Experiences following a suicide attempt

Anne Carolyn Graham, B.A.(Hons), M.A.

School of Social Sciences and Psychology
Faculty of Arts, Education and Human Development
Victoria University

Submitted in fulfillment of the requirements of the degree of
Doctor of Philosophy

December, 2012

Abstract

A suicide attempt is a very significant and usually disturbing event for the person who makes the attempt, for his or her family, and for clinicians who respond. Moreover, epidemiological studies have established that a suicide attempt is associated with an increased risk of subsequent attempt or suicide, suggesting that understanding more about experiences following a suicide attempt may have implications for prevention. Yet, despite calls for more qualitative research in the field, there have been few studies investigating these experiences. This thesis reports on a qualitative research study in which adults who had made a suicide attempt were interviewed about their experiences following the attempt. Lethality of suicide attempts varied but was within the moderate to severe range of medical seriousness. Ten participants (eight women and two men, aged 28 to 52) were asked about the nature of the suicide attempt, their personal experiences in the period that followed, their interactions with family and friends, and their experiences of clinical services. Findings support theorising a suicide attempt as trauma, with core experiences of loss of control, helplessness, disconnection from others, shame, guilt and humiliation. Movement from helplessness and disempowerment toward a sense of agency and control, and from disconnection and aloneness to repaired relationships were crucial aspects of the recovery process,. Analysis of interactions with family and friends noted the significance of sustained relationships and support, while also identifying a pattern of reciprocal recoil from the horror of the suicidal crisis and mutual silences aimed at protection of self and other, followed by efforts to repair ruptures in relationships. Experience of significant losses characterised the period following the suicide attempt. Respect and being taken seriously vs humiliation, blame or indifference was the overarching theme in relation to experiences with clinical services. Collaborative decision-making in the clinical setting was experienced as central to overcoming helplessness and regaining a sense of agency. Psychotherapy was valued for containing distress and/or working through underlying issues. Recommendations for practice are presented, while acknowledging the limitations of the study.

Student Declaration

"I, Anne Carolyn Graham, declare that the PhD thesis entitled 'Experiences following a suicide attempt' is no more than 100,000 words in length including quotes and exclusive of tables, figures, appendices, bibliography, references and footnotes. This thesis contains no material that has been submitted previously, in whole or in part, for the award of any other academic degree or diploma. Except where otherwise indicated, this thesis is my own work".

Signature   Date

Acknowledgements

Table of Contents

List of Appendices

List of Tables

Chapter 1 Introduction

There has been very little study of the natural life course following a suicide attempt. Research following up people who have made a suicide attempt has mainly focussed on the statistical risk of a repeat attempt and/or completed suicide. Epidemiological studies have examined the rate of suicide or repeated attempts and investigated risk factors predictive of later suicidal behaviour. In contrast, the current study is focussed on the experience of the person who has made a suicide attempt, and the impact of that attempt on his or her internal emotional life and interpersonal relationships. Also of interest are the person's experiences of clinical services, and what aspects of these services are experienced as helpful or unhelpful.

The starting point for the study came from reading a paper by McGinley and Rimmer (1992) discussing patient and clinician responses in the period immediately following a suicide attempt. The authors worked in a psychological assessment service for people presenting to an Emergency Department having made a suicide attempt. On the basis of their clinical work they described how, in the immediate aftermath of a suicide attempt, the person is shocked by what he or she has done and is plagued by a range of depressive and persecutory anxieties. He or she is filled with depressive pain but is also frightened about others knowing about the suicidal action and worried about how others will react. McGinley and Rimmer (1992) suggested that the patient is often 'more concerned about the state of mind of those treating him than he is about his own state of mind' (p. 58). The patient expects to be attacked for what he or she has done (the damage to self and the pain caused to others), expects to be seen as mad, bad or both. In response to these persecutory anxieties the patient may be defensively angry and attacking. This anger also functions as a defensive shield against depressive affect. The person may feel humiliated about being so helpless and out of control. He or she may feel guilty and ashamed, or may be frightened of being overwhelmed again by the psychological state which felt intolerable at the time of the suicidal action. Given this complex and intense emotional experience, the person may find it very difficult to think about or discuss what has happened, and may wish to minimise the seriousness of the suicidal action (McGinley & Rimmer, 1992).

McGinley and Rimmer (1992) identified the suicide attempt as a traumatic experience, and suggested that the pattern of the emotional responses described above could be understood within the context of reactions to trauma. It is trauma of a very particular kind, however, in that the suicide attempter is both the victim of a violent attack and the perpetrator of a violent attack. Defensive responses to the trauma of attempted suicide include rationalisation and dissociation as well as splitting and projection. Rationalisation may be used to minimise the seriousness of the act, to hide the sense of compulsion often experienced, and to deny the fantasy, as described by Maltsberger and Buie (1980), that the self can survive the death of the body. Dissociation is a frequent response to psychological trauma (Herman, 1992), and manifests as feelings of detachment, numbness or unreality. In the Emergency Department the patient may appear misleadingly calm (McGinley & Rimmer, 1992).

Further defensive manouvres involve splitting of the self and others. Hospital staff may be perceived as good (idealised) versus bad (cruel). McGinley and Rimmer (1992) pointed out that at the moment of suicidal action the self is both abandoned and cruelly treated and also abandoning and cruel. It is painful to think of oneself as abandoning and cruel and more tenable to present oneself as the victim, but underneath the person may feel intense shame and/or concern about his or her capacity to control aggressive impulses. The patient's anxieties about being attacked may be mirrored in negative, and indeed persecutory, responses from staff (Pallikkathayil & Morgan, 1988). In struggling to respond to the complexity of the victim-perpetrator duality, the staff may respond to the perpetrator with condemnation or alternatively may respond with sympathy to the victim. Either of these responses, based on splitting, involves an undue simplification and overlooks or denies part of the reality (McGinley & Rimmer, 1992).

McGinley and Rimmer (1992) wrote about the person's psychological state in the first few hours, or perhaps days, after a suicide attempt and whilst in a hospital setting. The question arises as to what happens after that. The current study is interested in following this lead, and exploring experiences during the year or years following a suicide attempt. Surprisingly there is very little research focusing on the period following a suicide attempt, even though the risk of a repeat attempt is highest during

that time (Owens, Horrocks, & House, 2002). Thinking about why this might be the case raises the issue of where such research might sit within the overall field of suicide research.

There has been some debate about the priorities and directions for suicide-focused research. For several decades the most common research paradigm has been epidemiological, large scale, quantitative studies investigating rates, methods and risk factors for suicide or attempted suicide. These studies aim to provide information relevant to prediction of suicide risk and to the planning and targeting of preventive programs. While these studies have yielded large amounts of information about populations at risk, they do not and cannot address all the necessary questions. Robinson et al. (2008) in Australia and Berman (2012) in the U.S. have both argued for a re-balancing of priorities, with greater emphasis being given to studies focused on intervention. While these recommendations refer to clinical trials evaluating interventions, it can also be argued that an understanding of subjective experiences related to suicidality is necessary in order to inform effective intervention (Cutcliffe, Joyce, & Cummins, 2004). Among a number of further recommendations, Berman (2012) suggested we need studies that provide a clearer understanding of how a person moves from a chronic to an acute level of suicide risk. Studies of experiences following a suicide attempt could contribute to an understanding of what perpetuates and/or exacerbates suicidality.

Cutcliffe et al. (2004) called for more use of experience-near, qualitative research methodology in the study of suicidal feelings, thoughts and behaviour. This type of research sits within another main strand of suicide studies, the in-depth examination of psychological processes in a single case study, multiple case studies or small sample of suicidal individuals. This strand encompasses clinical case studies, psychological autopsy studies and qualitative research. Much of this work involves investigating and/or theorising the nature of the suicidal experience or state of mind and the aim is to understand psychological processes relevant to clinical assessment and therapy (Berman, 1991). The approach has also extended to investigating experiences of overcoming suicidality (Everall, Altrows, & Paulson, 2006) and experiences of being in treatment (Samuelsson, Wiklander, Åsberg, & Saveman,

2000). The current study is in the tradition of this strand of research, focussed on in-depth exploration of psychological processes and life experience.

One reason for focusing on experiences following a suicide attempt concerns the elevated risk for further suicide-related actions. In many epidemiological studies, a previous suicide attempt has been the best single predictor of completed suicide (Moscicki, 1995). Approximately 1% of suicide attempters die by suicide during the year following their attempts. The risk is greatest in the first year and especially the first six months after the attempt, but remains elevated for some years (Hawton & Catalan, 1987). However another reason for studying experiences after a suicide attempt is because making a suicide attempt is in itself a crisis for the person and for family or friends. The suicide attempt is likely to generate significant distress and have an impact on the person's inner life and on his or her interactions with others in the period after the attempt. How long these impacts will reverberate and how they will develop in the longer term is unclear.

The current study aims to explore experiences following a suicide attempt including experiences associated with a person either becoming less suicidal or continuing to struggle with suicidality. The study aims to explore the person's emotional life, his or her experiences with family and friends and the way in which life unfolds during the year or years following the suicide attempt. Not everyone who makes a suicide attempt seeks medical treatment or mental health care (De Leo, Cerin, Spathonis, & Burgis, 2005), although a majority have some contact with mental health services within a year of the attempt (Johnston, Pirkis, & Burgess, 2009). Nevertheless this study aims to explore experiences with health care and/or mental health care services and systems. It is hoped the study will have significance for how clinicians engage with those who have made a suicide attempt, and how they plan responses and programs which are most likely to reduce pain and suffering as well as lessen the risk of further suicide-related actions.

Chapter 2 Epidemiological context

This chapter first discusses issues of terminology, a complex issue in the field of suicide studies. This is followed by a brief overview of rates and risk factors pertaining to suicide and suicide attempts, with a particular focus on Australia as the location of the current study. Finally the chapter considers the issue of repetition of suicide attempts.

2.1   Terminology and definitions

Despite many years, indeed decades, of clinical work and research concerned with suicide-related behaviour and ideation there is still no commonly agreed upon or widely adopted terminology for this field. While there is debate about how suicide should best be recognized and defined, especially in the official determination of cause of death, there is general agreement on two essential elements: self-inflicted death and some level of intent to die (De Leo, Burgis, Bertolote, Kerkhof, & Bille-Brahe, 2006; O'Carroll et al., 1996). In the context of fatal outcomes, it is the issue of intent, what it is and how to determine it, that provokes the most discussion. There has been even more debate, however, about nomenclature for non-fatal self-injurious behaviour, much of this also concerned with the issue of intent, and this is the main focus of this section.

A range of motivations and intentions may lie behind deliberate self-harm or suicide-related behaviours and the nature of the intent may be shifting and ambivalent. O'Carroll et al. (1996) set out to develop a system of nomenclature which they offered to the field for consistency of usage. Within a larger system of terms, they distinguished between a 'suicide attempt' where there is evidence, explicit or implicit, that the person intended at some level to kill him or herself (even if ambivalent), and 'instrumental suicide-related behavior' where the person did not intend to kill him or herself but 'wished to use the appearance of intending to kill himself/herself in order to attain some other end' (p.247). Thus, in this nomenclature, reaching a conclusion about the nature of intent is crucial.

Around the same time, however, Diekstra and Garnefski (1995) argued in favour of the term 'parasuicide' precisely because it makes no reference to intent. They suggested that when asked about intent many people who have self-harmed will either deny a wish to kill themselves or will simply say 'I don't know'. Diekstra and Garnefski held that this 'obscurity of intent' (p.37) is not surprising, since at the time of the act, most people, especially the young, are in the midst of an interpersonal crisis and are feeling desperate and confused (and may be affected by alcohol or drugs). Thus they argued that this obscurity of intent means that intent does not provide a sound basis for classification. Instead they distinguished parasuicide from some other forms of self-harm by specifying that in parasuicide the act should not be habitual. A major multi-country research program (WHO European Multicentre study) initially followed this path, defining parasuicide in terms of a deliberate, non-habitual 'act with a non-fatal outcome that, without intervention from others, will cause self-harm' (De Leo et al., 2006, p.8).

The term 'deliberate self-harm', including acts 'with or without suicidal intent', has been preferred by some investigators, again because it does not require differentiation of intent. However while terms such as 'parasuicide' or 'deliberate self-harm' avoid the need to make a difficult, at times even impossible, judgment about intent, they end up grouping together actions which may have a very wide range of meanings. In its literal meaning the term 'deliberate self-harm' does not distinguish between self-harm with intent to die, self-harm which is in some less straightforward way associated with the idea of suicide, and self-harm (including repetitive self-harm) which does not involve suicidal ideation but rather has other aims and purposes. Furthermore O'Carroll et al. (1996) argued that the term suicide attempt is so widely used and intuitively accepted that any efforts to banish this term are likely to be unsuccessful.

One of the reasons for retaining terms such as 'suicide attempt' and 'suicidal behaviour' is to maintain the conceptual link between suicide and similar actions with non-fatal outcomes (De Leo et al., 2006). However the idea that intent (in fatal or non-fatal outcomes) can be defined in terms of 'intent to die' is problematic. There is widespread acceptance of Shneidman's (1993b) view that the suicidal person may not primarily want to die but that living, as the person currently experiences it, may be

unbearable. In this case, intent is not intent to die but intent to cease suffering, which may nevertheless entail death. There is the further complication (in non-fatal outcomes) of who specifies intent – a clinician or the person whose intent is being characterised. Research (e.g., Bancroft et al., 1979) suggests clinicians and patients may have different views. Moreover intent may change quite rapidly and it is also possible that the person's characterisation of their own intent may change over time, from before the action, to immediately afterward and again sometime later. Despite the complexity of defining intent, the major nomenclature systems of the past decade see intent as a necessary component.

The North American O'Carroll group (Silverman, Berman, Sanddal, O'Carroll, & Joiner Jr., 2007a) re-visited their earlier nomenclature in the light of debates over the ten years since the initial proposals. They acknowledged, among other issues, that the term 'instrumental suicide-related behavior', though accurate in their view, had not been seen as user-friendly. Their revised system of nomenclature included a category termed 'Suicide-related behaviors', and within this category the authors distinguished between 'self-harm' (by definition with no suicidal intent), 'undetermined suicide-related behavior' (when intent is undetermined) and 'suicide attempt' (with some degree of suicidal intent) (Silverman, Berman, Sanddal, O'Carroll, & Joiner Jr., 2007b). This nomenclature is somewhat different from the European-developed system of definitions put forward by De Leo et al. (2006). According to these authors, the WHO European Multicentre study had earlier adopted the term 'parasuicide' but concluded over time that this term had proved confusing and too readily misused or misinterpreted. De Leo et al. proposed instead the term 'non-fatal suicidal behavior' which could then be specified as 'with intention to die' or 'without intention to die'. Both the North American and the European proposals made a conceptual distinction between actions with suicidal intent (intent to die) and those without such intent. Moreover despite use of the phrase 'intent/ion to die' both groups of authors acknowledged, in their discussion, that this may be about escaping from unbearable life, as much as it is about wanting to die.

The above proposals focused on nomenclature for 'suicide-related' or 'suicidal' behaviour (while recognising a category of actions without suicidal intent). There have also been efforts to distinguish among forms of self harm that do not arise from

suicidal thoughts but serve other functions. Favazza (1996) developed a classification of non-suicidal self-injury in which he first distinguished culturally sanctioned practices from pathological behaviour and then discussed three categories of pathological self-injury. In this system, major self-injury refers to actions that occur infrequently, involve major damage to body tissue and are most likely to occur in the context of psychosis. Stereotypic self-injury refers to repeated acts with a relatively fixed pattern of expression (e.g. head-banging) which are devoid of symbolism, often rhythmic and most likely to occur in pervasive developmental disorders. Moderate/superficial self-injury refers to actions which are compulsive, episodic or repetitive, resulting in moderate to minor tissue damage (e.g. many, but not all, instances of cutting). Moderate/superficial self-injury is the most common type of self-injury and is understood as serving functions such as emotional regulation, countering dissociation and re-establishing a sense of reality. Within the Australian mental health system the term 'self-harming' most often refers to this type of self-injury.

2.2 Rates

2.2.1 Suicide

Overall rates of suicide in Australia remained fairly stable across the 20th century averaging between 10 and 13 deaths per 100,000 population, despite some fluctuations, notably peaks in the early 1930s (males only) and in the middle to late 1960s (both sexes) and a lower rate (mainly among males) in the early to mid-1940s (Hassan, 1995). While the overall suicide rate decreased between 2001 and 2010, it still fell within the confines of the 100 year trend. The age-standardised suicide rate in 2010 (the most recent year available) was 10.5 deaths per 100,000 population, down from 12.7 per 100,000 in 2001 (Australian Bureau of Statistics, 2012).

What has changed in recent decades, however, are the age patterns of suicide, particularly for males. First there was a marked increase in male youth suicide from the 1960s to 1990s, and then since 1999, a significant decrease in rates for young males, 15 to 34 years of age (Page, Taylor, & Martin, 2010). Female rates across all ages have remained relatively stable, and are consistently lower than male rates.

Across the 2001-2010 period, males were between 3 and 4 times more likely to die from suicide than females. For both males and females, half of all suicide deaths occurred among those aged from early 30s to mid/late 50s (Australian Bureau of Statistics, 2012).

2.2.2   Attempted suicide

Johnston et al. (2009) analysed data from the 2007 Australian National Survey of Mental Health and Wellbeing to provide population-based estimates of suicide attempts among Australian adults (aged 16 and over). Those surveyed were asked to respond separately in relation to suicide ideation, plans and attempts, and given a brief phrase defining each of these experiences. Johnston et al. (2009) calculated that 12 month and lifetime prevalence rates for suicide attempts were 0.4% (males 0.3%, females 0.5%) and 3.2% (males 2.1%, females 4.4%) respectively. Suicide attempts were more common in women (based on lifetime prevalence rates), though not by as big a factor as was once thought, and in younger people (based on 12 month rates). Extrapolating these figures to the whole Australian adult population indicated that over a 12 month period 65,000 Australian adults make a suicide attempt, while more than half a million Australians make an attempt during their lifetime (from an adult population of approximately 16 million).

