in herself. For her, compassion was at times "exhausting, like, mentally and emotionally having to constantly be there for someone and having to constantly listen…to their problems." She added: "[It] affected me because them being sad would make me sad." With ongoing concern for her friends, Jessie worried incessantly, sometimes all night. To help cope with emotional exhaustion, Jessie recognized "when to take a step back and take care of myself." Although knowing her limits remained difficult, Jessie had "gotten better" at acknowledging and tending to her own needs. Sometimes tending to her needs meant "recharging my social batteries." However, Jessie required a balance between alone time and social connection so as not to fall back into isolation. The balance could be challenging; nonetheless, Jessie knew she could not help her friends if she was not caring for herself.

Other participants discussed how they navigated the balance between compassion for others and self-care. For these participants, the balance meant choosing to extend compassion to certain deserving individuals. In Flynn's case, compassion proved to be a double-edged sword. While Flynn experienced benefits when giving compassion to appreciative others, he also noticed a deterioration in his mental health when his compassion was exploited. Flynn spoke about an individual who he felt had taken advantage of his compassion:

> This person that I met who also lived on my floor that year…and you know, we just talked, she had her own issues going on mentally and whatnot, and I was there to help, like, "If you need anything if you want to talk." And then, over time, it's when you realize that person was just using you, I guess maybe this is one way compassion became unhealthy.

After this one-sided experience of compassion, Flynn understood and firmly believed that compassion could only be beneficial for him if it were mutual or at least appreciated by others.

Similarly, Holleigh found it easier to express compassion to individuals who were grateful for her efforts. Holleigh shared a memory of an experience with a "pseudo friend" who took advantage of her kindness:

> You're starting to get out of your shell and trying to talk to people more and trying to, I guess, form meaningful bonds that are meaningful to you, and some people just don't care about anyone…It was a one-sided friendship on my side.

Holleigh felt her spirits drain when trying to express compassion for individuals who did not appreciate her compassion. Conversely, Holleigh gained energy when others were grateful for her efforts. Therefore, to best support her personal well-being, Holleigh focused her compassion on those people who showed her gratitude in return.

Chapter 5: Discussion

The purpose of this qualitative study was to obtain an understanding of the meaning and experience of compassion for others, from the perspectives of undergraduate students who had previously recovered from suicidality. I interviewed six undergraduates about their experiences of compassion for others and its impact on their suicidality recovery, and I analyzed the data using IPA (Smith et al., 2009). My interpretation of participants' experiences yielded six main themes: a sense of purpose through making a difference in others' lives; reciprocity; positive self-concept; non-judgement and acceptance; social connection; and the cost of compassion. More specifically, participants experienced an increase in their sense of purpose, as they noticed the positive impact of their compassionate actions on the recipients of compassion. Several participants also discussed benefitting from reciprocal compassion. As the participants expressed compassion for others, they often received compassion back. Additionally, compassion for others helped most participants form a positive self-concept. Participants' beliefs about themselves shifted in a positive direction, such that they noticed and took pride in who they were as compassionate individuals. Some participants also articulated a reduction in their negative judgements and an increase in acceptance, of both other people and themselves. Most participants also described an increase in social connection while expressing compassion toward others. Lastly, several undergraduates discussed how compassion for others occasionally impacted them negatively, especially when the participants neglected their own self-care.

In the subsequent sections, I discuss each theme in relation to prior research, noting key similarities or dissimilarities to the existing literature, as well as any novel findings. I also consider potential contributions of my findings, in addition to implications for counselling. Lastly, I describe the study's limitations and suggest future research directions.

Discussion of Findings

Sense of Purpose Through Making a Difference in Others' Lives

Nearly all participants mentioned how compassion for others helped them recover from suicidality in part through finding a purpose in life, which related to a sense of responsibility to others. The participants indicated that thinking how their death would negatively impact others motivated participants to keep living. This finding is in accordance with previous research that demonstrates a positive relationship between compassion for others and responsibility to others (Leedham et al., 2020). Responsibility to others might also be used as a protective factor against suicide (Moody et al., 2015).