By comparison a large survey conducted across 17 countries found a cross-national lifetime prevalence for suicide attempts of 2.7% (Nock et al., 2008), slightly lower than the Australian figure of 3.2%. Johnston et al. (2009) noted however that the Australian rates were somewhat lower than those in the countries considered most similar to Australia, namely New Zealand (lifetime suicide attempts 4.5%) and the United States (5.0%).

2.2.3   Suicide ideation and transition to suicide attempt

The large-scale population based surveys reported above have asked about suicide ideation, and suicide plans, as well as suicide attempts. In Australia Johnston et al. (2009) calculated that 12 month and lifetime prevalence rates for suicide ideation in adults were 2.3% (males 1.8%, females 2.7%) and 13.3% (males 11.5%, females

15%) respectively. The rates for making suicide plans (12 month prevalence 0.6%, lifetime 4.0%) were much closer to the rates for suicide attempts than to rates of ideation. Based on an earlier 1997 population survey Pirkis, Burgess, and Dunt (2000) found that 12% of those who reported suicide ideation within the previous 12 months went on to make a suicide attempt within the same 12 month period.

In the 17 country study (Nock et al., 2008) the cross-national lifetime prevalence for suicide ideation was 9.2% and for suicide plans was 3.1%, both rates somewhat lower than the comparable Australian ones (13.3% and 4.0%). Once again however the Australian rates were generally lower than those in New Zealand (lifetime ideation 15.7%, plans 5.5%) and the United States (15.5% and 5.4%) (Johnston et al., 2009). In the Nock et al. (2008) study, when suicide ideation was followed by suicide plan and attempt, 60% of these transitions occurred within the first year after the onset of suicidal thoughts.

2.3   Methods

In 2010 almost 60% of male suicides in Australia were by hanging, with poisoning by substances other than drugs the next most common method (almost 11%; total self-poisonings 18%). Rates of firearm suicides have decreased since the introduction of stricter gun control measures. Hanging was also the most common method for women (45%), though not by such a large margin. The next most common method for women was poisoning by drugs (28%; total self-poisonings 35%) (Australian Bureau of Statistics, 2012).

2.4   One population or two?

Farberow and Shneidman (1961) and Stengel (1970) long ago began a conversation about whether those who suicide and those who attempt suicide constitute one population or two. These authors were inclined to think they were two different populations, based largely on demographic patterns, such as higher rates of suicide in men and higher rates of attempts in women. The issue has since been re-visited by Linehan (1986) and more recently by Beautrais (2001). Looking specifically at suicide and medically serious suicide attempts, Beautrais concluded they were

overlapping populations, which, despite gender differences, shared common psychiatric history, diagnostic and socio-economic characteristics.

2.5   Risk factors

Since the focus of the current study is on experiences following a suicide attempt rather than factors associated with initial risk, an extensive discussion of risk factors is beyond the scope of this thesis. However, consistent with Beautrais' (2001) conclusion about overlapping populations, there are significant commonalities in risk factors for suicide and attempted suicide, particularly for medically serious attempts. Many researchers have suggested that 90% of suicides occur in the context of psychiatric disorders (Moscicki, 1995), although it is clear that a majority of individuals with a psychiatric disorder do not suicide. Nearly all psychiatric disorders are associated with elevated rates of both suicide and suicide attempts, with psychoses, substance-related disorders, major affective/mood disorders and personality disorders posing particular risk (Beautrais, Wells, McGee, & Oakley Browne, 2006; Brent & Perper, 1995; Carter, Page, Clover, & Taylor, 2007; Li, Page, Martin, & Taylor, 2011; Paris, 1990; Robinson et al., 2009). There is some evidence that anxiety disorders may be more commonly associated with attempted suicide than with suicide (Beautrais, 2001). However Fawcett et al., (1990) found that co-morbid anxiety, in the context of depressive disorder, was associated with increased risk of suicide.

Interestingly Borges et al., (2010) found that while psychiatric disorder was significantly associated with the experience of suicidal ideation, few psychiatric disorders predicted suicide attempts among those reporting such ideation during the preceding 12 months. (Of the few psychiatric disorder predictors, conduct disorder was the most consistent.) This was a large cross-national study using epidemiological community samples. The findings suggest that while psychiatric disorder is associated with the kind of distress that may lead to serious thoughts of suicide, it is frequently other factors that trigger a move from thoughts to action. Predictors of suicide attempts among ideators in developed countries included unemployment, childhood abuse or neglect and/or family violence (Borges et al., 2010). These factors also

feature in the findings of other studies looking at risk factors beyond psychiatric diagnosis.

In general, divorced and widowed persons have higher rates of suicide and attempted suicide than married persons (Cantor & Slater, 1995; Moscicki, 1995; Pirkis et al., 2000), with the acute separation phase being particularly high risk (Ide, Wyder, Kolves, & De Leo, 2010). Other significant risk factors for suicidality include intimate partner violence and childhood sexual abuse (Devries et al., 2011, consistent with Borges et al, 2010), lack of acceptance or victimization associated with lesbian, gay, bisexual or transgender sexual orientation (Waldo, Hesson-McInnis, & D'Augelli, 1998), homelessness (Sibthorpe, Drinkwater, Gardner, & Bammer, 1995) and a range of family discord factors (Brent & Perper, 1995; Séguin, Lynch, Labelle, & Gagnon, 2004). Unemployment and low income are associated with elevated risk for suicide attempts (Borges et al., 2010) and suicide (Hassan, 1995). Li et al. (2011) found that socio-economic factors, such as low educational achievement and low occupational status, carried a similar level of attributable risk for suicide as did affective and substance-related disorders.

2.6   Fatal or non-fatal repetition of self-harm

Early risk factor research established a previous suicide attempt as a risk factor for later suicide and in many studies this has been the strongest single predictor of suicide (Hawton & Catalan, 1987; Moscicki, 1995). In Maris' (1981) study the most powerful predictor of completed suicide was the number of previous suicide attempts. More recently Joiner et al., (2005) found, across a series of studies, that the association between past suicidal behaviour and current suicidality persisted even after controlling for covariates including demographic factors, hopelessness and a range of psychiatric symptoms. Nevertheless a majority of those who die by suicide do not have a recorded history of a previous attempt (Clark & Fawcett, 1992; Maris, 1981).

In a systematic review of research since 1970, Owens et al. (2002) found the median rate of repetition following a hospital-treated episode of non-fatal self-harm was approximately 15-16% during the first year, rising to 20-25 % over the longer term. Almost 2% had died by suicide by the one-year follow-up, rising to 5-7% after

approximately nine years. In this review, hospital-treated non-fatal self-harm was broadly defined without reference to the issue of suicidal or non-suicidal intent. Owens et al. noted methodological issues in relation to sample size, comprehensiveness of case inclusion in the sample and ascertainment of outcome at follow-up. Nevertheless the rates reported above reflect the findings of the better quality studies.

Research on repetition of self-harm has frequently used a definition of 'deliberate self-harm' based on the 1980s/1990s WHO definition of parasuicide (De Leo et al., 2006) – deliberate, non-habitual self-harm without a requirement for specification of suicidal intent. In these studies repetition of deliberate self-harm was found to be associated with the presence of a psychiatric disorder/more psychiatric symptoms (Scoliers, Portzky, van Heeringen, & Audenaert, 2009; Sinclair, Horton, & Gray, 2010), harmful use of alcohol (Sinclair et al.), female gender and lower level of education (Scoliers et al.) and also with 'passive avoidance' as a mode of problem-solving (McAuliffe et al., 2006). However a limitation in some of these studies (e.g. Scoliers et al.) is the rate of attrition between index episode and follow-up. More comprehensive population monitoring may yield somewhat different findings. For example, according to Arensman, Corcoran, and Fitzgerald (2011), recent population-based studies in Ireland have found a higher rate of self-harm repetition in men than in women - in contrast to earlier reports. In these studies the risk of repetition was highest in the first three months after the index episode, with half the repetition events occurring in that timeframe. As Arensman et al. (2011) argued, this suggests a need for more consistent psychosocial assessment and better follow-up care for this group.

2.7   Conclusion

Over the past two decades suicide prevention has been a significant focus of mental health policy and research in Australia. Much of this has focused on youth suicide (in response to the increase in male youth suicide from the 1960s to 1990s). However given that half of all suicide deaths occur among those aged from early 30s to mid/late 50s, the broader adult age group warrants more attention. There is substantial research indicating that a previous suicide attempt is associated with an increased risk for further attempts and/or subsequent suicide. This suggests the importance of further

research aimed at understanding experiences following suicide attempt and the processes of recovery or non-recovery. To some extent research in the field of suicidology has been held back by a lack of standard nomenclature, making it difficult to compare studies using different criteria and terminology to select and describe their samples. While there has been some progress in analysing the definitional issues and proposing revised nomenclature, the process of characterising suicidal (or non-suicidal) intent remains a complex one.

Chapter 3 Phenomenology and theory

In parallel with the epidemiological investigations discussed in the previous section, there is a substantial body of work focussed at the individual level and aimed at describing and understanding suicidal actions and suicidal states of mind. The two figures who shaped the study of suicide in the first half of the 20th century were Durkheim and Freud. The second half of the century saw a significant expansion of the study of suicide in the clinical context with a greater diversity of voices and views and this has continued into the 21st century.

3.1   Beginning with Durkheim: The social context

Durkheim (1966) is usually credited as being the first person to conduct a systematic study of suicide. His theory is centrally concerned with variation in suicide rates, a social phenomenon, rather than with an individual's suicidal state of mind. As such Durkheim's theory highlighted the role of social or community connectedness in suicidal actions. The theory assumed the existence of vulnerable suicide-prone individuals and then argued that the nature of social bonds and/or social regulation may act either to hold such people in life or to facilitate their movement towards suicide.

According to Durkheim (1966) suicide may occur in the context of overridingly strong social bonding where the individual is highly identified with the group and group goals (altruistic suicide), or in the context of weak social bonding, where the individual has little sense of belonging, feels alone, and hence operates on the basis of individual needs, without being constrained by allegiance to the collective (egoistic suicide). Hassan (1995) defines Durkheim's concept of social regulation as the extent to which society is capable of 'exercising control over individual passions' (p.6). Anomic suicide is related to a sudden and unexpected change in the person's social situation such that the person feels outside of the usual structures of social regulation. Fatalistic suicide occurs in the context of excessive regulation which is experienced as blocking all personal control.

Thus Durkheim was not only a pioneer in developing theoretical explanations of essentially epidemiological data, he also made it clear the individual needs to be considered in social context. Furthermore he drew attention to the diversity of suicide, arguing that several types of suicide could be identified. It is well to remember that not all suicides or suicidal actions are the same.

3.2   Psychoanalytic foundations: The internal tyrant and the acquiescing self

Freud's paper 'Mourning and melancholia' (1917) laid the foundation for the psychoanalytic study of suicide. In 'Mourning and melancholia' Freud started with a clinical observation: He observed that what distinguishes melancholia from mourning is that the melancholic displays an extraordinary self-denigration. Mourning and melancholia both occur in the context of loss, in the case of melancholia the loss of a relationship marked by ambivalence where love and hate are both strongly felt. After the loss of the relationship, hatred for the other turns inward and is directed at a part of the self which is identified with the lost other. Freud argued that melancholia was more likely to develop if the relationship had been based on a degree of narcissistic identification. An excessively strong and harsh 'critical agency' (superego) rages against the ego, producing intense guilt or self-denigration. In this context Freud raised the issue of suicide and wondered how self-hatred can overcome the strength of the life force. He concluded (p.252) that 'the ego can kill itself only if ..... it can treat itself as an object' (i.e. as an other). Here he alluded to the role of intrapsychic splitting in the suicidal state.

Freud returned to the issue of suicide in 'The ego and the id' (1923), noting again how in melancholia, the superego 'rages against the ego in a cruel fashion' (p.54), in essence raging against the object which has been taken into the ego through identification. Freud referred to the superego as a tyrant who 'often enough succeeds in driving the ego into death'. Importantly Freud stated that 'The ego ventures no objection; it admits its guilt and submits to the punishment' (p.52). Freud (1923) went on to discuss circumstances in which the ego 'gives itself up', or gives up on itself, the main circumstance being one of abandonment. Freud said that in melancholia, 'the ego gives itself up because it feels hated and persecuted by the superego, instead of

loved. To the ego, therefore, living means the same as being loved' (p.61). Freud invoked the protective functions of both the father and the mother, and said that in certain circumstances, the ego 'sees itself deserted by all protecting forces and lets itself die' (p.61).

Thus Freud introduced four ideas which were to remain significant in the conceptualisation of suicide, although for a long time the first received the most attention:

  i.   identification with the lost or rejecting other and the turning of murderous aggression against the self
  ii.   an intrapsychic split between internal aggressor and victim
  iii. the ego (victim) acquiescing in its punishment, acquiescing in death (perhaps because of guilt for the death wish against the other)
  iv.   a sense of abandonment leading the ego to give up on itself and let itself die

It is possible to think about these either as elements of the one suicide scenario, or alternatively as two kinds of suicide: one where death is a consequence of attack, and one where death is a consequence of abandonment (as outlined by Maltsberger & Goldblatt, 1996).

Karl Menninger (1938) developed and extended the psychoanalytic view of suicide, with a detailed exploration of the role of aggression in the suicidal state. He argued that three elements converge in suicide: the wish to kill (aggression toward others), the wish to be killed (aggression toward self), and the wish to die (wish for cessation of suffering). According to Menninger all three elements are present in every suicide but one element predominates. (The Japanese author Mishima is an example where the wish to be killed was prominent - he arranged for a disciple, a 'loyal executioner' to kill him in a ceremonial and public way.) Menninger's three elements have sometimes been referred to as the suicide triad.

3.3   Suicidal actions as a 'cry for help'

While the theory of aggression turned inward remained very influential, the 1950s and early 1960s saw a significant focus on the communicative aspects of suicide and

especially suicide attempts. In 1961 Farberow and Shneidman (1961) published a book about suicide entitled 'The cry for help', in which they, together with other contributors, developed the view that a suicide attempt was a communication aimed (consciously or unconsciously) at engaging someone in helping to change a situation experienced as unbearable. They wrote 'The title, *The Cry for Help*, is meant to convey our feelings …. about the messages of suffering and anguish and the pleas for response that are expressed by and contained within suicidal behaviours' (p.xi). The authors were a pioneering group of clinicians in California who were, around that time, setting up the first designated Suicide Prevention Centre. Their concept of a suicidal action as a cry for help entered the lexicon of everyday speech.

Also in the 1960s Erwin Stengel (1970) in Britain published the first edition of a slim but influential volume. He observed that within every suicide attempt lies an element of appeal to someone else, sometimes to God or 'fate', to decide what the outcome will be. This came to be known as the appeal function of the suicide attempt. Taking this a step further, Jensen & Petty (1996) advanced the idea that the suicidal act involves a test for the person who is cast in the role of potential rescuer – this may be a family member or it may be a therapist.

3.4   A more differentiated phenomenology of suicide

By 1970 Robert Litman thought that in the decades after Freud there had been a relative over-emphasis on the idea of aggression turned inward and insufficient emphasis on the helplessness and dependency related to the sense of abandonment, and on erotic/masochistic elements, the sense at times of a love affair with death. Litman (1996) wrote 'The mechanism of regression and the themes in suicide of helplessness, constriction and paranoid distrust have made the deepest impression on me' (p.216). He thought that at a time of suicidal crisis the individual feels helpless, hopeless, and abandoned. The following two decades saw the emergence of an expanded and more differentiated phenomenology of suicide as clinicians and theorists sought more precise and comprehensive description of the suicidal state of mind, or perhaps more accurately, the various suicidal states of mind. In the following discussion various elements of a suicidal state are discussed separately, although in actuality many of the elements will be intertwined and co-existent.

3.4.1   *Unbearable psychological pain*

Edwin Shneidman (1984) disagreed with the early psychoanalysts about the idea that suicide involves wishing for the death of another and hostility directed at an introjected image of a loved one. He argued that the person who suicides does not usually even wish to kill him or herself, let alone someone else. According to Shneidman the central issue in suicide is not hostility or killing, but rather stopping the 'consciousness of unbearable pain'. In this view suicide is not a move towards death but a movement away from unendurable suffering. Shneidman (1984) wrote that the suicidal state is better understood as 'anguish over the plight of the writhing self' (p.321).

The view that suicide is about the cessation of unbearable psychological pain is accepted as fundamental in other influential theoretical accounts e.g. Beck and Weishaar (1990), Hendin (1991), Maltsberger (1988). Williams (1997) wrote of suicide as 'a cry of pain' in contrast to the earlier notion of a 'cry for help'. In the latter decades of the 20th century, clinical theorists analysed and extended ideas about the nature of the unbearable psychological pain which the suicidal person seeks to escape. Maltsberger (1988) described intense affective states characterized by a sense of utter and hopeless aloneness, burning self-contempt and murderous rage. Hendin (1991) discussed despair, guilt and rage, and also noted that some suicidal people describe an emotional deadness, which he saw as due to efforts to blot out rage and despair.

3.4.2   *Hopelessness-helplessness*

Bibring (1953) developed the idea that helplessness in the face of emotional suffering, and the associated hopelessness that ensues, are core experiences in depression. However the role of hopelessness as a central issue in suicide gained wide recognition with the work of Aaron Beck. Beck's extensive research found that hopelessness was more strongly related to current suicidal intent than was depression per se (Beck, Kovacs, & Weissman, 1975). Furthermore hopelessness was predictive of eventual suicide (during follow-up periods up to 10 years after index admission) in a sample of

hospitalised suicide ideators (Beck, Steer, Kovacs, & Garrison, 1985) and a sample of psychiatric outpatients (Beck, Brown, Berchick, Stewart, & Steer, 1990). This finding was not replicated in a sample of suicide attempters (Beck & Steer, 1989) possibly because hopelessness was assessed after the suicide attempt not before. In a major study of hospitalised patients with mood disorders, Fawcett et al. (1990) found that hopelessness (assessed at admission) predicted suicide occurring more than a year after discharge, but did not predict suicide in the first year.