In conjunction with responsibility to others, some participants also discussed a connection between purpose and hope. This is not surprising, given that the literature illustrates a positive relationship between hope and purpose (Spandler & Stickley, 2011). Since hope and purpose are inversely related to suicidality (Bryan et al., 2019; Sun & Long, 2013), this may suggest a link between hope and purpose, compassion for others, and suicidality recovery in undergraduate students.

Reciprocity

Several participants indicated that expressing compassion toward others strengthened participants' ability to receive compassion. The participants added that this sense of reciprocity allowed them to move away from suicidality. As mentioned earlier, compassion can be thought of as part of a flow or triad consisting of compassion toward others, compassion from others, and compassion from oneself (Gilbert, 2014). According to prior research, an individual's facility with one directions of compassion does not necessary translate into facility with other directions; in most cases, people tend to be more open to expressing compassion toward others and less

tolerant of accepting compassion from others (Best et al., 2021; Cunha et al., 2021). However, the literature also suggests that although some directions of the compassion flow might be difficult for individuals to access initially, the experience with one direction of the flow can act as a gateway for being more open to another direction (Falconer et al., 2014). According to Falconer et al. (2014), a continual practice of compassion for others might open individuals up to accepting compassion for themselves. With an association existing between accepting compassion from others and reduced suicidality (Frey et al., 2018), the present findings may support the notion that compassion for others helps expand an undergraduate student's openness to the other directions of compassion flow, while influencing recovery.

Positive Self-Concept

Participants credited compassionate behaviours toward others with assisting in suicidality recovery, in part due to how these behaviours promoted a positive shift in the participant's self-concept. *Self-concept* is defined as a collection of conceptualizations about oneself (Bracken & Lamprecht, 2003). According to prior research, individuals with a positive self-concept tend to experience higher self-esteem and well-being, as well as less anxiety and depression (Bracken & Lamprecht, 2003). Moreover, people with a negative self-concept are prone to unhappiness as well as suicidality (Kuper et al., 2018; Turner et al., 2010). Different strategies can positively impact how individuals see themselves, including having compassion for others (Meerholz et al., 2019). Therefore, further investigation into the links between compassion for others, self-concept, and suicidality recovery may be warranted in the undergraduate population, since students commonly struggle with their self-concept (Garcia-Martinez et al., 2022).

Non-Judgement and Acceptance

In the process of suicidality recovery, compassion for others led some participants to experience non-judgement and acceptance toward others. *Non-judgmental acceptance* involves approaching each situation with a neutral, inquisitive attitude, despite the nature of the experience (Cameron & Fredrickson, 2015). The literature suggests that non-judgement is an important factor in the practice of compassion for others, and the correlation between the two have been linked to feelings of well-being (Gilbert, 2009a; Neff, 2003a). Findings from the current study expand upon the literature by pointing to a potential connection between non-judgement of others and suicidality.

Participants also indicated that demonstrating compassion toward others allowed participants to reframe their own experiences through a non-judgmental lens; and greater self-acceptance was helpful in recovering from suicidality. This is in keeping with the literature, which suggests that when individuals learn to approach themselves with non-judgment and acceptance, they are less likely to turn to suicidality to cope (Williams et al., 2006). Furthermore, previous studies have linked high self-judgement and low self-acceptance to an increased tendency to exhibit suicidal ideation (Basharpoor et al., 2016; Brooks et al., 2021; Fan et al., 2022; Williams et al., 2021). Evidence also exists demonstrating the influence of compassion on acceptance of oneself; however, most studies to date have focused on the relationship between self-compassion and self-acceptance (Fan et al., 2022). Considering that my participants focused on compassion for others when discussing non-judgment and acceptance of the self, there may be a connection between compassion for others, non-judgmental self-acceptance, and suicidality recovery.