Hopelessness as a central element in suicide is widely acknowledged across a range of theories, and, as in Bibring's (1953) work, is often linked with helplessness. For example Shneidman (1992, 1994) identified hopelessness-helplessness as the common emotional state in suicide. Litman (1996) discussed hopelessness in the context of feeling helpless and abandoned. Hopelessness was seen as an affective state by some theorists (e.g. Hendin, 1991; Shneidman, 1992), but as a cognitive factor by Beck and Weishaar (1990) who defined it as a potentially recurring state of pessimism or negative expectations. Hendin (1991) argued that some people who feel hopeless are resigned to their situation and that suicide risk arises when desperation is combined with hopelessness

3.4.3   Rage

In keeping with the psychoanalytic tradition, Maltsberger (1988) and Hendin (1991) both considered murderous rage as one of the affective states leading to unbearable psychological pain. Hendin described rage which is experienced as out of control, disorganising of the self, and tearing apart the person's capacity to function. His observations suggested that suicidal disturbance is associated with feeling overwhelmed by loss of control over angry, murderous impulses. While Hendin suggested that what is disturbing is the fear of ego disintegration, Maltsberger suggested that occasionally suicide occurs to protect the lives of others (from one's own aggression).

Empirical studies have reported a link between aggression and suicide in at least some suicidal individuals (and of course the occurrence of murder-suicide is a particularly stark example of this). Brent et al. (1993) found that aggressive and homicidal

ideation was common among young suicide completers. Plutchnik and van Praag (1990) estimated that about 30% of violent individuals have histories of suicidal behaviour while 10-20% of persons who are suicidal have histories of violent behaviour.

3.4.4   Aloneness/sense of abandonment

For Shneidman (1992) a sense of isolation, of desertion and loss of support is one of the basic and omnipresent elements of suicide. Similarly Maltsberger (1988) saw aloneness as one of several types of potentially lethal and overwhelming pain. He stated that aloneness, in its most extreme form is 'an experience beyond hope' (p.50). Not only does the person feel alone and unloved but all memory of love and all possibility of love is inaccessible to mental life. In keeping with Freud's equation of love and life, Maltsberger suggested the person is gripped by 'the anxiety of annihilation' (p.50). The aloneness discussed here is beyond loneliness, for while the lonely person suffers from a painful loss of love and connection, the idea of connection remains possible and the memory of love endures and sustains the basic existence of the self.

Maltsberger and Buie (1980) suggested that the experience of unbearable aloneness is linked with a lack of identifications with a comfort-giving carer. The inability to comfort oneself means it is not possible to rest easy when alone or separate: 'The suicidal patient finds the state of adult separateness a source of constant anxiety' (p.70). It also makes the person vulnerable to intense feelings of helplessness.

3.4.5   Self-contempt, shame and guilt

Burning self-contempt is another variety of lethal psychological pain identified by Maltsberger (1988). This scornful attack on the self is harder to bear when the person also feels valueless and worthless. In Hendin and Haas' (1991) study of U.S. Vietnam veterans, suicidality was associated with guilt about actions committed in combat, often involving civilians and while feeling out of control. Hendin (1991) noted that guilt related to suicidal behaviour may be reality based or it may be delusional as in depressive delusions of sin and worthlessness.

King and Apter (1996) pointed to the relevance of shame and perceived failure. They reported on youth suicide in the Israeli army, thus considering a population where major psychiatric disorder had been largely screened out. They found that common precipitants of suicide were self-perceived failure and perceived humiliation, occurring in a context of 'unrealistic and uncompromising self-demands for high levels of achievement and coping, even in the face of difficulties' (p.497). Shame combined with a life-long isolative personality style prohibited these young people turning to others for help. King and Apter suggested that for some suicidal people the key trigger may be loss and for others the key trigger may be perceived failure. In this analysis King and Apter followed the work of Blatt (2004) in suggesting there are two types of depressive vulnerability, one related to dependent personality features and the other based on a self-critical personality. They suggested that negative interpersonal events, such as rejection and loss, may be significant triggers for suicidal actions in dependent personalities while achievement failures may have particular significance for self-critical personalities.

3.4.6   *Perturbation/desperation*

Reflecting on those few patients he had seen shortly before their suicides, Hendin (1991) reported that their affective state was characterised by desperation more than by hopelessness or despair. He noted that desperation involves a sense of anxiety and urgency as well as hopelessness. This is similar to Shneidman's (1992) core concept of perturbation, a term referring to how disturbed or anguished the person is. In Shneidman's view perturbation is central to the suicidal state and includes an element of agitation and action-orientation. Interestingly Fawcett et al. (1990) in their follow-up study of people hospitalised for depression, found that anxiety-related symptoms (in the context of depression) were predictive of suicide within the next 12 months.

3.4.7   *Ambivalence*

Shneidman (1992, p.55) found a ubiquitous ambivalence in the 'internal attitude toward suicide: to feel one has to do it, and at the same time to yearn (even to plan) for rescue and intervention'. Ambivalence is widely recognised as a crucial aspect of

suicidal ideation, with the balance between the desire for death (or cessation of consciousness) and the desire for life fluctuating over time. Aiming to understand more about ambivalence, and how to assess it, lead to research on reasons for living within a context of suicidal ideation (Linehan, Goodstein, Nielsen, & Chiles, 1983).

3.4.8   Perceptual/cognitive constriction

Shneidman (1984) argued that the cognitive state associated with suicide is characterised by a constriction of the mind, a pathological narrowing of focus such that the person sees only two choices, either unbearable suffering or death. The mind's narrowed focus excludes and disregards normally life-sustaining factors such as relationships with loved ones. Weishaar and Beck (1992) identified a similar cognitive state which they characterised as dichotomous or 'all-or-nothing' thinking.

3.4.9   Perceived burdensomeness

More recently Joiner and colleagues (Joiner, 2005; Joiner, Van Orden, Witte, & Rudd, 2009) have identified a sense of being a burden on others, and that this was an irremediable condition, as a core component of suicidality. Perceived burdensomeness (and Joiner emphasised the 'perceived') involves a sense of being ineffective and helpless, and that this impinges on, and lets down, others whose wellbeing is held dear. Joiner et al. (2009) described perceived burdensomeness as one of the twin motors of suicidal desire, the other being thwarted connectedness or a painful sense of not belonging.

3.5   Suicide fantasies and the meaning of death

Two very interesting papers (one by Maltsberger and Buie, another by Asch) published in the same issue of International Review of Psychoanalysis in 1980 explored fantasies underlying suicide. Asch (1996) argued that in suicide there is frequently a double aim: 'first cleansing the self', and then uniting, re-uniting or fusing with 'an omnipotent love object' (p382). In relation to the first part of the fantasy, Asch suggested that while the suicidal aim may be in part to punish the self, the primary aim is to cleanse, to get rid of the 'bad part'. He quoted Alvarez (1971):

'the act, successful or not, is fundamentally an attempt at exorcism'. Once cleansed, the person can be loved again by the significant other. The fusion fantasy involves the internal conflict between sadistic superego and hated 'bad part of the self' being externalised by projecting the superego sadism onto an external object. The person then sees himself (or herself) as a passive victim, a role he (or she) may seek out or resist. Asch argued that not enough emphasis has been given to the passive aims in suicidal behaviour. As discussed previously by Stengel (1970), Asch (1996) noted that 'the power of life or death, the role of executioner, is thrust onto "fate" ' (p.386) – fate will decide. Asch advocated the need to discover who it is 'that fate is a screen for', i.e. who is it that the person has chosen to be executioner.

Thus in contrast to Jensen & Petty's (1996) idea that the suicidal act involves casting someone in the role of potential rescuer, Asch (1996) argued that the suicidal person may be 'responding to loss with an effort to enlist or force the significant object to act as an actual or imagined executioner'(p.381). In a related vein, Hendin (1981) cautioned that the therapist needs to consider whether the patient has cast him or her for the role of rescuer or the role of executioner. However while his paper focussed on unconscious submission to a passive masochistic role, Asch (1996) said that not all suicides are passive. Some suicides may be a defence against surrender, an expression of control over one's life and death. He cited the 'realistic' suicide of a cancer patient. In fantasy, 'the helpless, passive role is shifted to an active "identification with the aggressor", "fate" is thwarted, the cancer is cheated of its death power' (p.383).

Maltsberger and Buie (1980) discussed suicidal fantasies around the themes of revenge, riddance, and rebirth. These fantasies carry within them a sense that life continues after death, that the person will somehow be able to 'see' or experience the consequences of the suicidal act. The fantasy associated with suicide may be one of revenge and punishment ('they'll be sorry'), with an implication that the person will in some way be able to witness the effects of his or her suicide on others. Both Hendin (1991) and Maltsberger and Buie discussed the fantasies of rebirth and reunion. Death may be viewed as 'the bliss of dreamless sleep', or as a passage to a new world with a chance to start again. The person may anticipate a reunion or fusion with a dead loved one, or may see death as becoming 'nothing'. However the 'nothingness' sought is not eternal solitude, but rather the fantasy is to lose one's sense of identity and

separateness and become one with nature or the universe. In relation to the theme of riddance, Maltsberger and Buie returned to the theme of a divided inner life, where parts of the self are engaged in a murderous struggle. For example, a scornful conscience relentlessly attacks a depressed, helpless self (identified with the body-self) until the depressed self acquiesces in death. (This is Freud's model of melancholic suicide.) Alternately, the body may be identified with a hostile, attacking part of the self, which is experienced as separate from the thinking, feeling 'real me'. In fantasy the attacker-torturer is killed to preserve the 'real me'. In this analysis, suicide may be understood as an effort to get rid of an intolerable part of oneself, but the aim is not total self-annihilation.

Hendin (1991) noted that for Freud the desire for revenge via self-destruction was unconscious, but today feelings of murderous rage are often disturbingly conscious. Hendin also discussed the concept of suicide as a 'retaliatory abandonment', through which the person gains an illusion of control by abandoning rather than being abandoned. The fantasy underlying suicide may also be one of self-punishment or atonement, which may relate to not living up to an impossible, idealised image of the self, guilt for actions taken or sins committed, or a painful sense of failure and humiliation.

3.6   The alienated body self

Maltsberger (1993) wrote that 'suicidal patients are restless tenants of their bodies' (p.148). They frequently have disturbed relationships between the body and the rest of the self. In exploring this issue Maltsberger referred back to Freud's formulation about identification of the self with another person who is both loved and hated, making it possible to treat a part of the self as a hated other. Maltsberger argued that this formulation becomes more helpful in relation to suicide if we consider which part or parts of the self become identified with the other. He argued that it is the body or body-self which takes on the identification with the other and is experienced as 'not me'. Similarly Laufer and colleagues (Laufer, 1995) in discussing adolescent suicide referred to the development of the alienated body-self, that in some way through puberty the body of the suicidal adolescent has developed into an enemy. Maltsberger (1993) suggested that the alienated body may be experienced as troublesome or

defective to various degrees, as unreal, empty, as a cage or prison, even as a persecutor or as possessed by alien presences (e.g. in psychoses). Once the body has been objectified it can be seen as the vile source of unacceptable erotic or sadistic fantasies. According to Laufer (1995) and Maltsberger (1993) many people who suicide have the fantasy (at the edge of awareness) that the mental self will escape from the flesh, and survive the physical self-destruction, thus making suicide more possible.

3.7   Dyadic/systemic aspects: The relationship context

There is general agreement that the suicidal person's relationship to others is characterised by a sense of isolation and loss of support. Shneidman (1984) noted that the suicide context is often a highly charged relationship crisis, and Hendin (1991) discussed experiences of loss, separation and abandonment. Maltsberger (1988) suggested that the suicidal person has often been dependent on others (or sometimes on work) as a stabilizing influence, because of an incapacity to comfort or sustain him or herself. Despair threatens when the sustaining relationship is lost. Hendin noted that in some instances the suicidal person may use his or her possible death as a way of relating to and attempting to control others. It is worth noting that at times the suicidal person's perception of loss of support may be a product of despair and cognitive constriction leading to an inability to see or access support which is potentially available.

Richman and Rosenbaum (1996) argued for more attention to the dyadic/systemic nature of hostility and death wishes within some families of suicidal people. While some suicidal people have more family support available to them than they are able to recognize, for others family relationships may well be toxic. In any case it seems that suicide-vulnerable people are supremely sensitive to rejection and to families' exhausted withdrawal or giving up.

3.8   From the suicidal state of mind to suicidal action

In his 1970s/1980s formulations Shneidman (1993b) conceptualised a tendency to action as an inherent part of the state of perturbation, which he saw as the key driver

of lethality. Nevertheless in the clinical/conceptual literature the focus was more on mapping the internal mental states associated with suicide. In the past 15 years or so there has been increased focus on the way people move from the mental state of suicidality to engaging in a suicidal action. Thomas Joiner has been a leading voice in this discussion and has re-examined the question raised by Freud about how a suicidal person overcomes the life force.

Joiner (2005) argued that 'the ability to enact lethal self-injury is acquired' (p.46) through repeated exposure to pain, injury and/or physical danger. Such exposure allows habituation to pain and to the fear responses usually aroused by the prospect of injury, including self-injury, while also building knowledge about dangerous behaviours. The most readily identifiable form of such exposure is previous self-injury or suicide attempts, which may also serve to reduce the sense of taboo around suicidal actions. Joiner also suggested that as the fear recedes, the idea of suicide or self-injury as a comfort may increase. Furthermore Joiner (2002, 2005) argued that other forms of exposure to pain, injury or violence, or even intense mental rehearsal of suicide plans, may also lead to an acquired capacity for self-injury. However he also noted that acquired capability, of itself, is necessary but not sufficient for high suicide risk. Acquired capability only becomes a risk when there is also a desire for suicide, which in interpersonal theory (Joiner et al., 2009) arises from a sense of failed belongingness and perceived burdensomeness. Joiner (2005) cited a range of evidence to support the theory of acquired capability including a study which found that, among people presenting with a current suicidal crisis, those who had previously made multiple suicide attempts presented with more severe suicidality than those who had made a single attempt and those with previous suicidal ideation but no attempt (Rudd, Joiner, & Rajab, 1996).

3.9   The suicidal crisis as trauma

In recent years Maltsberger, Goldblatt and colleagues have published a series of papers examining trauma and the suicidal crisis. The role of trauma, whether experienced early in life (Devries et al., 2011) or in adulthood (Hendin & Haas, 1991), in developing, or contributing to, a vulnerability to suicide has been recognised for some time. However Maltsberger, Goldblatt, Ronningstam, Weinberg, and

Schechter (2011) have conceptualised the suicidal crisis itself as a traumatic experience. In this conceptualisation, the subjective experience of suicidality is one of intense and unbearable affect which is unregulated and completely overwhelming, inducing a sense of helplessness and a breaking up of the self via a disintegration of internal self-representations. The overwhelming affect is experienced as coming from outside the increasingly helpless self, in an 'intolerable deluge' (Maltsberger, 2008), akin to a traumatic assault. This process may be triggered by external events, sometimes by a recapitulation of an earlier trauma, but the subjective traumatic experience arises within the mind. As discussed by Maltsberger et al. (2011) the nature of the traumatic affects may include many of the types of unbearable pain discussed above: desperation, hopelessness and despair, self-hate, guilt, rage, feelings of abandonment and aloneness, together with anxiety. Whether the experience becomes one of traumatic disintegration of the self, depends on the person's capacity to bear intense affect (or perhaps the capacity to bear this particular intense affect at this time). If suicidal crisis is, in essence, a traumatic experience arising from within, then it is relevant to consider the psychological consequences of living through a traumatic event. Re-experiencing symptoms are a well-recognised feature of post-trauma reactions and Maltsberger et al. argued that these phenomena provide a way of understanding the elevated risk of repetition after an initial suicide attempt. In this analysis experiencing the initial suicidal crisis produces a vulnerability to re-experiencing the overwhelming affective deluge. Moreover the horror and helplessness engendered by the first experience may have further damaged the capacity of the self to endure the onslaught. Thus there is an increased likelihood that escape from the intolerable will be sought through a suicidal action.

3.10   Conclusion

Over the past century, and particularly the past few decades, theorists have mapped a range of unendurable affective, cognitive and relationship experiences that are considered central to a suicidal state of mind. Maltsberger et al. (2011) argued that this overwhelming and intolerable affective onslaught is experienced by the self as a traumatic assault. Thus a suicidal crisis is a traumatic experience, a view consistent with McGinley and Rimmer's (1992) characterisation of a suicide attempt as a traumatic event (as discussed in Chapter 1). The period following a suicide attempt is

then potentially marked by post-trauma reactions and post-trauma vulnerabilities, vulnerabilities which Maltsberger et al. argued are associated with increased likelihood of further suicidal crisis or action. According to Joiner (2005) a suicide attempt, the act of self-injury, has particular consequences in countering the taboo around self-harm and reducing the associated fear, thus developing a capability for further attempts. It seems particularly important then to understand more about experiences following a suicide attempt, how the attempt impacts on the person, and the way in which the unbearable affects of the suicidal state may, or may not, recede, intensify, recur or resolve. Furthermore a suicide attempt takes place in a relationship context and the way the attempt impacts on relationships also warrants particular attention. The next chapter reviews the literature about experiences following a suicide attempt.

Chapter 4 Experiences following a suicide attempt

This chapter reviews the recent literature on experiences following a suicide attempt. It begins with a brief discussion of clinical and theoretical perspectives and then proceeds to discuss empirical research studies. Much of the (comparatively limited) post-suicide attempt research has focused on statistical outcomes in terms of rates of, and risk factors for, further suicide attempts or suicide. It is mainly in the past decade that some studies have begun to focus on the nature of experience following a suicide attempt. Because of the focus of this thesis on exploring and understanding experience, there is an emphasis in this chapter on studies using qualitative methodology.

4.1 Suicidality after a suicide attempt: A range of possibilities

4.1.1 Catharsis

In a paper initially presented in 1938, Zilboorg (1996) discussed the case of a female patient who showed remarkable improvement after an attempted suicide by hanging. He suggested that many suicidal people feel calmer and more serene shortly after a suicide attempt especially if it has been a medically serious one. He went on to develop the argument that the reason is that a highly charged emotional state, in this case aggression against the self, has been expressed or discharged. He likened this to a situation where a person who is very angry, and has been holding it in, erupts in a tirade or punches someone and then finds the anger has dissipated and the person is now calm. This view of a suicide attempt having a cathartic effect held considerable currency in decades past but has been less widely accepted in recent times. However Sarfati, Bouchard, and Hardy-Baylé (2003) have advocated for its continuing relevance. They argued that a suicide attempt has a 'resolving power' (p.76), and went so far as to suggest that the seeking of this cathartic resolution of painful affect may contribute to the occurrence of repeat attempts. This is a similar argument to the more widely held view that non-suicidal self-harm (such as cutting) serves an emotional regulation function, releasing tension, anger and distress (Favazza, 1996).

4.1.2   The attempt as a gateway to further suicidality

Contrary to the position outlined above, Joiner (2002) has argued that a suicide attempt effectively opens a gateway to further suicidality. In this view a suicide attempt is a kind of rehearsal, a way of 'working up to the act' (Joiner, 2005, p.47). It reduces the fear, and the sense of danger and alarm, that is otherwise associated with self-injury and usually likely to prevent it. According to Joiner a suicide attempt also enables the person to learn more about how to do it. Joiner (2005) argued that the ability to enact lethal self-injury is acquired, and it is acquired through mental or physical rehearsal. This means that after a person has made one suicide attempt he or she has increased capacity to make another – but will do so only if the desire to suicide and the painful states that underlie such a desire are also present. Joiner (2002, 2005) argued that the theory of acquired capability is consistent with, and at least partially explains, the epidemiological findings that a suicide attempt is associated with elevated risk for further attempt or suicide. According to this view, the reason that many people who make one suicide attempt do not make another is because the desire for suicide is no longer present even though the capability is retained.

4.1.3   The attempt as disruptor of fantasy meanings of suicide

Another possibility may be that confronting the reality of a suicide attempt may create a shift in the underlying (at least partly unconscious) fantasy meanings of suicide, or of death. Alvarez (1971) may provide an example of this in what he says about his own suicide attempt, resultant coma and near death. He wrote that he expected something of death, some kind of solution: 'a synoptic vision of life, crisis by crisis, all suddenly explained, justified, redeemed' (p.235). But instead of 'something overwhelming, an experience which would clarify all my confusions', what he got was just 'a denial of experience' (p.234). Given his level of drunkenness at the time, it seems unlikely these ideas were particularly clear in Alvarez's mind at the time he overdosed. They may only have become clear in retrospect, but he described using the refrain of wishing he was dead as a kind of mantra 'to ward off devils' (p.226) for a long time before his suicide attempt. He located this fantasy of the power and promise of death somewhere within an idealistic, over-sensitive, over-intense self which

somehow hadn't quite grown up, and wrote that after (a rather slow) recovery from the suicide attempt, these aspects of his self were gone. He gradually emerged as 'less theoretical, less optimistic [although he had been severely depressed], less vulnerable' (p.234), and had accepted that there weren't going to be any answers, even in death.

4.1.4   *The attempt precipitates a change in life circumstances*

The three possible effects of a suicide attempt outlined above (sections 4.1.1 to 4.1.3) concern a change within the person's inner life or mental state. Another possibility is that a suicide attempt may result in a change to external life circumstances, which in turn may make a further attempt or subsequent suicide either more or less likely. In Joiner's (2005) terms the external change may impact on desire for suicide. This could occur, for example, where a suicide attempt somehow results in removal or escape from entrapment within a toxic and/or violent relationship or family. More generally a first suicide attempt may result in a first offer of psychotherapy or other psychiatric treatment, which may over time lead to significant change. Any such change in external life circumstances could occur at the same time as one of the internal psychological changes discussed above.

4.2   Research: Experiences and life course after a suicide attempt

The main body of research looking at what happens after a suicide attempt has focussed on the rates of, and risk factors for, repeat attempts and/or later suicide. Typically a range of information has been collected at the time of the index suicide attempt and some (perhaps 5 or 10) years later, hospital and/or coroner's records have been consulted to establish the number of suicide deaths or repeat presentations to hospital. These studies were discussed in Chapter 2. The research indicates that people who have made an initial suicide attempt have an elevated risk of repeat attempts or suicide, and also a higher rate of mortality in general. While some risk factors have been investigated, it has proved difficult to predict with any precision who is most at risk.

Much of this research has not involved following up the people concerned in person, face to face. Indeed there has been surprisingly little research focussed on people's

experiences after a suicide attempt and the nature of their subsequent life course, whether this entails a process of recovery or a continuing struggle or some combination of the two. Yet the elevated risk identified in the epidemiological studies provides a strong reason to try to understand more about experiences after a suicide attempt, in the short and longer term. This section reviews studies where people who have made a suicide attempt have been informants about their own experience of the attempt, its aftermath and/or their life in the years that followed. Firstly a group of studies are reviewed which have used structured interviews as the mode of data collection for long-term follow-up. These are large-scale studies using mainly quantitative analyses, and they sought to describe some aspects of life course (in addition to any focus on identifying risk factors). This is followed by a discussion of smaller scale studies, more exploratory in nature. The findings of one retrospective survey study are presented, followed by a review of studies using semi-structured or narrative style interviews and qualitative methods of data analysis.

4.2.1   *Large scale prospective follow-up studies*

The major large scale, prospective, interview-based follow-up study has been conducted in New Zealand by Annette Beautrais and colleagues. Prospective studies, more limited in scope, have also been reported from Ireland (Curran, Fitzgerald, & Greene, 1999) and Norway (Dieserud, Røysamb, Braverman, Dalgard, & Ekeberg, 2003). The New Zealand study followed up 302 individuals who made medically serious suicide attempts, defined as requiring hospital admission for more than 24 hours and, during admission, meeting criteria for severity based on type and extent of treatment required, or having used a highly lethal method (Beautrais et al., 1996). Males made up 46.4% of the sample and females 53.6%. After a wide-ranging interview at baseline, follow up involved personal interviews at 6, 18, 30 and 60 months. At 5 years 86% of surviving participants were interviewed, a high retention rate compared to other studies. As well as documenting rates of mortality, suicide and nonfatal suicide attempts, the Beautrais et al. study aimed to collect follow up information about psychiatric morbidity and aspects of psychosocial functioning. In contrast Dieserud et al.'s 18 month follow-up of 50 'suicide attempters' (defined in terms of parasuicide) focused mainly on predicting repetition. Curran et al. focused on psychopathology in following-up 39 parasuicide patients approximately eight and a

half years after initial hospital presentation. Compared to Beautrais et al. these two studies had smaller samples, narrower focus and only one follow up time point. They also used a broader definition of suicide attempt/parasuicide, with no inclusion criteria related to levels of lethality.

The baseline interview in the New Zealand study included a series of questions about reactions to surviving the index attempt. Beautrais (2004) provided response data for those who later suicided compared to those who did not. Using these data to calculate response rates for the whole sample of 302, it seems that immediately after the index attempt: 15.0% were angry they didn't die; 52.1% were relieved they didn't die; 50.6% still had thoughts they wanted to die; and 20.2% thought they would make another attempt.

At the 30 month follow up Beautrais, Joyce, and Mulder (2000) reported that many in the sample had continued to struggle with various aspects of their lives. At the time of at least one of the 3 follow-up interviews (6, 18 and/or 30 months) 46% met DSM-III-R criteria for major depressive disorder and 40% met criteria for a substance-use disorder. Similarly Curran et al. (1999) found significant psychopathology at follow-up, with approximately half the sample meeting criteria for a disorder or receiving maintenance treatment. Beyond diagnosis, Beautrais et al., (2000) found that other psychosocial difficulties were frequently experienced. Within the 30 month period approximately 59% reported relationship problems, 30% had faced legal charges and 9% had at least one term of imprisonment. Almost 73% had been social welfare beneficiaries at the time of at least one follow-up interview, with almost half the sample receiving benefits at the 30 month point. Beautrais and colleagues' study is important in widening the focus of suicide attempt outcome research beyond a count of subsequent suicides or further attempts and even beyond the assessment of psychopathology. Nevertheless it provides only a limited window onto the nature of participants' experience in the months or years following a suicide attempt.

Beautrais and colleagues were also interested in the question of prediction. After 5 years 6.7% of their participants had died by suicide (1 in every 15) and an estimated 37% had made at least one non-fatal suicide attempt (Beautrais, 2004). These rates are higher than those reported elsewhere in the literature, but Beautrais noted that most

other reports concern groups not specifically selected as high risk. A wide range of baseline variables were examined to see whether it was possible to predict who was most likely to make a further attempt or to suicide. Predictors for a further suicide attempt were hopelessness (measured on the Beck scale), having made a previous attempt prior to baseline (i.e., having already established a history of a repeat attempt), and admission to a psychiatric hospital in the year prior to the index attempt. Interestingly Dieserud et al. (2003) reported quite different predictive factors. In their study, neither hopelessness nor previous attempt prior to baseline predicted repetition of suicide attempt/parasuicide, while the predictors were low self-efficacy and low self-appraised problem-solving ability. The contrasting findings may reflect the different definitions of suicide attempt (inclusion criteria) in the two studies. Beautrais (2004) also examined prediction of suicide, with relevant factors being formal educational qualifications, strong hope to die at index attempt and reactions to surviving initial attempt (not being relieved at surviving, still having thoughts of wanting to die and anticipating making a further attempt). While these factors were statistically significant, they had only limited capacity to distinguish those who later suicided from those who did not. Psychiatric diagnosis was generally not helpful in predicting risk.

Beautrais (2004) concluded that capacity to predict repeat suicide attempts and/or suicide from baseline characteristics is poor. She suggested that 'the factors that determine subsequent suicidality may relate to treatment, life events, changes in social circumstances, and mental health' (p. 10). In relation to implications for clinical practice Beautrais (2004) emphasised the need for the whole of this high risk group to receive treatment, follow-up, support and monitoring to reduce risks of further suicidal actions, rather than trying to identify those at the very highest risk.

4.2.2   *Retrospective survey*

Chesley and Loring-McNulty (2003) surveyed 50 people who had made a suicide attempt. Participants were recruited through newspaper advertisements or stories in several US states. Suicide attempt was self-defined and, unlike the Beautrais study, there were no criteria concerning medical seriousness. The sample was 86% female and 52% had made more than one suicide attempt. Average time since last attempt

was 10 years, although some participants had made an attempt in the previous year. Overdose of prescribed or non-prescribed drugs was the most common method (62% of all attempts), with other methods including cutting wrists, strangulation, jumping, asphyxiation, use of firearm, and deliberately driving offroad. In a mail-out survey, participants were asked open questions about feelings after the suicide attempt and protective/preventive aspects of their current situation.

In relation to emotions experienced immediately after the suicide attempt, at least half the sample reported feeling sad, depressed, disappointed and/or empty. Other feelings were anger, embarrassment/shame, and happiness/relief (Chesley & Loring-McNulty, 2003). Participants were not specifically asked about continuing feelings of wanting to die in the period immediately after the attempt, though the response of 'disappointed' suggests this may have been the case for some. Current feelings related to having survived the suicide attempt were predominantly more positive with 60% of participants glad or grateful. Other current feelings were hopeful, angry, sad or depressed, ambivalent and shame/embarrassment. It would have been interesting to hear more about meaning of these latter feelings and their place in the participants' current life. However in summary these participants did not seem to experience a cathartic effect immediately after the suicide attempt but years later most were glad to be alive.

Chesley and Loring-McNulty (2003) also asked participants about preventive factors past and present. When asked whether someone or something had made a difference in keeping them alive (subsequent to the attempt), the most common response was children (32% of sample), followed by treatment with a health care professional, sense of empowerment, improved self-esteem, stronger sense of self, spirituality, relationship with significant other, and/or relationship with family and friends. These responses are consistent with Beautrais' (2004) comment about the likely role of life events and treatment in influencing long-term outcomes. A question about what is keeping the respondent from attempting suicide now, yielded many of the same categories, treatment with a health care professional being the most common response (26%), with a new outlook on life and/or achieving personal or professional success emerging more prominently. Asking participants how they learned to cope with suicidal feelings yielded a wide range of responses. Most commonly mentioned were

treatment with a health care professional (36% of sample), sharing feelings with others (28%), and involvement in activities/hobbies (28%). Other responses included relationships with friends, improved self-esteem, spirituality, recognising that suicidal thoughts are transient, involvement in support groups, having a sense of control over one's life, medication, journaling and professional success.

Participants identified a great many, no doubt inter-related, experiences as helping them in managing or overcoming suicidality. Relationships and sense of self seem central and it is encouraging that treatment with a health care professional was helpful to many. Chesley and Loring-McNulty (2003) noted as limitations the study being retrospective (with possible inaccuracies in remembering) and the participants being self-selected with males possibly under-represented. A further limitation is that a survey (even one with open questions) does not allow for any additional exploration of the participants' initial responses.

4.2.3   Qualitative research: Lived experience following a suicide attempt

Qualitative studies aim to throw some light on the factors (essentially experiences over time) that Beautrais (2004) thought likely to influence subsequent suicidality. Such studies seek to understand experiences of suicidality and how these connect with experiences of treatment, the impact of life events and social circumstances and fluctuations in mental health. Qualitative research aims to elucidate intrapsychic and interpersonal processes and experiences and ultimately to inform intervention.

Qualitative studies of experiences following a suicide attempt tend to be widely dispersed in the literature and are rarely brought together for review. PsycInfo, Medline and Cinahl databases were searched using the following terms: 'suicide attempt', 'attempted suicide' or 'suicidal' and 'recovery', 'experience' or 'qualitative'. Studies were included for review if they a) used qualitative methodology and b) had asked people who had made a suicide attempt about their experiences following the attempt. Hence qualitative studies that focused on experiences preceding a suicide attempt or at the time of being suicidal, but did not discuss experiences following the attempt, were not included (except where they were part of an inter-related group of studies).

Following the initial database searches, some further studies were identified through examination of the reference lists of studies identified in the search. This pointed to some studies using the term 'deliberate self-harm' rather than 'suicide attempt', which in turn led to some further database searching. Studies using the term 'deliberate self-harm' were only included for review if they clearly defined self-harm as encompassing actions both with and without suicidal intent. Studies which used the Favazza (1996) definition of self-harm (i.e. without suicidal intent) were excluded from the review.

The published reports of these studies can be divided into those which focus on internal psychological experience, relationships and life circumstances (discussed in this section) and those which focus on experiences of treatment or contact with services (discussed in section 4.2.4). There are also a small number of studies reporting from the perspective of family members of people who made a suicide attempt.

The studies are relatively few in number, and study participants vary in terms of cultural context, age range and life circumstances. Moreover summarising the findings of qualitative studies necessarily runs the risk that some rich description and analysis of meaning will be lost. In an effort to minimise this and keep a sense of context, in the following section studies are discussed individually before an attempt is made to draw together the overall patterns emerging from this body of research.

4.2.3.1 Inner life, relationships and life circumstances

In the first two studies reviewed, participants were interviewed days or weeks after their suicide attempt, some while still in a psychiatric or medical ward. In the remaining studies a longer time had usually elapsed between the suicide attempt and the interview. Crocker, Clare, and Evans (2006), in the U.K., interviewed older adults (aged 65-91) about their subjective experience and understanding of the pathway to and from a recent suicide attempt. (Attempts construed as euthanasia were excluded.) In relation to the period after the suicide attempt the participants were concerned about regaining control and becoming visible to others. Participants felt prior to the

suicide attempt that they had lost control over significant aspects of their life or functioning (often in ways that were associated with the ageing process). Hope and optimism were generated when participants were able to regain a sense of control afterwards, with regained control often a product of medical intervention to reduce pain and/or other symptoms. Those who failed to regain a sense of control struggled with feelings of failure and shame about the suicide attempt and experienced a continued helplessness about the future. In relation to becoming visible, participants had felt, prior to the suicide attempt, isolated, lonely, disconnected even if others were present, and that they were becoming invisible to the world. After the suicide attempt participants had either a positive or negative experience of becoming more visible. For some, the suicide attempt mobilised support systems and revealed that people did notice and care, revitalising the participant. Others, sadly, felt that they became more visible, but visible as a burden to others, including medical staff. Crocker et al. (2006) wrote about their participants' suicidal struggle taking place within a context of ageing and perceived or potential decline, and hence of belonging to a marginalised and stigmatised group. Since suicidal behaviour also attracts stigma, these participants may be doubly stigmatised, especially in the case of those who did not emerge from the experience with renewed optimism. (An alternative, but not encouraging, possibility is that the stigma of ageing reduces the stigma of suicide as the life is seen as less valuable.)

Tzeng (2001), in Taiwan, interviewed men and women (aged 20-52) who had made a suicide attempt in the previous two to eight weeks. At the time of the interview participants were still experiencing high levels of distress and seemed to be struggling with the same issues as they had struggled with prior to the suicide attempt. Tzeng (2001) characterised the struggle as 'feeling trapped in a circle' (p.304). Three dimensions or conflicts were identified as underlying the sense of being trapped: being controlled by others vs. striving to live for oneself; being rebuffed by others vs. seeking company and being loved; wanting to leave the family vs. feeling responsible for family. It is noteworthy that these are all relationship issues, and also that the issues of control and connection emerged again as they did in the Crocker et al. (2006) study, although these may be manifested differently in the two differing contexts. Tzeng (2001) reported that participants felt embarrassed about attempting suicide and, while they still struggled with suicidal thoughts, there was some shift

because of not wanting to lose face or be seen to lack filial piety. These important cultural values acted as a counterweight to suicidality. Some participants found that their families offered special support and care after the suicide attempt. Despite this, participants' difficulties communicating with their families, present before the suicide attempt, did not resolve after the attempt (at least not in the two to eight week span of the study). In discussing Chinese cultural attitudes to suicide Tzeng (2001) noted that suicide is shameful if done for the individual self (rather than for the greater good) and stressed in conclusion that health professionals must understand suicide attempters' embarrassment.