Social Connection

Several participants mentioned an increase in social connection through acting compassionately toward others, which contributed to participants' suicidality recovery. The concept of belongingness may help illuminate the relationship between compassion for others, social connection, and suicidality recovery for the participants. As highlighted by Joiner et al. (2009), connecting socially with others, even during arduous times, can increase belongingness, and potentially, reduce suicidality. Consistent with Joiner et al.'s (2009) research, many participants in the current study discussed how expressing compassion toward others helped them feel a greater sense of belonging in their relationships, even when the interactions were difficult or negative. These findings might be useful to future researchers, seeing that university students tend to experience feelings of isolation and diminished social interactions (Boddy, 2020).

Alongside belongingness, some participants also described how social connection was accompanied by reduced feelings of burdensomeness. Feelings of burdensomeness were also connected to the earlier theme of purpose, where participants noticed that others needed and valued them, thereby challenging thoughts of burdensomeness. This finding is consistent with research that associates diminished burdensomeness with lowered rates of suicidality (Joiner et al., 2009).

The Cost of Compassion

The participants described compassion for others as being a positive experience for the most part; however, some participants also discussed how compassion for others was associated with feelings of emotional exhaustion, which was not helpful toward suicidality recovery. Although not something that I initially considered at the onset of my research project, these findings appear consistent with the literature on compassion fatigue. *Compassion fatigue* is the

experience of emotional and physical exhaustion from helping others, leading to diminished compassion and empathy, as well as the inability or unwillingness to persist in carrying others' suffering (Turgoose et al., 2017). The mechanisms through which an individual may experience compassion fatigue appear to be complex and multifaceted; but common characteristics of individuals suffering include struggling in their personal lives, being overworked, and experiencing systemic issues at a job (Ray et al., 2013). *Compassion satisfaction*, on the other hand, refers to the rewarding feelings that arise from helping others (Slocum-Gori et al., 2013). Having regular self-care practices, social support, and a positive work environment helps increase compassion satisfaction (Ray et al., 2013). Although most research regarding compassion fatigue and satisfaction focuses on healthcare workers, especially those working with trauma survivors (Turgoose et al., 2017), it is possible that these phenomena might also occur in individuals who are recovering from suicidality and expressing compassion in their personal lives.

Implications for Counselling

Undergraduate students are at an increased risk of suicidality (Mortier et al., 2018). From the perspectives of participants in the current study, it appears that acting compassionately toward others may facilitate suicidality recovery in undergraduates. Each theme in my findings offers potential strategies that might be considered and discussed when counselling suicidal undergraduate students. As mentioned by most of the participants, compassion for others increased a sense of purpose. If a suicidal student presents in therapy with a lack of purpose and direction, counsellors might consider offering compassion-based strategies to increase their purpose in life. For example, the client and counsellor might collaborate on ideas that best fit

with the client's interests, such as volunteering, or offering compassion to a person struggling in their life.

Similar strategies used to influence purpose might also work for increasing social connection. Specific compassion-based strategies described by my participants might be considered, such as reaching out to friends in need and offering help, checking in with friends in a casual setting, or volunteering. For example, clients might consider volunteering for a peer support group on campus. Through peer support, students can help their peers navigate change and stress that university brings (Crisp et al., 2020). Research has shown that peer support benefits both the person seeking support, as well as the volunteer (Crisp et al., 2020).

The theme of reciprocity might also point to potential strategies for counselling suicidal students. With compassion for others often being easier for most individuals than expressing and accepting compassion for the self (Best et al., 2021), counsellors might choose to focus on compassion toward others before approaching the other directions of the flow. As the client enters the flow of compassion through acting compassionately toward others, it is possible that they might eventually be more open to accepting compassion from others (Falconer et al., 2014). When having clients practice compassion for others, counsellors should consider asking the client about their experience, such as shifts in their willingness to accept compassion from others (Gilbert et al., 2017). Additionally, the practitioner could explore fears that the client might have with regard to accepting compassion from others (Gilbert et al., 2011).

Furthermore, therapists might also recommend that suicidal clients practice compassion for others, as a potential means of improving clients' self-concept. A possible strategy could include imagining the self as having positive qualities such as compassion and helpfulness (Gilbert, 2014). From there, counsellors could lead their clients in a practice of acting in a way

that a person with such qualities would act (Gilbert, 2014). Through imaginary and actual practices of compassion, a client might notice a shift in their self-perceptions (Gilbert, 2014). Considering that a positive self-concept is inversely related to suicidality (Taylor et al., 2019), this compassionate approach might be particularly helpful for undergraduate students who are suicidal.

Given how several participants' judgments of themselves and others decreased while practicing compassion for others, counsellors could consider adding compassion-based interventions into a suicidal client's therapy, specifically focused on lessening judgement. For example, a counsellor could have a client focus on the suffering of another person and ask how the client might approach them in a non-judgemental way (Falconer et al., 2014). Then, the counsellor could have the client repeat the same practice, but whilst focusing on the self (Falconer et al., 2014). After the practice, the counsellor might ask the client if they noticed a shift in their judgements toward others as well as themselves.

Lastly, counsellors should consider the potential for compassion fatigue. For example, the counsellor should inform the client about signs of compassion fatigue (e.g., apathy, withdrawal, loss of hope; Turgoose et al., 2017), and monitor these signs. Additionally, the practitioner and client might collaborate on a self-care plan that fits with the client's needs, since students who practice suitable self-care during their undergraduate studies are more likely to report better well-being, work-life balance, and less stress (Lewis & King, 2019). Considering each client is different, the counsellor and client should also discuss an appropriate balance between supporting others and supporting the self.

Limitations

Although this study presented several novel findings, it is not without limitations. For one, all interviews took place either via video conference or telephone due to the COVID-19 public health mandates. While the alternative communication methods allowed me to interview the participants amidst the pandemic, the methods may have limited a more complete understanding of the participants' experiences. For example, video conferencing communications often limit the researcher's ability to capture the nuances in a person's expressions (e.g., body language, thoughtfulness, emotional reactions, etc.). These nuances were especially difficult to detect when speaking to participants over the telephone, where I could not see the participants' physical reactions.

Another limitation to consider is the inclusion criteria. As mentioned previously, to be eligible for this study, participants needed to be willing and able to articulate their experiences of compassion for others, and how it aided in suicidality recovery. Although the inclusion criteria fit my research question as well as IPA standards (Smith et al., 2009), the study did not capture the experiences of individuals who struggled with compassion for others; however, their experiences are nonetheless valid.

In addition, for ethical reasons, I did not ask participants for more details on their experiences of suicidality. That is, I spoke with the participants specifically about their suicidality recovery. Perhaps the participants' experience with compassion for others might have differed depending on the severity of their suicidality. For example, pathways to recovery may have varied if an individual experienced occasional thoughts of suicide, compared to a person with frequent suicidal ideations and behaviours.

A further limitation surrounds gender differences. Previous research has shown a discrepancy between genders regarding suicidality (Lamis & Lester, 2013). In my study, I

included perspectives of men and women and did not tease apart the differences in experience for either gender. Additionally, my participants all identified as cisgender, and my study lacks the perspective from individuals who identify as non-binary, transgender, and gender-divergent.

Lastly, because the study relied upon participants' retrospective recall of their experiences of compassion for others and suicidality recovery, some information may have been inaccurately remembered. Additionally, the inclusion criteria required that participants be free of suicidal thoughts and behaviours for at least one year for safety measures (Baiden & Fuller-Thomson, 2016). However, I did not require a maximum amount of time between the experience and the interview. Therefore, some participants may have experienced suicidality more recently than others, possibly impacting participants' memory of their experience. Accordingly, researchers should consider implementing a minimum as well as a maximum period to reduce recall bias.