In a relatively early study, Mehta (1990) investigated attempted suicide in 'Indian' (South Asian) Singaporean women. She interviewed 35 women with a main focus on understanding the factors that contribute to the (at least at that time) comparatively high rate of attempted suicide in women of this community. Socio-cultural issues and associated family relationship problems (the subordinate roles of Indian women as daughters and wives, expectations and conflicts about both arranged and 'love' marriages, marital conflict, conflict with in-laws) emerged as important factors along with family violence, migration stress and social isolation. Among those women with the most serious suicidal intent, the main cause of stress was relationship problems with husbands. In relation to the period after the suicide attempt, Mehta (1990) inquired about responses to the suicide attempt by those close to the women. Among the 24 women who had a spouse or a boyfriend, half reported that the attempt had a positive effect in that the spouse/boyfriend expressed concern or sympathy. This concern was reassuring for those who had previously felt their spouse/boyfriend did not care about them anymore. Four women reported a negative response (scolding or anger), and for the remainder, there was no effect or the spouse/boyfriend did not know about the attempt. When asked about family members and friends, 24 of the 35 women reported a positive reaction (concern, sympathy or a greater understanding of the respondent's needs or problems). For five unhappily married women the suicide attempt paved the way for their return to the parental home. Six respondents spontaneously related that the suicide attempt had been a self-strengthening and maturing experience in their lives, which resulted in greater adjustment to and acceptance of their life situation. Overall Mehta (1990) suggested that the suicide attempt was a turning point in the lives of a majority of the respondents. Twenty two

of the 35 women emerged from the aftermath with a hopeful attitude toward the future. However 12 expressed little hope and felt their problems remained unresolved. One respondent had 'no hope' and was seen as being at high risk for a further suicide attempt.

Several studies have set out to explore the process of overcoming or moving away from suicidality or self-harming. In England, Sinclair and Green (2005) interviewed 20 participants selected from a larger cohort who, seven years previously, had received hospital treatment for deliberate self-poisoning. Participants were selected for the qualitative study if they had not self-harmed in the past two years. They were asked about life at the time of the self-poisoning, about life now, and about what had changed, or stayed the same, in the intervening seven years. The researchers identified three key narratives, with each narrative pertaining to a sub-group of participants. For those who were adolescents at the time of the index self-harm, the key narrative concerned resolution of adolescent chaos. The chaos was in the unpredictability of family life, and in some instances experiences of abuse or violence. Resolution came through establishing autonomy and independence, breaking away from family and overcoming the lack of control previously experienced. A second key narrative concerned recognising alcohol as a factor in deliberate self-harm. For this group, whereas alcohol had perpetuated a cycle of depression, anger and self-loathing, abstaining from alcohol permitted a regained sense of self-worth. The third narrative concerned coming to see deliberate self-harm as a consequence of depressive illness, and subsequently finding ways to manage or treat depressive symptoms.

Everall and colleagues (Bostik & Everall, 2007; Everall, Altrows, et al., 2006) reported on a series of studies in Canada focused on adolescents' and emerging adults' experiences of overcoming suicidality. Study participants reported persistent suicidal ideation spanning several years (on average), with many having made one or more suicide attempts, but they had not been suicidal for at least six months. The experience of being suicidal was characterised by overwhelming despair, shame and self-loathing, alienation and isolation (Everall, Bostik, & Paulson, 2006), and a sense of lack of control (Everall, 2000). The experience of overcoming suicidality was associated with several inter-connected processes which Everall, Altrows, et al. (2006) analysed in terms of resilience. Participants actively sought and managed to

establish at least one caring and supportive relationship, whether with a parent, friend, teacher or counsellor. They described facing difficult feelings (sadness, anger, fear) and beginning to express these feelings to others, as well as through writing. Having someone who listened without judging, who cared and saw 'good' in them, led to a shift in self-perceptions and a greater recognition of the possibility of personal control. A sense of agency and control was built up by taking action in relation to their own lives and developing goals, plans and a sense of purpose. On the basis of their analysis, Everall, Altrows, et al. (2006) argued that resilience and the factors underpinning it are not necessarily present (or inherent in the person) prior to suicidal experience and recovery, but are built during the process of healing.

In a similar adolescent sample, Bostik and Everall (2007) aimed to look more closely at the nature of the interpersonal processes that contributed to the experience of overcoming suicidality. They identified attachment relationships as central to the experience of healing. Components of the attachment experience included finding acceptance (even of feelings that had previously been kept hidden for fear of rejection), experiencing intimacy and closeness, and a sense of consistency or permanency within the relationship. Receiving encouragement was also significant, with participants valuing the experience of having someone who was interested in what they were doing right rather than wrong. As participants developed a sense of connection within attachment relationships, they developed a greater sense of self-worth and stopped feeling so different from others. A life that had felt empty began to feel meaningful. For the adolescents in these studies, the processes of overcoming suicidality and the processes of 'growing up' seem to have been complementary in supporting the development of a greater sense of autonomy, meaningful identity and belonging (Everall, Bostik, & Paulson, 2005).

Bergmans, Langley, Links, and Lavery (2009) also sought to understand the process through which young adults move away from suicide-related behaviours. They interviewed 16 young Canadians (aged 18 to 25) who had completed an intervention program for people with a history of repeated suicide attempts. Participants were seen as still in the process of recovery from suicidality, with 11 reporting no suicide attempts since the intervention and 5 reporting reduced suicide-related behaviour. Using grounded theory methodology, Bergmans, Langley, et al. (2009)

conceptualised the transition toward lower suicide risk as a pathway with three major elements. The pathway began in a place identified as 'living to die' (p. 122), characterised by a strong affinity with death, as a comfort, as a way of not feeling, or as an identity of non-deservedness. Then something unsettled this initial state and nudged the person toward a painful ambivalence, a transitional space marked by unanticipated turning points. The turning points involved experiences that led to a changing realisation about wanting to die versus wanting to live. The third element was termed pockets of recovery, underpinned by new skills and insights such as awareness of choices, and recognising and tolerating intense feelings. The process of change was seen as incremental. Support from family, friends and professionals made a significant contribution, although some participants found it necessary to jettison toxic relationships.

In a collaboration between researchers and graduates of the above-mentioned intervention program, Bergmans, Carruthers, et al. (2009) explored the experience of returning to paid employment after a process of healing from recurrent suicide attempts and associated mental illness. While acknowledging employment as a marker of renewed strength and confidence, the paper focused mainly on the challenges of returning to work. Stigma was a central issue. A stigmatised sense of self acquired through immersion in the mental health system and self-definition as mentally ill was associated with loss of belief in one's skills and abilities. This was mirrored by stigmatising attitudes within the workplace which acted to prohibit disclosure of personal experience and history. Managing a mental illness while navigating the written and unwritten expectations of the workplace was identified as a considerable challenge, and Bergmans, Carruthers, et al. (2009) argued for more understanding and support from employers and managers.

While some studies specifically recruited participants who had not been suicidal for some time, in other studies suicidality was more of an ongoing struggle. Biong, Karlsson, and Svensson (2008) interviewed four Norwegian men and characterised their narratives as expressing a shifting sense of sense of self before and after, and sometimes in between, suicide attempts. Participants in this study were aged 32 to 40, were recruited from substance abuse services, had used illicit drugs for more than five years, had previously attempted suicide, were receiving treatment and not currently

under the influence of illegal substances. The men described what seemed like a longstanding sense, before their suicide attempt(s), of being isolated, an outsider, abandoned or trapped - in their drug use and in their sense of alienation. As their situation deteriorated they moved to a point characterised by the researchers as 'being close to the point of no return' (p.38), where a sense of existential emptiness or loss of control combined with a major negative life event to precipitate a suicide attempt. At the time of interview (for three of the men more than six months after, but in one case only one month after, their last suicide attempt) they were understood as 'still being on the edge' (p.39). The men described ambiguous or contradictory positions where they still experienced suicidality but also felt to varying degrees engaged in treatment, which held out a possibility of hope.

A few studies which focused mainly on pathways toward a suicide attempt, or the experience of suicidality, nevertheless gave some attention to experiences after the attempt. From Canada, Kidd and Kral (2002) reported a qualitative study in which 29 street youth, many of whom had engaged in prostitution, were interviewed about their experiences with, and understanding of, suicide and attempted suicide. Seventy six per cent of participants reported a history of attempted suicide with most of these reporting more than one attempt. Much of the interview and analysis focussed on the feelings and experiences preceding a suicide attempt (abusive and neglectful upbringing, a range of negative experiences on the street, with themes of isolation, rejection/betrayal, lack of control and low self-worth). However there was some brief discussion about experiences following a suicide attempt. The study included five participants who were gay and made their only suicide attempt before they were living on the street. These participants found that a level of acceptance among the street community had reduced their suicidality. In contrast, participants who attempted suicide while on the street spoke of the superficiality of most street 'friendships' and said that after they had made a suicide attempt no-one really cared. Despite this, participants did see talking to friends as a way of dealing with pain. When discussing what helped them through bad times, 26% of participants rather poignantly mentioned 'the thought that they were not meant to die as a result of a suicide attempt after surviving so many' (Kidd & Kral, 2002, p. 424).

In New York City, Zayas, Gulbas, Fedoravicius, and Cabassa (2010) interviewed 27 adolescent Latinas following an incident of suicide-related behaviour or self-harm. Approximately half the girls expressed suicidal intent. Suicide-related behaviour took place against a background of disrupted family structures, conflict with parents, abuse or bullying. The loneliness and alienation experienced by the girls was understood by the researchers in terms of cultural discontinuity, in particular, shifting roles for women as the girls tried to bridge two cultures. At the time of the interview (2 to 26 weeks later), some girls expressed regret about their actions, and worried about the implications for their future, e.g., being seen as 'crazy', or not being able to get a job. A similar concern about stigma was expressed by some adolescents in a British study (Dorer, Feehan, Vostanis, & Winkley, 1999). Some girls in Zayas et al.'s (2010) study were facing current stigmatisation, being teased and bullied by schoolmates who had discovered their contact with the mental health system. For some others, however, the self-harm or suicide-related incident had positive repercussions in bringing the family together, opening up communication, and making it clear that someone cared.

While some adolescent participants within the above studies reported that family relationships improved over the medium to long term following a suicide attempt, there has been little reporting of family reactions in the short term. This was addressed in a British semi-structured interview study following hospital admission for overdose (Dorer et al., 1999). The most common parental reaction, as perceived by adolescents, was distress and concern. The second most common response was anger. Almost one third of the adolescents reported they had been ignored, while one-fifth felt those around them had responded by being overprotective. Peers were reported as thinking the overdose was 'stupid'.

4.2.3.2   *Family member perspectives*

There have been very few interview studies of family experiences following a suicide attempt. Of those few, some structured interview studies analysed their data in terms of response percentages. Two such studies (Kjellin & Östman, 2005; Magne-Ingvar & Öjehagen, 1999) found that family members of people who have made a suicide attempt continued to worry that their relative would harm themselves again. Many of these family members (parents, partners or others nominated by the suicidal person)

expressed a need for more professional support, psychological care or counselling for themselves after their relative's suicide attempt. Many also expressed a desire for greater involvement in their relative's psychiatric treatment. The fact that, one year later, nearly half the family members in Magne-Ingvar and Öjehagen's (1999) study had not talked to their relative about the suicide attempt, could suggest that more family involvement in treatment would be helpful in establishing more communication. Magne-Ingvar and Öjehagen noted however that little is known about the effect on patients of involving family members in their treatment.

Studies of family member experiences in which there was a more extensive qualitative data analysis were hard to find. However in one such study Sun and Long (2008) interviewed Taiwanese family members about their experiences of caring for a relative who had recently been discharged from hospital following a suicide attempt or persistent suicidal ideation. The ex-patients, many of whom had made multiple suicide attempts and some of whom continued to have suicidal thoughts, were also asked about their experience of their family members caring for them. Fifteen families participated and interviews were conducted within six weeks of discharge. While family members struggling with suicidality indicated that strong family support was helpful to them, the family carers found providing care and support difficult and stressful. They felt they had to be 'on guard day and night' (p.1945) to try to ensure their family member's safety, and put a lot of time and energy into maintaining activities of daily living and trying to create a nurturing environment. Sun and Long (2008) characterised the family carers' core experience as one of 'impending burnout' (p.1946), noting they were physically and mentally exhausted. There was, however, some variation across families, in terms of the quality of relationships and family carers' capacity to cope. When family relationships were good, suicidal family members were more likely to express painful feelings and to receive a supportive response. On the other hand, when family members experienced intolerable burnout they could no longer respond or provide daily care and the former patient's suicidality escalated. In general however, across the whole group, family members were more able to provide practical care than to respond to mental health issues. Family stress was further complicated by the stigma attached to suicide in Chinese society (Sun & Long, 2008; Sun, Long, Huang, & Huang, 2008). The researchers advocated psycho-education for family members caring for a recently suicidal relative.

4.2.3.3   Summary: Inner life, relationships and life circumstances

In the studies outlined above, experiences of suicidality were characterised by intense feelings of despair, shame and self-loathing, alienation, isolation, existential emptiness (Biong et al., 2008; Everall, Bostik, et al., 2006; Kidd & Kral, 2002), and a sense of close affinity with death (Bergmans, Langley, et al., 2009). Feelings of lack of control were common (Biong et al., 2008; Crocker et al., 2006; Everall, 2000), as was the experience of feeling trapped, whether by family relationships and internal conflicts (Tzeng, 2001), by drug use and position as an outsider (Biong et al., 2008), or by rigid family and social expectations (Mehta, 1990). In some instances these experiences were underpinned by chaos and unpredictability within families, or by histories of abuse and violence (Curtis, 2006; Kidd & Kral, 2002; Sinclair & Green, 2005). Zayas et al. (2010) identified shifting cultural values as a significant contextual factor in some communities.

Psychological outcomes following a suicide attempt were varied, with some people still feeling suicidal and struggling with, or feeling trapped by, the same difficulties as before the attempt (Biong et al., 2008; Tzeng, 2001). Feelings of shame and embarrassment about the suicide attempt were prominent in more than one cultural context, as indicated by Tzeng (2001) in Taiwan, Wiklander, Samuelsson, and Åsberg (2003) in Sweden, and, when loss of control issues were not resolved, by Crocker et al. (2006) in the UK. However for some, the suicide attempt constituted a turning point, either by allowing escape from a trapped position, e.g overcoming cultural prohibitions against leaving an unhappy marriage (Mehta, 1990), or through contact with services that helped the person regain a sense of control, e.g by treating physical infirmity (Crocker et al., 2006) or depressive symptoms (Sinclair & Green, 2005). For others, the suicide attempt seemed to trigger a re-assessment of, and re-adjustment to, the person's life situation, resulting in a sense of self-strengthening (Mehta, 1990).

In some instances following the suicide attempt, family members offered increased care and support (Tzeng, 2001; Zayas et al., 2010) or greater understanding of the person's needs (Mehta, 1990). Nevertheless relationship and communication difficulties within families did not necessarily resolve (Tzeng, 2001), and in some

families the suicide attempt was not spoken about, or at least not spoken about with the person who made the attempt (Magne-Ingvar & Öjehagen, 1999). More immediate family reactions, as perceived by adolescents following an overdose, included distress, concern, anger, ignoring the incident, and over-protectiveness (Dorer et al., 1999). From the perspective of family members, their relative's suicide attempt generated a great deal of worry (Kjellin & Östman, 2005; Magne-Ingvar & Öjehagen, 1999), and those caring for suicidal family members at home were struggling with impending burnout (Sun et al., 2008). It seemed family members found it more difficult to respond to their relative's mental health needs than to provide physical care (Sun et al., 2008).

Some studies focussed specifically on the process of overcoming or recovering from suicidality. These experiences were characterised by regaining or developing a sense of control, connecting or re-connecting with others, and recognising and tolerating intense, difficult feelings and beginning to express them (Bergmans, Langley, et al., 2009; Crocker et al., 2006; Everall, Altrows, et al., 2006). For adolescents and young people, establishing independence and autonomy and taking action in relation to their own lives was often an important part of the process (Everall, Altrows, et al., 2006; Sinclair & Green, 2005), and this could sometimes mean breaking links with a toxic family situation (Bergmans, Langley, et al., 2009). Establishing a close, consistent relationship with a supportive other was a foundational experience within the process of overcoming suicidality, at least for adolescents (Bostik & Everall, 2007; Everall, Altrows, et al., 2006). In this context many parents were able to respond to this need, but for some adolescents the core relationship was with someone outside the family. Key components within these attachment experiences were finding acceptance, receiving encouragement, experiencing intimacy and closeness and being able to trust in the ongoing nature of the relationship (Bostik & Everall, 2007). Finding acceptance was also noted by Kidd and Kral (2002) as significant for gay street youth within their study. For some young people, transitioning from suicide-related behaviour involved an incremental process of responding to life events or existential triggers that prompted a shift in the balance between attachment to life and attachment to death (Bergmans, Langley, et al., 2009). For others, across adulthood, a key experience was recognising and addressing contributing factors, such as alcohol abuse or depression (Sinclair & Green, 2005).

Many of the studies reviewed focussed on the experiences of adolescents and emerging adults and one study (Crocker et al., 2006) on the 65 plus age group. Only four studies (Biong et al., 2008; Mehta, 1990; Sinclair & Green, 2005; Tzeng, 2001) examined experiences of a broader adult age group, encompassing the decades of early and middle adulthood. Moreover two of these studies were conducted in Asia (Mehta; Tzeng) where cultural attitudes and beliefs about suicidal behaviour may, in some respects, be different to attitudes prevailing in the West. This paucity of focus on the middle years is not so evident in studies of post-suicide-attempt experiences with clinical services which are reviewed in the next section.