Future Directions

Future researchers might choose to expand on my study in several ways. First, researchers could explore the experience of compassion for others and suicidality recovery from the perspective of individuals from different populations. For example, in exploring the relationship between compassion for others and suicidality recovery among undergraduates, a better understanding of gender differences is needed. Such understanding could help inform gender-sensitive approaches for counselling their suicidal clients. Furthermore, researchers should develop an understanding of the phenomenon from the viewpoint of different age groups. Accordingly, researchers might focus on age groups outside of the undergraduate population. Although there was notable cultural and ethnic diversity in this study's sample, future

researchers might also consider further exploring this phenomenon across and within specific cultures.

Investigators could also conduct research on compassioned-based interventions specifically aimed at compassion for others, with a focus on suicidal undergraduate students. For example, researchers might use specific therapeutic approaches for expanding compassionate capacities. One such approach could be CFT, where clients learn to access their warmth/contentment system through compassionate practices (Gilbert, 2009a). Through CFT, a suicidal client may begin to feel safe with others and be motivated to relieve the suffering of individuals around them (Gilbert, 2009a). Additionally, researchers could explore the impact of mindful self-compassion (MSC; Germer & Neff, 2019). Considering that MSC supports clients in focusing on a sense of common humanity, suicidal clients might benefit from MSC by recognizing their commonalities with others and thus perhaps motivate the client to help others (Germer & Neff, 2019). Furthermore, researchers might consider compassion-based interventions that help clients clarify a sense of purpose and meaning in life, such as meaning-centered psychotherapy (MCP) with CFT (Gil et al., 2018). Through a meaning-centered compassion-based therapy, clients learn to focus on meaning in life, compassion for others, and self-compassion, whilst considering how these aspects can benefit them and those people around them (Gil et al., 2018). Lastly, researchers might explore the effects of such interventions on purposefulness, social connection, self-concept, and non-judgmental acceptance, which participants in this study found to be particularly salient benefits of compassion toward others.

Finally, future researchers should investigate balancing self-care and compassion for others. I suggest that investigators focus on the experience and meaning of compassion satisfaction versus compassion fatigue (Slocum-Gori et al., 2013), where researchers strive to

develop an understanding of these aspects from the perspective of individuals who have recovered from suicidality.

Conclusion

Despite there being research on risk and protective factors for suicidality in undergraduate populations (Seeman et al., 2017), compassion for others has largely been overlooked as a source of recovery for students. This study utilized a qualitative approach to explore the experience and meaning of compassion toward others, from the perspective of undergraduate students who have recovered from suicidality. To address my research aims, I interviewed six undergraduate students who believed compassion for others helped them recover from suicidality. My findings are largely consistent with previous research, while also offering novel evidence linking compassion for others to suicidality recovery. Additionally, the findings point to new avenues of study within the compassion and suicide fields. Future researchers should focus on investigating compassion-based interventions, specifically focusing on undergraduate students who are suicidal. Lastly, investigators should consider the importance of self-care when acting compassionately toward others, especially to mitigate the possibility of compassion fatigue. Although researchers have uncovered an understanding of suicidality in undergraduate students, suicide continues to be a major cause of death for this population (Mortier et al., 2018). Therefore, the work is not finished; researchers must continue to develop preventative and treatment measures in order to protect this at-risk population from succumbing to suicide.

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Appendix A

Recruitment Statement for the Undergraduate Listserv

FYI: Seeking participants for a research study on compassion and recovery from suicidality

Master's Student looking to recruit participants for my research study on how compassion for others helped recovery of suicidal thoughts and/or behaviours. Participants will be asked to volunteer approximately 2 hours of their time to participate in semi-structured interviews discussing their experiences. To be eligible to participate, you must be a current undergraduate student and have experienced suicidal thoughts and/or behaviours in the past, and be free of these thoughts and/or behaviours for at least one year. All participants will receive a $25.00 Tim Horton's or Starbucks gift card. If you are interested in participating, please email me at allegro@ualberta.ca.

Appendix B

Recruitment Post for the Undergraduate Research Initiative Facebook Page

Research participants needed (Posted on behalf of a U of A Master's student): I am a master's student in counselling psychology at the University of Alberta. I am looking to recruit participants for my research study on how compassion for others helped recovery of suicidal thoughts and/or behaviours. Participants will be asked to volunteer approximately 2 hours of their time to participate in semi-structured interviews discussing their experiences of compassion for others and how this helped in their recovery of suicidal thoughts and/or behaviours. To be eligible to participate, you must be a current undergraduate student and have experienced suicidal thoughts and/or behaviours in the past, and be free of these thoughts and/or behaviours for at least one year. All participants will receive a $25.00 Tim Horton's or Starbucks gift card. If you are interested in participating, or would like to know more about the study, please email me at allegro@ualberta.ca.

Appendix C

Recruitment Statement for the Undergraduate Listserv, Indicating Male/Non-Binary Participants

FYI: Seeking participants for a research study on compassion and recovery from suicidality

Master's Student looking to recruit participants who identify as male or non-binary for my research study on how compassion for others helped recovery of suicidal thoughts and/or behaviours. Participants will be asked to volunteer approximately 2 hours of their time to participate in semi-structured interviews discussing their experiences. To be eligible to participate, you must be a current undergraduate student and have experienced suicidal thoughts and/or behaviours in the past, and be free of these thoughts and/or behaviours for at least one year. All participants will receive a $25.00 Tim Horton's or Starbucks gift card. If you are interested in participating, please email me at allegro@ualberta.ca. This study (Pro00098126) has been reviewed for its adherence to ethical guidelines by a Research Ethics Board at the University of Alberta.

Appendix D

Consent Form

RESEARCH STUDY INFORMATION AND CONSENT FORM

Title of Project: The place of compassion for others in undergraduate students' recovery from suicidality

Research Investigator: Hailey Allegro, B.A. (Hons), M.Ed. Student
Department of Educational Psychology, University of Alberta
allegro@ualberta.ca

Supervisor: K. Jessica Van Vliet, Ph.D., R.Psych., Associate Professor
Department of Educational Psychology, University of Alberta
jvanvliet@ualberta.ca

Background and Purpose

I am a master's student in counselling psychology at the University of Alberta. As part of my thesis, I am exploring undergraduate student's experience of compassion for others, and how this aided in the recovery of suicidal thoughts and behaviours. Studying the experience of compassion for others and suicidality recovery will help us better understand compassion for others, and how individuals can recover from suicidality. Additionally, this study may help inform mental health professionals who work with young adults who are suicidal. You are encouraged to ask questions if you feel anything needs to be made clearer. You will be given a copy of this form for your records.

Procedure

If you agree to participate:

1. You will be asked to take part in a research interview with me. The interview will consist of questions about your experience of compassion for others and how it helped in your suicidality recovery. While social distancing restrictions due to COVID-19 are in place, the interview will occur either through video conferencing or over the telephone. Once these restrictions are lifted, the interview will occur in person at Clinical Services (Department of Educational Psychology) at the University of Alberta. The interview will take between 1-1 ½ hours. The interview will be audio recorded and transcribed by me.
2. You will be sent a copy of the transcript where you will have the opportunity to review the transcript for accuracy.
3. You will be invited to participate in a brief (approximately 20 minute) interview where I will ask you questions to clarify any information in the first interview.

Benefits

There are no direct benefits to participating in this study. However, you may appreciate having the opportunity to speak in detail about some of the positive experiences that led to your suicidality recovery. Additionally, as a small token of appreciation for your participation, you will receive a $25 Tim Horton's or Starbucks gift card.