4.2.4   Research: Experiences of clinical services

4.2.4.1   Qualitative studies

In this section, experiences of hospitalisation are discussed first, followed by experiences of psychotherapy and counselling. A Swedish study by Samuelsson et al. (2000) focused on experiences of inpatient psychiatric care after a suicide attempt. Eighteen people, who had been admitted from an emergency department to a specialized hospital ward for suicidal patients, were interviewed shortly before discharge. Participants expressed shame about the suicide attempt and hospitalisation but also relief about being hospitalised as they felt they could no longer cope. Those who had been on the same ward previously felt particularly embarrassed at returning after a further suicide attempt. Many participants commented about the care and sense of security provided on the ward. This contrasted with the experience on arrival at the psychiatric emergency room where many respondents perceived staff as uncaring and lacking in consideration. Participants emphasised the importance of staff commitment (e.g. responding when patients needed to talk) and respect. They found it confirming that staff regarded their suicide attempt as serious but also communicated a belief that the patient could be helped. Also important were understanding, sensitivity to patients' needs (e.g. whether they needed to talk or to be left alone) and the sense that the staff trusted them or had confidence in them. Perceptions of the care provided were more positive than negative. However participants perceived instances of lack of respect (eg being treated like a child, arrangements made without explanation, having

to tell their story over again to various staff without knowing the purpose of doing so). Instances of feeling not understood or confirmed gave rise to feelings of being burdensome. Some participants reported tensions around staff searching belongings or removing items considered dangerous; they understood why it was done but were sensitive to the lack of confidence in them. Overall nearly all participants in this study saw their hospitalisation as helpful. They described the opportunity to talk and to be understood as of central importance. Samuelsson et al. (2000) noted that participants in this study were describing experiences on a ward specialising in care for suicidal patients, with many staff trained for this purpose. Experiences may be different in less specialised mental health services.

Wiklander et al. (2003) elaborated on the shame reactions spontaneously described by 13 of 18 patients interviewed in Samuelsson et al.'s (2000) study. Aspects of the shame reactions included feelings of failure, feelings of being exposed, being ashamed of oneself, impulses to hide or flee and experiences of transgressing boundaries. Respondents' experiences of care, and especially admission to care, had an influence on shame reactions. Being treated with kindness and respect at admission tended to alleviate initial shame reactions pertaining to the suicide attempt. Patients were sensitive to the attitudes of hospital staff at initial encounter and this experience influenced willingness to be admitted. It helped when staff were non-judgmental about the suicide attempt. A tolerant and flexible atmosphere and low demands helped patients to accept treatment and feel less ashamed. 'Feelings of shame were exacerbated when [patients] felt that they had exposed themselves too much and when they experienced the personnel as unsympathetic, disrespectful, authoritative, and punishing' (Wiklander et al., 2003, p. 297). When staff were perceived as punishing or abusing their power, respondents felt petrified and reacted with silence and withdrawal.

The importance of being treated in a non-judgemental manner was reiterated by the adolescents in Dorer et al.'s (1999) study. Consistent with McGinley and Rimmer's (1992) observations, the adolescents had expected to be judged harshly and seen as wasting staff time, and were comforted when, against expectations, their distress was taken seriously. Staff friendliness and acceptance was seen as the most positive aspect of the hospital experience.

In Sinclair and Green's (2005) British study, outlined above, sub-groups of participants had contrasting experiences of hospital admission following deliberate self-poisoning. Those who were adolescents at the time found hospital admission traumatic and frightening. It exacerbated their feelings of lack of control and they had difficulty engaging with professional staff who were strangers, whereas existing relationships with doctors and school counsellors were experienced as helpful. In contrast, those who came to see their self-harm as a consequence of depression, found hospital services helpful in initiating the recognition and treatment of depressive symptoms. Those whose self-harm was connected to alcohol abuse saw hospital admission as a temporary respite, but one which did not help them to identify and address their alcohol problems.

Strike, Rhodes, Bergmans, and Links (2006) explored the difficulties a group of Canadian men had in relation to accessing hospital and other mental health care. The focus on men is interesting given that many other studies tend to have had more female than male participants. Interviews were conducted with 15 men who had a history of suicidal behaviour, together with a substance use disorder, antisocial behaviour or borderline personality disorder. Two cyclical patterns were described, one where the men responded to negative experiences with mental health care providers by avoiding care settings, culminating in a crisis, which then precipitated involuntary care. In the second pattern, men went in search of care, approaching one provider after another (e.g. emergency department, crisis team, family doctor), but were unable to find the type of help they wanted. This led to loss of respect for care providers and potentially a deterioration in mental health. Processes contributing to these cycles included the men's difficulties in acknowledging mental health problems or, if problems were recognised, their difficulty in articulating and showing emotions. Equally significant were providers not recognising the men's distress and need for services, instances of disrespectful treatment, and assessments that were not sufficiently comprehensive. In addition the men resented being prescribed medication without being offered counselling or other opportunities to talk about their problems.

A few studies have investigated experiences of psychotherapy, within the post-suicide attempt context. Curtis (2006) interviewed 24 New Zealand women who had made a

suicide attempt before the age of 25, had engaged in no suicidal behaviour for the past year and saw themselves as having recovered from their suicidality. The women spoke about their experiences with therapists and counsellors as well as how and why they became suicidal. Nearly all the women saw family experiences (sexual and/or physical abuse, parental conflict, parental death, family suicidal history) as being key factors in their suicidality. Sexual abuse, usually by a family member, was the issue most commonly identified. In addition to the actual abuse, experiences around disclosure of abuse, either to family members or health professionals, also contributed to suicidality. The women's experiences with therapists and counsellors were mixed, with most reporting that at least one of the counsellors/therapists they had seen was unhelpful. Sometimes this meant the contact was ineffective or the woman had not felt ready to talk, but one third of the women reported a counselling or therapy that had been detrimental. Often the detrimental impact was related to issues about disclosure of sexual abuse (disbelief, minimisation, but also being pressured to disclose when not ready), and sometimes to feeling unvalidated and disempowered more generally. Women who found therapy/counselling helpful spoke of the importance of affirmation, acceptance, being able to set their own pace, and establishing a relationship that felt trustworthy and where the woman was an equal partner in the work. Unfortunately in the report of this study, it is not clear how many of the therapy/counselling experiences occurred before or after the suicide attempt or during a period of recurrent suicidality.

In Sweden, Perseius, Öjehagen, Ekdahl, Åsberg, and Samuelsson (2003) interviewed ten women (and four therapists) about their experience of dialectical behaviour therapy (DBT, a combined individual and group program). The women had been in therapy for 12 months or more and, with one exception, reported a previous history of multiple suicide attempts. Overall the participants regarded the therapy as life-saving. They valued the respect, understanding and confirmation they experienced in the therapy, as well as specific features of the DBT program such as skills development and crisis support. Participants felt that the therapy had helped them to become more self-accepting, overcoming a previous pattern of self-hate. Nevertheless they described therapy as a difficult struggle and noted the need for particular support in the beginning when they were ambivalent about continuing. The study provides a strong endorsement for the DBT program, especially in contrast to the patients'

negative accounts of earlier psychiatric care. However it might be expected that patients who have stayed in therapy for twelve months find it a valuable experience. As a complementary narrative, it would be interesting to hear about the experiences of the two patients who began the therapy but did not continue with it.

Paulson and Everall (2003), in a Canadian study, investigated previously suicidal adolescents' experiences of psychotherapy. In particular they were interested in perceptions of what was helpful. A total of 37 adolescents, predominantly female, participated over two stages of the study. The therapy/counselling received was not confined to any particular orientation, and had taken place in a range of public and private settings. The aspects of therapy found to be helpful were conceptualised as enhanced self-understanding, communication (related to open, personal disclosure), creative expression, therapeutic relationship (characterised by respect, understanding and acceptance), and therapeutic strategies. Paulson and Everall (2003) noted that a possible limitation of the study was its retrospective nature.

4.2.4.2   *Review paper*

A recent systematic review provides some complementary information about service user experiences, and echoes many of the themes discussed above. Taylor, Hawton, Fortune, and Kapur (2009) conducted a review of studies investigating views about clinical services among people who self-harmed. Self-harm was defined as 'any intentional self-poisoning or self-injury regardless of the degree of suicidal intent' (p. 104), and the most common form of self-harm across the studies was self-poisoning. The review focused on hospital-based medical and psychiatric services and post-discharge management, and covered quantitative and qualitative studies published before July 2006 and also a number of reports written for professional and government bodies. The reviewers commented on the similarity of participants' experiences across countries despite the variation in health care systems. (However most of the studies reviewed were from English-speaking countries which may suggest some degree of convergence in professional cultures even where health care systems differed.) Service users described a range of positive and negative experiences. On the negative side, service users identified a lack of patient involvement in decisions about treatment and medical/psychiatric management,

inappropriate staff behaviour and lack of staff knowledge about self-harm even when staff were seen as very competent in other ways. Inappropriate staff behaviour included being treated differently from other patients in Emergency Departments, and unsympathetic and humiliating interactions in the context of physical treatment. There were also concerns about how psychosocial assessments were carried out and about difficulties accessing after-care. Positive experiences were associated with greater participation in care and care decisions, the perception of staff as sympathetic and respectful, and being given the opportunity (usually in after-care) to talk about the issues that contributed to the self-harm.

4.2.4.3   *Summary: Experiences of clinical services*

Experiences of hospital services could be positive or negative or, most often, a mixture of both. Positive experiences were associated with perceptions of staff as caring, respectful, non-judgmental, and offering an opportunity to talk. Conversely, uncaring, disrespectful and judgmental attitudes were defining features of negative experiences (Dorer et al., 1999; Samuelsson et al., 2000; Taylor et al., 2009; Wiklander et al., 2003). Experiences of the admission process were important in either moderating or exacerbating the shame reactions associated with the suicide attempt and hospitalisation (Wiklander et al., 2003). While hospitalisation was also a relief for some (Samuelsson et al., 2000), for adolescents it could be traumatic and frightening (Sinclair & Green, 2005). Lack of involvement in decisions about treatment was a further defining feature of negative experiences, one that emerged more strongly in the review paper (Taylor et al., 2009) than in individual qualitative studies. A key negative experience identified across studies was inappropriate staff behaviour such as humiliating or punitive interactions (Taylor et al., 2009; Wiklander et al., 2003). Negative experiences of mental health care lead to avoidance of care and subsequent mental health crises, especially in men (Strike et al., 2006) but probably also, at least to some extent, in women for whom a comparable study could not be located. Men may have particular difficulties accessing care which also results in deterioration in mental health (Strike et al., 2006).

Some of the findings in relation to experiences of psychotherapy mirrored the themes identified in studies of hospital experiences. Affirmation, acceptance and respect were

core features of psychotherapy that was experienced as helpful (Curtis, 2006; Paulson & Everall, 2003; Perseius et al., 2003), facilitating the development of self-acceptance and self-understanding. Related to, and perhaps encompassing these features, was the importance of establishing a therapeutic relationship that felt trustworthy (Curtis, 2006; Paulson & Everall, 2003). In contrast, therapy or counselling was experienced as detrimental when the person felt unvalidated, disbelieved and disempowered (Curtis, 2006). Also important were being able to set one's own pace, rather than being pushed to disclose when not ready (Curtis, 2006) and being supported at the beginning of therapy when often ambivalent about continuing (Perseius et al., 2003). These findings come from a very small group of studies but are consistent with the broader literature about psychotherapy, where the therapeutic relationship is seen as an essential foundation underpinning specific therapeutic strategies.

In their review, Taylor et al., (2009) commented on the similarity of experiences across countries. Nevertheless it is worth noting that none of the qualitative studies reviewed in this chapter were conducted in Australia, and of the studies reviewed in Taylor et al.'s paper, only one report (focussed on youth) originated in Australia.

4.3   The current study: Rationale and aims

The study of experience after a suicide attempt offers an avenue to a greater understanding of suicidality during a period of potentially increased vulnerability and risk, as well as potentially illuminating processes of recovery from suicidality. This is an under-researched area and one which has considerable potential to inform clinicians' and services' engagement with suicidal people, and to contribute to the development of effective interventions and services.

One of the strengths of qualitative research is its capacity to provide a close-up, experience-near account of complex processes and multi-faceted lives. The corollary however is that the picture is, initially at least, quite context-specific. It is context-specific not only in terms of place and culture, but also in terms of type of suicide-related behaviour, age, gender, kinships, networks and the particularities of researcher-participant interactions. To look across contexts and see the patterns of similarity and difference in experience means we need a layering of many studies.

The research discussed above provides rich and valuable information about experiences of suicidality and experiences in the period after a suicide attempt. However the studies are still relatively few in number. Moreover there has been a somewhat greater focus on experiences in adolescents and youth than in adulthood, although this is not the case in studies of experiences in clinical services. There has been very little study of the way in which a suicide attempt impacts on interactions with family and friends, other than exploring the role of attachment experience in overcoming suicidality in adolescents. A number of the studies had mixed samples in the sense of including participants who had made a suicide attempt (or engaged in deliberate self-harm with unclear intent) and others who had sustained periods of suicidality without an actual suicide-related action. The current study will have its own context and boundaries but will add another layer to the existing patterns of understanding about experiences of suicidality and in particular, experiences following a suicide attempt.

The overall aim of the study is to explore the experiences of adults in the months and years following a suicide attempt. Within this broad aim, the researcher recognises several domains of experience, each of which is of interest:

- The person's emotional life or internal world
- Interaction and relationships with family and friends
- Experiences of clinical services

The researcher is also interested in what was helpful and what was not helpful across any of these domains of experience.

Chapter 5 Method

Given the exploratory nature of the research aims and the focus on understanding experience, the study employs qualitative research methods. This chapter begins with a discussion of epistemological and methodological frameworks informing the study. Then, after identifying key ethical issues, the chapter goes on to describe recruitment of participants and methods of data collection and analysis. The chapter concludes with a discussion of trustworthiness and rigour and an outline of the research context.

5.1   Epistemological and methodological frameworks

> *I tried to be honest in this book. But honesty is another can of worms:*
> *what do we mean by it? There's honesty as emotional truth and*
> *honesty as factual accuracy, and it turns out that the two are*
> *incompatible.*   (Fitzpatrick, 2010, p. 4)

Sheila Fitzpatrick wrote these words when, as a historian writing a memoir of her own childhood and family life, she confronted the gaps between her enduring, self-defining memories and the documentary record. As a memoirist she opted for emotional truth – to tell her story – but with some reference to disputed facts and alternate accounts. The issue of emotional (or narrative) truth versus historical accuracy has also been at the core of many of the debates and developments within qualitative methodology (Denzin & Lincoln, 1994, 2000) and within psychoanalysis (Schafer, 1992; Spence, 1982). The issues concern the framing of the research endeavour and the meaning of data, how we understand or interpret what people tell us and how we then report on that understanding.

Charmaz (2003, 2009) addressed these issues in contrasting what she termed, somewhat polemically, 'objectivist' grounded theory and constructivist grounded theory. The constructivist approach assumes multiple realities (rather than the one external reality of the 'objectivist' position), interactive construction of experience (rather than discovery) and that the researcher's values and positions affect process

and outcome (thus challenging the concept of the neutral observer). Furthermore constructivist grounded theory views knowledge as partial, relativistic, situated in time and space, and aims for 'interpretive understanding' (Charmaz, 2009).

Spence (1982) examined similar issues in the field of psychoanalysis. He argued that there was a tension within Freud's writings between the idea of excavating historical truth (the archaeology metaphor) and the actual practice of constructing narrative truth, which gave sequence and coherence but whose link to historical fact was less than certain. Spence (1982) referred to the analyst as 'a pattern maker not a pattern finder' (p.293). He acknowledged the existence of narrative facts ('plain' narrative), events that have occurred and are readily verifiable, but the significance and meaning of such events and the connections between them are not 'plain'. Moreover he cautioned that the push for narrative closure can lead us to 'prematurely streamline' chaotic experience (p.23).

As Kvale (2003) has argued, qualitative methods made significant contributions to psychology long before the recent surge of interest in applying qualitative paradigms developed in the social sciences. For Freud, psychoanalysis was a method of research as well as a method of treatment. Just as dreams were the 'royal road to the unconscious' of the individual patient, psychoanalysis was an avenue toward understanding human nature. The influence of the psychoanalytic method extended beyond the treatment setting to academic research contexts. Kvale (2003) traced the role of 'psychoanalytically inspired' (p.280) interview research in some of the classic and most influential psychological studies of last century, notably Piaget's studies of children's thought processes, Adorno and colleagues' study of the authoritarian personality and the Hawthorne studies of human relations in industry. He identified aspects of the psychoanalytic method that were common to interview-based research studies, notably an open mode of interviewing that allowed participants to talk freely, interpretation of meaning closely based on what was said (and not said) rather than on predetermined categories, and a tolerance for ambiguity. He noted important differences as well, in particular the treatment aims and extended timeframe of psychoanalysis, and the associated level of emotional intensity within the analyst-patient relationship. It could be argued that these differences place significant limits on adapting psychoanalytic method to qualitative research.

Nevertheless, coming from a clinical psychology background, for this researcher the clinical interview served as an entry point to qualitative methodology. A clinical interview (distinguished from a specifically diagnostic one) aims at understanding internal psychological experience and interpersonal processes, the person beyond the diagnosis (McWilliams, 2002; Sullivan, 1954). Both the clinical interview and the qualitative research interview aim to understand experience and arrive at meaning. An inclusive, open-minded mode of listening and an awareness of the interactional nature of the interview are at the core of both. Broadly speaking both are concerned with understanding the meaning which people give to their experience. The researcher (like the therapist) aims to enter into the other person's frame of reference, seeks to understand the other person's experience, while monitoring the influence of his or her own frame of reference, own role in, and experience of, the interaction. (Of course the purpose of the interview and the roles of the interviewee and interviewer are different in research compared to clinical interviewing, and hence the 'contract' between the two is also different.)

However, despite the apparent fit between psychological practice and qualitative methodology, some researchers report significant strains in trying to apply methods derived from anthropology, sociology or philosophy to the study of psychological processes. Hollway (2001, 2009) argued that qualitative methods derived from social sciences gave insufficient attention to less conscious psychological processes and privileged social identities over internal dynamics. In a related argument, Willig (2001) noted that grounded theory was originally designed to study social processes and wondered whether its approach to theory-building could be applied to psychological processes. In contrast Wertz et al. (2011) recently described the application of five qualitative research methodologies to a psychological topic, namely the experience of 'misfortune' in the form of serious life-changing illness. Smith (1996) developed interpretative phenomenological analysis at least partly as a way of bringing phenomenological method into health psychology.

There is a diverse range of qualitative approaches and the literature tends to focus on what characterises one method compared to another. However Wertz et al. (2011) recently identified foundational commonalities among five methodological

approaches (including phenomenology, constructivist grounded theory and narrative methods) as well as further potentially common constituents. Most of these commonalities concerned the process of analysing the data. Interestingly Braun and Clarke (2006) recently argued that thematic analysis is a foundational method which should be regarded as a method in its own right. They saw it as a flexible method that can be applied across a range of theoretical and epistemological frameworks. Braun and Clarke's (2006) account of thematic analysis is quite consistent with the analytic commonalities identified by Wertz et al. (2011). They noted however, that while the method is adaptable across frameworks, it is important to specify the researcher's epistemological position.

In the light of poststructuralist emphasis on language and narrative, Hollway (2006) questioned whether we have gone too far in focusing on socially mediated realities, multiple truths and the way discourse and the researcher's choices construct meaning and subjectivity. Taken too far this focus may obscure rather than illuminate experience. Discussing James and Joyce Robertson's 1950s films of children in hospital (Robertson, 1970), Hollway (2006) argued that 'attachment theory mediated the evidence because it influenced what they noticed and then how the Robertsons filmed and edited it, but it did not create the children's distress' (p.472). Recognising the reality of the children's distress (without disavowing the significance of constructivist processes) leads to what Hollway (2006) and others call a 'critical realist' epistemology.

The current study adopts a critical realist position. The researcher understands that the participant's experience, as recounted in the interview, has been constructed and reconstructed in memory and in language, and that construction has been shaped not only by the process of putting experience into words but also by emotional needs, research context and the interactional processes within the interview. Despite these processes of constructing and reconstructing, at its core the experience is real – in the inner life of the informant and in the here and now of the interview. The historical referents of the present day account are also real though they are interpreted through the lenses of time and internal mental life, which, as Fitzpatrick (2010) found, will likely mean discrepancies with the 'documentary record'. Following the interview there is another process of constructing - the researcher's process of analysing the

data and developing a research report. Here fidelity to the subject matter is an important criterion (Wertz et al., 2011).

The current researcher considered constructivist grounded theory as an overarching methodological framework and this is reflected in the research insofar as it aims to build knowledge from the ground up, employ inductive reasoning and make links to theory. However it was not possible, for practical reasons, to do theoretical sampling and, as indicated above, the interpretive stance is more critical realist than fully constructivist. The study adopts thematic analysis as its basic data analytic strategy.

5.2   Study design

5.2.1   Retrospective interview study

As advocated by Clandinin and Connelly (1994) this research takes the study of experience as its starting point. It seeks to understand more about the experience of people after a suicide attempt. In-depth interviewing, with its focus on asking the participant to articulate his or her experience, is the main data collection strategy. The research is retrospective insofar as it is asking people about their experience over the past year or several years. A retrospective approach was adopted because:
a) The ethical difficulties and, in particular, the resource implications associated with prospective study are prohibitive and form part of the reason for the paucity of research mapping out the period after a suicide attempt.
b) The research is interested in the person's own understanding, perception and construction of his or her experience. The structuring of one's own experience is an ongoing process and involves a degree of retrospectivity at any time along the course of development.

5.2.2   Defining suicide attempt

Kienhorst and de Wilde (1995) raised the question of self-definition of suicide attempt versus definition by others and noted that, while the complexity of the process may be similar for both self-report and definition by others, the perceptions of self and other do not always coincide. The accuracy or validity of self-report has been questioned

(Silverman et al., 2007a). However this has usually been with reference to large-scale epidemiological surveys or prevalence studies, where the query has arisen on the basis that many of the suicide attempts reported have not resulted in medical attention.

In research investigating the experiential aftermath of a suicide attempt, self-definition of the self-harm behaviour as a suicide attempt seems fundamental to the study. In addition, since one of the aims is to investigate experiences of clinical services, the study is interested in recruiting participants where the suicide attempt led to engagement with such services. Taking the medical seriousness of the attempt into account also helps to define the boundaries of the sample and thus facilitate comparison across studies. For the purposes of this study a suicide attempt is a self-harming action regarded as a suicide attempt by the person him or herself, and resulting in presentation for medical care or assessment and/or involving a highly lethal method.

5.3   Ethics

Ethics approval was obtained from the Victoria University Human Research Ethics Committee (Appendix E). Any study of attempted suicide raises some complex ethical issues. A central issue is risk. There is a risk of psychological pain and distress which comes from discussing painful feelings and experiences, and also a risk that pre-existing psychological distress could be stirred up or exacerbated. While there are no physical risks arising directly from the study's procedures, it is possible that physical risks (of self-harm) could arise from pre-existing psychological distress which is brought temporarily into heightened focus during the study. Some potential participants may continue to struggle with self-destructive thoughts and impulses, meaning that they are 'at risk' already whether or not they participate in the research. The ethical concern then is for the research not to increase the level of risk.
On the other hand it could be argued that an overly protective stance that implies fragility could undermine a participant's confidence in his or her ability to cope and that this too constitutes a risk.

It is also possible that the study could potentially have some benefits for the participants. For some participants the opportunity to speak about a difficult period in

his or her life may be beneficial in terms of the opportunity to reflect on life circumstances, on strategies for managing turmoil and on personal change and development over time. Some participants may gain a sense of satisfaction or an increased sense of worth from the knowledge that they are making a significant contribution to the study of an important social and personal problem.

A number of aspects of the study design aim to minimise risk. Firstly the process of recruitment (as outlined in section 5.5) aimed to provide potential participants with the time and information to make a considered decision about participating. The student researcher/interviewer is a clinical psychologist with previous experience working with people who have made a suicide attempt or struggled with suicidal thoughts. The aim was to conduct interviews with a dual focus of gaining information for the research and maintaining the participant's equilibrium. It was understood that the participant's welfare needed to have priority over the research. A further ethical safeguard was to recruit participants who were likely to be in contact with both support groups and mental health service providers and to ascertain that the person was currently seeing a mental health professional. This meant the participants had sources of support in the event that they found the research interview unsettling.

5.4   Sample

The sampling strategy was a purposive one, aiming to recruit participants who could provide information-rich accounts (Patton, 1990). This principle guided the selection of avenues for recruiting participants.

Participants were ten adults who had made a suicide attempt at least six months prior to entering the study. The sample comprised eight women and two men with a mean age of 41.8 years (range: 28 to 52). Initially eleven people had volunteered to participate, but one man withdrew for family reasons prior to the interview. In view of the complexity of defining a suicide attempt, and as outlined above, two aspects were taken into account in defining eligibility for the study:

- The person regarded the action as a suicide attempt.

- The suicidal action was medically serious enough to result in presentation for medical care or assessment and/or involved a highly lethal method.

Both aspects were to be present for inclusion in the study.

For ethical reasons, particularly concerning informed consent, exclusion criteria were determined. People were to be excluded from the study if they

- had a recognised intellectual disability
- were currently in a phase of acute psychosis
- were subject to a compulsory treatment order - in view of the complexity of deciding whether informed consent is freely given in these circumstances

As it turned out, no-one who volunteered for the study had to be excluded on any of these grounds.

In exploratory qualitative research, the aim is to continue interviewing more participants as long as substantially new information is still being obtained i.e. until 'saturation'. However, from the beginning of this study, it was anticipated that sample size would depend on gaining ethical access to potential participants and on their readiness to volunteer to participate. Given also the expected diversity of experience, it was recognised that 'saturation' may not be achievable.

5.5   Recruitment of participants

Accessing a suitable sample was always likely to be quite complex. The aim was to recruit people some time after a suicide attempt, not immediately after (so not in Emergency Departments of hospitals). Initial discussions with a major metropolitan hospital indicated that major hospitals offer limited out-patient services for people presenting with suicide attempts, tending instead to refer people to community-based agencies or back to general medical practitioners.

It was decided to approach community-based organisations offering ongoing support and advocacy services for people with mental health problems to seek permission to approach potential study participants through the organisation. Four organisations were approached. Each organisation had mental health professional and mental health

consumer involvement in the running of the organisation. The degree to which the organisation was consumer-led or professional-led varied across the four organisations.

Initial contact with each organisation was made by phone call and/or letter to a consumer leader or health professional who had a prominent role in the organisation. One organisation did not respond to my initial letter. The other three organisations considered my approach in a very thoughtful and careful manner, taking time to work through the ethical and safety issues inherent in my proposal. Two organisations invited me to attend a committee meeting to present my proposal and to answer questions. The third organisation invited me to meet with key staff members. After, in some cases, quite lengthy deliberations, all three organisations agreed to facilitate making an 'invitation to participate' available to mental health consumers who were members of and/or being supported by the organisation. Information about the study (see Appendix A) was made available to people either at support groups or via the organisation newsletter. (To safeguard the privacy of members who chose not to participate, I did not attend any support group meetings and thus information was given out in my absence.) The 'invitation to participate' outlined the purpose and aims of the study, described what participants would be asked to do and provided information about confidentiality and other ethical principles or processes. People interested in participating were invited to contact the researcher by phone or email.

5.6   Data collection: Procedure

When a potential participant made contact, the researcher explained the aim of the project and discussed what the participant would be asked to do (thus reiterating some of the information that the potential participant already had in written form). As part of this process the researcher discussed with the potential participant the risk of psychological distress and the need to give priority to the participant's safety.

Interviews were conducted in the participant's home, at the researcher's university or at another mutually agreed and suitable space. The participant was asked to read, or re-read, the invitation to participate (Appendix A) and invited to ask questions or raise any concerns about the study. It was made clear that the participant may cease

participation at any time. Participants were then asked to sign the permission form (Appendix B). The term 'permission' was used rather than 'consent' after one of the mental health 'consumers' consulted about recruitment suggested this was preferable due to its conveying a greater sense of agency on the part of those giving permission. The permission form included statements about permission for the interview to be audio-taped, and permission for the use of direct quotes from the participants in writing up the research. Participants were advised they could cross out these sections if they did not want to give this permission. Two participants did not want to be audio-taped (so the researcher made notes, as verbatim as possible, during the interview), but all gave permission for use of direct quotes in the write-up.

Prior to starting the main part of the interview, the researcher asked the participant some questions about demographics and medical history, including history of mental health problems and psychiatric diagnosis if any (see Appendix C). To safeguard privacy (by keeping demographic and medical information separate from the main interview material), these questions were asked before the audio-recording began. Information was recorded in writing on the form in Appendix C. The audio-recorder was then turned on (except for the two participants who declined this) and the main interview began.

Although an interview guide was developed (Appendix D), the researcher intended that, once the interview was underway, she would be open to following the participants as they spoke of their experiences in their own way. Thus the participants could take a lead in determining what was significant to talk about, with the interview guide acting as prompt sheet for the researcher to inquire about any areas that had not been addressed. The researcher began the interview with an introductory statement about the research, similar to the initial statement in the interview guide: 'I'm interested in people's experiences after making a suicide attempt, how this impacts on their life and how they might begin to recover. But to talk about that I need to start by asking you about your suicide attempt'. Once the participant assented to this, the researcher asked whether he or she had made one suicide attempt or more than one. If more than one, the researcher asked the participant to select one: 'Well I think if we can focus on one particular attempt to begin with and then towards the end I can ask you whether there is something you would like to say about the other experiences'.

Participants were free to select an attempt in any way that seemed meaningful to them, whether it be the first, or the most recent, or one that was particularly significant or seemed most useful to talk about. Once the participant began speaking about the suicide attempt, he or she usually went on to tell the story of what happened next (immediate aftermath, treatment etc) and then continued, often initially in a broadly chronological manner, later with some detours and backtracking, or sometimes following first one track and then another. Thus, after the researcher initiated the starting point, the participants largely set the direction of the interview, telling what they wanted to tell. The interview became very much a conversation. The researcher's statements or questions were responses to what the participant said or were generated by the researcher's desire to understand the experience, sometimes seeking clarification, asking to hear more, making a brief comment, occasionally sharing a laugh or trying to summarise or re-state. Usually domains of interest for the research, such as how the participant had been feeling, interaction with family and friends, experiences with clinical services, and what had been helpful, entered the conversation without need for prompting. However if one aspect did not emerge, then the researcher asked a rather broad, open question about it. Towards the end of the interview, as the story or discussion seemed to be drawing toward a close, the researcher asked whether there was anything important that we had not yet talked about. At the end the researcher asked participants how they felt after doing the interview, opening up an opportunity to speak about any distress or need for support. Some of the participants had arranged for someone close to come to visit after the interview, thus managing their own support needs. There were no instances where the researcher felt it necessary to take any action in relation to risk or support.

5.7 Method of data analysis

The interviews were analysed using thematic analysis methods, informed by Braun & Clarke (2006), Miles & Huberman (1994) and by Wertz et al.'s (2011) discussion of commonalities and near commonalities across the various approaches to data analysis. The researcher was interested in the nature of experience within the domains that had been identified prior to data collection (emotional life/internal world, interaction with family and friends and experiences with clinical services) and in the broad question of what had been helpful and what had been unhelpful. However, through the data

analysis process, the researcher was also interested in any significant aspects of experience outside these domains (or which might extend the scope of the domains). While broad areas of interest had been identified, the method of data analysis was inductive, working from a close reading of the data. Sequential steps in the analysis are outlined in the following paragraphs.

All audio-taped interviews were transcribed by the researcher, a process of listening and, to some extent, re-living the interview, which assisted with developing familiarity with the material. The interviews that were recorded by note-taking were typed up immediately afterward (with various shorthand expressions being turned into full renderings wherever possible). Next the interviews were read and re-read several times, and notes made about reflections on the interviews and their context.

The more formal, systematic process of data analysis commenced by undertaking a within-case analysis of each interview, moving later to a comparative, cross-case analysis (Miles & Huberman, 1994). The analysis of each interview began with initial (line by line) coding and then engaged in a process of identifying themes within that particular interview. Identification of themes was based on their salience or significance within the interview. Salience involved a judgement by the researcher taking into account not only interview space devoted to the matter, but emotional intensity in the telling, and apparent significance or importance of this aspect of experience for the participant (overtly stated or inferred). This process mirrored Charmaz's (2011) question 'What is most significant in these data?' but without necessarily looking for one fundamental theme. The decision to conduct a thematic analysis of each interview rather than wait until the whole data set had been coded, was an effort to acknowledge and take account of the variation in life circumstances and the range of experiences of the participants. While there were likely to be some experiences that participants had in common, initial readings suggested there were also some experiences that were not common but which had particular salience for some individuals. It seemed important to capture these experiences which might have risked being overlooked in a whole data set analysis.

The next step however was a return to the whole data set for a comparative analysis across all the interviews. This involved comparing themes from each interview and

identifying those that recurred across interviews or that were connected, in that they referred to similar, or in some cases contrasting, experience or meaning. The aim was to identify themes that would stand in the final analysis, and for each 'candidate theme' (Braun & Clarke, 2006), it was necessary to go back to the interviews and review the relevant coded elements. This meant looking at how well the theme was grounded and shaping or modifying the theme, sometimes creating sub-themes, in search of the best fit between the thematic analysis and the data. Themes from the within-case analysis that seemed to be grounded in the experience of one or two people were reviewed to see whether they had sufficient saliency to remain in the overall account, with attention also to how these themes might be anchored in particular circumstance or context. The specificity of circumstance or context could be important in providing a more inclusive account.

5.8   Trustworthiness and rigour

Trustworthiness and rigour are among the terms used by qualitative researchers in relation to maintaining the quality of the research process. They serve a similar purpose to the concepts of validity and reliability in quantitative methods, the latter referring to specific procedures or issues not directly applicable to qualitative methods. Trustworthiness or credibility of the research is sometimes seen as comparable to internal validity (Liamputtong, 2013), while transferability, the extent to which the findings have relevance to other individuals, groups or settings, has some parallels with external validity. Against a background of diverse views about the nature of quality in qualitative research, Yardley (2000) argued that, while there are core principles, the ways in which these may be achieved will vary from study to study.

The current study looks to three processes in establishing trustworthiness. Firstly, in the early stages of data analysis, another psychologist (also a qualitative researcher) was asked to read two of the (de-identified) interviews. While not asked to do a full line by line coding, he was asked to mark passages he considered significant, note themes, concepts or meanings suggested by these passages, and to develop some thoughts about how to understand the experience of the participant considered as a whole. For each of the two interviews, the researcher then met with this psychologist

to discuss the interview and our preliminary analyses, to compare notes, themes and understandings. Although a core of shared understanding emerged, this was not undertaken as an inter-rater reliability procedure (as might be done in quantitative research), but rather as a way of refining the approach to analysis, clarifying the researcher's own thinking and pushing her at times to consider alternative ways of thinking about the data.

The other trustworthiness elements involve transparency and coherence in the writing up of research (Smith, 2003; Yardley, 2000). There is a fairly extensive use of quotes from participants with the aim of making transparent the fit between the data and the themes emerging from the analysis. Finally situating the findings in relation to the theoretical and research literature assists the reader in evaluating the coherence of the analytic argument.

Rigour has been defined variously as encompassing both trustworthiness and transferability (Liamputtong, 2013) or as 'the thoroughness of the study, in terms of the appropriateness of the sample to the question in hand and the completeness of the analysis undertaken' (Smith, 2003, p.233). The appropriateness of the sample is judged 'not in terms of size' but in terms of the capacity of the sample 'to provide all the information needed for a comprehensive analysis' (Yardley, 2000, p.221). Thus the thoroughness of the study depends on three elements: recruitment of participants who can provide a rich account of relevant experience (providing depth); a sample of participants whose accounts span the range of diverse experience (providing breadth); and the completeness and sensitivity of the analytic and interpretative process. In the current study there are two issues that relate to breadth of analysis. The delineation of the sample, in terms of recruiting participants who had sought medical attention or used a highly lethal method, potentially places limits on transferability of findings. For example the findings may not be applicable to people in the community who made a suicide attempt but did not seek medical attention. A second issue is that, within the designated boundaries of the study, saturation of data may not be achieved. Thus the analysis may not cover the full diversity of experiences following a suicide attempt even for those who had sought medical attention or used a highly lethal method. However this limitation does not negate the value of a trustworthy and credible analysis of what is, nevertheless, a substantial sample of relevant experience.