Risks

Participating in an interview about your experiences of compassion for others and how it helped in your recovery from being suicidal may bring up short-term difficult feelings. However, we expect these feelings to be temporary, and we do not anticipate they will be harmful. If you experience distress as a result of your participation, please contact Hailey Allegro (allegro@ualberta.ca) or Dr. Van Vliet (jvanvliet@ualberta.ca). At the end of the study, a list of mental health referrals will be available. Please note that for students at the University of Alberta, mental health services are available at Clinical and Counselling Services.

Voluntary Participation

You are under no obligation to participate in this study. Participation is completely voluntary. You can withdraw from the study at any time or refuse to answer any questions without penalty. Even if you agree to be in the study, you can change your mind and withdraw up until two weeks after you have received the interview transcript. After the two-week period, all data will be kept.

Confidentiality and Anonymity

All information in this study will remain confidential, with the following limitations. If I have reason to believe that you are seriously considering harming yourself or another person, then I am under obligation to disclose this information in order to protect your safety and the safety of others. Additionally, if I have reason to believe a child is being abused or neglected, or at risk of being abused or neglected, I will be required to disclose this information.

Any identifying or potentially identifying information will be changed to protect your anonymity. All paper documents will be stored in a locked filing cabinet in either the researchers' lab or place of residence, while all digital documents will be stored on an encrypted password protected computer. The audio recordings of the interviews will be kept on an encrypted password-protected USB stick that will be stored separately from the paper documents in either the researchers' lab or place of residence. After five years, all audio recordings will be deleted. All other data will be retained for a minimum of ten years.

If the interview is to occur remotely, it will be conducted using either telephone or a secure online video conferencing service (Doxy.me). To protect the privacy of users, the service uses full encryption, does not require or store any identifying information from you, and does not store any data (i.e., the video or audio recordings). However, there may be limits to using any online platform in terms of potential breaches of security. To help minimize this risk, the computer used to conduct the interview will be up to date in terms of the software, operating system, and antivirus and firewall programs.

Uses of Data

The information that you share will appear in my master's thesis and may also appear in academic venues such as scholarly publications and presentations. It is possible that your data will be used for future research purposes. However, approval from the University of Alberta Research Ethics Board will be obtained before doing so. Data used for these and any other purposes will be non-identifying.

Contact Information

If you have any further questions or concerns regarding this study, please do not hesitate to contact Hailey Allegro at allegro@ualberta.ca or Dr. Van Vliet at jvanvliet@ualberta.ca. If you wish to receive a summary of findings of the study, please contact me at allegro@ulaberta.ca. The plan for this study has been reviewed by a Research Ethics Board at the University of Alberta. If you have questions about your rights or how research should be conducted, you can call (780) 492-2615. This office is independent of the researchers.

Consent Statement

I have read this form and the research study has been explained to me. I have been given the opportunity to ask questions and my questions have been answered. If I have additional questions, I have been told whom to contact. I agree to participate in the research study described above and will receive a copy of this consent form. I confirm that I have not experienced suicidal thoughts and/or behaviours for at least one year.

_____	_____
Participant's Name (printed) and Signature	Date
_____	_____
Researcher's Name (printed) and Signature	Date

Appendix E

Inclusion Criteria

Hello [NAME],

Thank you for your interest in participating in my study. I have attached the consent and information form for your review. I have also listed the criteria for participation below. If you meet the criteria and are still interested in participating, please send me a signed copy of the form (a scan or photo of the consent form, or a digital signature is fine). Afterwards, we will set up a day and time for us to conduct the interview, which will occur via video conference.

Here are the criteria for participation. All participants must:
1. Be a minimum of 18 years of age
2. Be able to speak and understand English
3. Be an undergraduate student
4. Have experienced suicidal thoughts and/or behaviours in the past
5. Be free of serious suicidal thoughts and/or behaviours for at least one year
6. Believe compassion for others aided in suicidality recovery

Please let me know if you have any questions or concerns.

Thank you and take care,

Hailey

--
Hailey Allegro, B.A.
M.Ed. Student, Counselling Psychology
Department of Educational Psychology
University of Alberta
allegro@ualberta.ca

Appendix F

Interview Protocol

Pseudonym: _____ Date: _____Time: _____

Interview Protocol for STUDY

Hello, and thank you for agreeing to be a participant in my thesis research on compassion for others and suicidality recovery. Today, you are being asked to participate in an interview that will last between 1 and 1.5 hours, in which we will discuss your personal experiences with compassion for others and how this helped you recover from being suicidal. You are under no obligation to participate in this interview. If you are uncomfortable with any of the questions throughout the interview, please let me know and we will not discuss it. If you decide you would not like to be a participant even after starting the interview, you are able to rescind your consent without penalty. Once the interview has finished, I will be replacing your name with a pseudonym, and will exclude any other identifying or potentially identifying information from the interview transcript. Do you have any questions for me before we get started?

1. Can you recall and describe a meaningful example of a time that you acted compassionately for others during your recovery? Please describe your experience in as much detail as possible, for example, when, what, who, where, why, etc.
   a. In this example, how long ago did this happen?
   b. What about this event made it most meaningful for you?
   c. How did this event help you in your recovery?
   d. How did your experience of compassion in this situation impact your recovery?
   e. What did you feel, think, do, want to do, etc.
   f. Can you think of other examples? Please describe them.

g. Is there anything else you can say about acting compassionately towards others that impacted your recovery?

2. In what ways, if any, does compassion toward others continue to make a difference for you in your life?
3. While you were recovering from suicide, were there times when compassion for others had an unhelpful impact on your recovery? If so, how?
4. We have talked about your experience of compassion toward others when you were recovering from suicide, and I am wondering more generally, how would you define compassion for others?
5. Is there anything else you would like to share with me that I have not asked or we haven't already covered?

Appendix G

Demographics Form

Demographics Information

Name: _____

Age: _____

Gender: ☐ Male ☐ Female ☐ Non-binary

Ethnic/cultural background: _____

Undergraduate year:

☐ First year

☐ Second year

☐ Third year

☐ Fourth year

☐ Fifth year and above

Appendix H

Optional Counselling Referrals Form

LIST OF COUNSELLING REFERRALS

Distress Line
Phone: 780-482-HELP (4357)

University of Alberta Clinical and Counselling Services *(No cost for University of Alberta students)*
Phone: 780-492-5205
Address: 2-600 Students' Union Building (SUB)
https://www.ualberta.ca/current-students/counselling/index.html

University of Alberta Clinical Services (Department of Educational Psychology)
Phone: 780-492-3746
Address: 1-135 Education North Building
https://www.ualberta.ca/educational-psychology/centres-and-institutes/clinical-services

University of Alberta Psychiatric Walk-In
Phone: 780-407-6501

Cornerstone Counselling Centre
Phone: 780-482-6215
Address: 302-10140 117 St. NW, Edmonton
https://www.cornerstonecounselling.com/

Momentum Walk-In Counselling
Phone: 780-757-0900
Address: Suite 706, 5241 Calgary Trail NW (Centre 104), Edmonton
https://www.momentumcounselling.org/contact/

Catholic Social Services (*All faiths welcome*)
Phone: 780-391-3233
Address: Multiple locations in Edmonton
https://www.cssalberta.ca/

Jewish Family Services (Integrity Counselling Services) (*All faiths welcome*)
Phone: 780-454-1194
Address: 100-8702 Meadowlark Road, Edmonton
https://www.jfse.org/contact-us/

City of Edmonton Counselling Services
Phone: 780-496-4777
https://www.edmonton.ca/programs_services/programs-family-individuals.aspx