Yardley (2000) identified impact and utility as a further key characteristic of quality, where potential impact may be in terms of enriching understanding and/or implications for policy and practice. In view of the relative paucity of research on experiences following a suicide attempt, the researcher argues that, despite some limitations, this study can make a valuable contribution to the field.

5.9   Research context: Person and place

It is usual in qualitative research to position the research in relation to person (the researcher) and place (geographic and/or social systems). One aim is to give the reader some context for considering the researcher's interpersonal presence within the interview and interpretive perspective in approaching the data analysis. A complementary aim is to provide some relevant particularities of the social context or social systems within which the participants' experiences took place. In this instance some brief comments about the mental health system in the state of Victoria may be helpful.

5.9.1   The researcher

I came to this project with a background of working as a clinical psychologist. (In Australia Masters qualifications establish eligibility for registration). In the formative years of my professional life I worked in mental health services, including inpatient settings, where in many instances a suicide attempt had precipitated entry to the service. Later I looked back and wondered whether we worked with this experience in the best way we could. I was trained in a psychodynamic orientation and continue to find this the most helpful framework for thinking and understanding, but working in inpatient mental health instilled the need for flexibility and pragmatism in terms of enacted practice. I believe it is important in clinical practice and in qualitative research (and often in everyday life) to be open to however and whatever a person may present, to listen without making assumptions, at the same time recognising that engaging with someone else's experience involves an emotional as well as reflective response. This project was completed part-time over a lengthy period in parallel with commitment to work and family.

5.9.2   *Mental health system context*

As in many other countries, the late decades of the 20th century saw Australian
mental health services re-shaped by deinstitutionalisation and mainstreaming (Croll,
1995). This section aims to provide a brief overview of the mental health service
system in the state of Victoria in the past ten to fifteen years, a period which includes
the times of contact with clinical services discussed by participants in this study. The
adult mental health system includes public (government-funded, state-run) and private
services. The public system includes inpatient units (usually within or co-located with
general medical hospitals) and community mental health services which provide on-
site outpatient appointments, mobile support teams which visit people (usually with
long-term problems) at home or in supported accommodation, and community
assessment and treatment teams (CATT). The CATT teams aim to respond to mental
health emergencies in the community, making an assessment of whether or not the
person needs to be admitted to hospital, and providing crisis support or treatment and
referral links to other services. Depending on the nature of the emergency, police
and/or ambulance teams may also be involved. Adult community mental health
services have guidelines about eligibility for services, aiming primarily to provide
services for those with 'serious mental illness' (and excluding those whose problems
are seen as less serious). Within the public system there are also services for children,
adolescents and families (but no participant in the current study spoke of experiences
with these services).

The private mental health system consists of private hospitals (often stand-alone
facilities) and individual private practitioners – mainly psychiatrists and psychologists
– who may be co-located in shared practices. Referral to private practitioner mental
health specialists is via primary health care doctors (known as general practitioners or
GPs). Australia has a government-run universal health insurance system (Medicare).
For decades only medical doctors (including psychiatrists) were covered by the
Medicare system, but in the last few years Medicare has extended to psychologists,
albeit for a much more limited number of sessions than is the case for psychiatrists.
Most commonly the patient pays the practitioner and then receives a rebate from
Medicare. Usually there is a gap between the payment made (fee charged) and the
rebate, meaning that the patient pays the gap amount. It is also possible for

practitioners to 'bulk bill' Medicare directly, in which case the practitioner receives the rebate amount only and the patient does not pay a gap payment. Over time bulk billing has become less common, but some practitioners do this for patients with very limited financial resources. In relation to hospitalisation, private psychiatrists can arrange admitting rights with private hospitals, but have to involve the CATT team if they want to admit a patient to a public mental health inpatient unit. Psychologists do not generally have admitting rights anywhere and also do not have the right (or currently the training) to prescribe medication.

If a person makes a suicide attempt they will be taken to the Emergency Department of a general medical hospital. His or her medical condition will be assessed, treated and a decision made about the need for admission to a ward. When the person is medically well enough, mental health needs will be assessed. If a person in the community is struggling with suicidal thoughts and he or she (or a family member or treating professional) feels a hospital admission is needed, the avenues are to present to an Emergency Department or to call the CATT team. The emergency assessment function of the CATT team means it is the gatekeeper to hospitalisation in the public system. At one level the philosophy around this is that it is better for people to be treated in the community and spend as little time in hospital as possible. However some (e.g., Croll, 1995) have argued that pragmatic issues of bed availability and funding for services play just as big a role in this policy. When a person is admitted to a public hospital, responsibility for treatment moves from the private practitioner to the hospital team, who will also decide on readiness for discharge. Admission to a private hospital gives the psychiatrist (and hence potentially the patient) more control over length of stay. However private hospital admissions are not covered by Medicare, so the person needs private health insurance to pay for this.

Chapter 6 Inner life, relationships and the external world

In this chapter, and the next two, findings from the interviews with those who had attempted suicide are presented and discussed. As is common in qualitative research, discussion is integrated with the findings as the best way to provide a full account of the themes and ideas emerging from the study, while at the same time reducing repetition. The limitations of the research will however be discussed in the final and concluding chapter.

This chapter begins by describing the participants and then presents an overview of the findings in terms of themes. The focus of the chapter thereafter is on findings concerning the participants' inner psychological life following the suicide attempt, their relationships with others (especially family and friends) and experiences of the external world. Chapter 7 discusses experiences with clinical services, while Chapter 8 looks toward recovery. This division is somewhat artificial as all domains of experience are inter-connected, but it is helpful in terms of providing organisation and clarity.

6.1   Maintaining anonymity of participants

One of the challenges in writing up the findings is how to present the full richness of the material while at the same time maintaining the anonymity of the participants as is ethically required. Two main procedures have been employed to safeguard anonymity. The first is the withholding of certain details that could be potentially identifying. At the most straightforward level this includes, for example, details of occupations and workplaces, and names of hospitals and other treatment facilities attended. In addition, while reporting the methods used in the suicide attempts, some details about the circumstances have been withheld. Similarly some details of family structure, history and circumstances have not been specified. Overall, in the view of the researcher, the omission of certain details has not made a significant difference to the exposition of themes. In a very few instances further detail may have added richness to the account, but the main point has stood nevertheless.

The second procedure to safeguard anonymity is that, in contrast to some qualitative studies, participants' quotes have not been identified by an alias or by any other method that enables linking of the quotes which come from any one participant. Similarly sample characteristics are described for the group, not individual by individual. This was judged to be necessary to comply with the assurance given to participants that any reports of the research would 'focus on common themes and issues emerging from a group of interviews'. As part of the consent procedure participants gave permission for their words to be quoted anonymously, and this anonymity could be threatened by linking quotes systematically to one person.

6.2   Sample characteristics

6.2.1   Demographics

The sample consisted of eight women and two men, ranging in age from 28 to 52 with a mean age of 41.8 years. At the time of interview one participant was married, three divorced, one in a de facto relationship and five were single. The education level of the sample was relatively high. Six participants had tertiary or equivalent qualifications, one a vocational qualification plus some tertiary study, one a trade qualification and two were current students in vocational or further education. Seven participants worked or had worked in health, education or social policy, one in a trade, one in information technology and one running a small business. At the time of interview six participants were working (full or part-time) and one was a 'pensioner/student'. Three participants indicated they were not currently working (one of whom was studying part-time). Nine participants were living in a large metropolitan centre and one lived in a regional township.

6.2.2   Mental health

Current psychiatric diagnoses as reported by participants were as follows:

Depression/Major depressive disorder: three participants, one with a comorbid diagnosis of personality disorder which was contested by the participant.

Bipolar disorder: three participants, one also diagnosed with 'borderline personality features' which the participant understood as only being present during periods of depression.

Post-traumatic stress disorder (PTSD): four participants, one with comorbid diagnoses of anxiety, panic and depression, and two with an additional diagnosis of borderline personality disorder (contested by one participant).

At least half the participants reported that they had had several diagnoses that had changed over the years. Three participants had at one stage been thought to have a psychotic disorder of a schizophreniform type (schizophrenia, 'query schizophrenia' and/or schizoaffective disorder). These three participants in particular may have been seen by clinicians as presenting a diagnostic puzzle – one participant implied that even the current diagnosis was still really an open question. Two participants had former diagnoses of borderline personality disorder, a diagnosis with which their current psychiatrists (and the participants) disagreed. Other former diagnoses included 'multiple personality', depression and anxiety disorder.

A current or former diagnosis of borderline personality disorder was contested by several participants. Some participants thought that the diagnosis had been incorrectly applied and did not match their symptoms. Some rejected the diagnosis itself as 'contentious' and 'a judgmental diagnosis'.

Participants in this study were living with, managing and/or struggling with significant mental health problems. Onset of mental health problems was at age 16-19 (four participants) or during the 20s (five participants), with a later onset for one participant. All were currently seeing a mental health professional or agency. This reflects the method of recruiting participants through mental health support and advocacy groups and organisations. People who may have previously struggled with mental health issues or life crises and made a suicide attempt but have long since recovered are less likely to be in current contact with support and advocacy organisations.

6.2.3 General health

Five participants reported ongoing general health problems. Health problems nominated were gall bladder problems, epilepsy, thyroid problem (understood by participant to be lithium induced), orthopaedic problem, recurrent back pain, arthritis, and chronic fatigue syndrome. In addition two participants had ongoing health issues or disabilities as a result of suicide attempts.

6.2.4 Health consequences of suicide attempts

Two participants spent time in a brain injury rehabilitation program during the period of physical and cognitive recovery after the suicide attempt. Even following rehabilitation both had sustained significant ongoing impairments or disabilities. One participant had an anterograde memory impairment, restricting the ability to lay down new memories. A second participant had impaired language functioning and also reported significant retrograde (long term, autobiographical) memory deficits which had improved with time and effort.

6.3 Nature of suicide attempts

Eight of the suicide attempts were by overdose and two by attempted hanging. Although full medical details were not available, it was possible to consider the medical aftermath in relation to Beautrais et al.'s, (1996) criteria for medically serious suicide attempts. Five of suicide attempts clearly met criteria for being medically serious (in hospital for more than 24 hours, admission to intensive care unit and/or highly lethal method). As a further indication of medical seriousness two participants were subsequently admitted to a brain injury rehabilitation program. The other five participants all spent some time in (medical) hospital after the suicide attempt. Estimated time in hospital was 12 to 24 hours for four participants and more than 24 hours (but no admission to specialised units) in one case. Considered as a group, the suicide attempts discussed by participants would be located across the moderate to severe range on a spectrum of medical seriousness.

The suicide attempts could also be considered psychiatrically serious. Setting aside the two participants who required months of medical care and rehabilitation, all participants, except one, were admitted to a psychiatric unit as a result of the suicide attempt or their continuing suicidality after the attempt. Three participants were transferred straight from medical care to inpatient psychiatric care, two more were admitted in the ensuing days, and two a little later. One psychiatric admission was involuntary. The remaining participant, who had been treated in ICU, thought that psychological recovery was very significantly slowed due to not having inpatient psychiatric care at that time.

A majority (but not all) participants had made more than one suicide attempt, sometimes using a different method from that used in the attempt that was the main focus of the interview. Three participants discussed their experiences after their first, or only, suicide attempt. Others chose to discuss an attempt that was particularly meaningful for them in some way. This may have been due to the recency of the attempt, the medical severity, or because the attempt, and the experiences afterward, had serious implications within their lives.

6.4   Introduction to themes

Themes emerging from the interviews have been grouped according to domains or aspects of life experience. The domains, themes and sub-themes are summarised in Table 1 below. This table also indicates the structure of the three Findings and Discussion chapters, in that the presentation and discussion of findings follows the structure in the table.

Table 1: Summary of domains, themes and sub-themes

Domain	Themes	Sub-themes
Suicidality	Suicidality after a suicide attempt	Emotional state on regaining consciousness Suicide attempt as an acute event within a suicidal episode Significant shifts in suicidality
	The experience of suicidality	
Inner life	Patterns of shame, humiliation and guilt	
	Issues of control and sense of agency	
Relationships and the external world	Family and friends: Reactions and relationships	Suicidality is disturbing and frightening A secret life: Painful seclusion vs strategy for managing Estrangement, dialogue, and support
	Losses at home and work	Losing a foundation in work Losing a home
Experiences with clinical services	An overarching theme: Respect and being taken seriously vs humiliation, blame or indifference	
	Trauma and traumatisation	
	Sites of Intervention	In emergency Hospitalisation - Borderline Personality Disorder as an accusation - Returning to the ward after inpatient suicide attempt Psychotherapy
	Medication for better or worse	
	Discrimination and disadvantage	Discrimination based on suicide attempt or mental health status Living in a regional township
	Negotiated control	Knowing the well self and the sick self Treatment plans

Table 1 (continued): Summary of domains, themes and sub-themes

Toward recovery	Recovery as process	
	Home as a secure base	
	Activity, work, contribution	
	Sustaining relationships and mending ruptures	The significance of relationship Reciprocity: Recoil, protective silences and re-connection Thinking, and re-thinking, about burden
	Disclosure of the real self	Acceptance vs secrecy and avoidance Writing the self
	Managing psychological pain: The idea of suicide as insurance	
	Clinical Services: Helpful and not helpful	Clinical encounters Systemic issues

6.5   Suicidality

6.5.1   Suicidality after a suicide attempt

6.5.1.1   Emotional state on regaining consciousness

Participants' experiences immediately after regaining consciousness following a suicide attempt varied from a momentary sense of calmness to a state of heightened agitation (distress or aggression). One participant described calmness and clarity but it lasted only a very short time:

> *I woke up with calmness and clarity, but as the minutes go by all the stress*
> *comes back.*

In contrast, another participant described waking up in a medical ward after some time in intensive care. She was behaving in an uncontrolled, aggressive way that was uncharacteristic of her usual self and attributable to acute brain syndrome:

> *When I come round I'm always agitated and abusive…*
> *I woke up and my dad was there. I said hello can you get me a cigarette.*
> *He said no ___[her name]. I said well bugger it, I'll go and get myself one.*
> *I unhooked myself, I went to walk out the main doors… and these three*
> *bouncers were there, the security guys,… I was swearing my head off,*
> *uncontrollably, and they said well you have to get past us first. I said well*
> *that's alright I will* [laughs]. *… I wasn't sort of thinking oh I didn't die, I*
> *just had this very aggressive, uncontrollable aggressive behaviour. I was*
> *swearing and shouting and carrying on, and I was told it was called acute*
> *brain syndrome.*

Another participant described a state of agitated distress in which she attempted further self-harm.

> *… so I ended up at __* [major metropolitan] *hospital and I was very*
> *groggy, I can't remember the first bit of it, … when I came to I was so*

upset that I was still alive that I grabbed anything I could find ... and
started to cut myself with it

In contrast to the specificity of these accounts, some participants remembered mainly a general sense of waking up sick or dazed or not quite aware of what was happening. While experiences upon regaining consciousness varied, there was much more agreement about what happened in relation to suicidal thoughts and feelings over the ensuing days, weeks and months.

6.5.1.2   Suicide attempt as an acute event within a suicidal episode

Contrary to ideas about a suicide attempt providing a catharsis (Zilboorg, 1996), participants in this study did not experience a significant diminution in suicidality after their attempt. In most instances the suicide attempt could be understood as a particularly acute manifestation of a suicidal episode which continued for some time. One participant made three suicide attempts within a period of a few weeks. Another told doctors at the hospital where she received medical treatment that she was no longer suicidal, even though she was, so she would be allowed to go home.

> *While lying in hospital I was still trying to think of a way to kill myself. ...*
> *Then the Psychiatry Registrar came. I told him I was OK. I was very very*
> *sad, but I didn't tell. I was trying to leave the hospital, and I went home. ...*
> *I was still suicidal ... and I was going to try again.*

Some participants continued to feel suicidal but felt they didn't know how to act on those feelings anymore. One woman, when discussing her medical recovery in hospital after her attempt, was asked whether she was still feeling suicidal afterwards or whether that had receded. She responded:

> *It hadn't receded but I didn't have a clue about how to go about it. I felt*
> *like I'd failed and I didn't know that I wouldn't fail again. I didn't have*
> *that confidence that I could successfully kill myself, because of the failure*
> *for it to work. ... [So] not making plans, just feeling suicidal, depressed*
> *and lost, without any sort of concrete plans.*

For some, with the realisation that the suicide attempt 'hadn't worked' came the thought of having to live. While this can be understood as an effort to turn away from suicide, it was experienced as a kind of forced effort, and as a significant struggle and very vulnerable to setbacks.

> *... the thing after a suicide attempt is I've always come to with this kind of sense of 'oh it didn't work' and I've still got to try and live, and it's this massive effort to try and get your brain into that 'I'm going to try and live now' kind of frame of mind.*

An exception to the theme of a continuing suicidal struggle in the period after the suicide attempt, was the participant who sustained ongoing language difficulties. This participant said that, within years of struggle with mental illness, this period provided some relief - from nightmares, traumatic memories and distress, 'the hell I've gone through' – and suicidal feelings were not present. However this remission of suicidality seemed related to cognitive function at the time, including impaired memory for previous trauma, rather than to an experience of catharsis.

> AG: Were you feeling suicidal at that stage?
> *No. The first 3 months there were some cases where someone would think that I, you know, am I in case where I could be attempting to kill myself or not. I told people that I had enough trouble trying to understand what my real world is, that there was no attempt for me to kill myself in those first few months or so. ...*
> *Yeah, I couldn't understand, I couldn't talk, I couldn't understand what was around me, for a start, just like a brand new baby, and it was only at the last few weeks at my last hospital that I started going back to having my nightmares, ... So it was only the last couple of weeks at that second hospital that I started going back to the hell that I've gone through.*

For most however the period following the suicide attempt was a time of suicidal thoughts, depression and emotional turmoil which lasted at least for weeks and sometimes for many months. Many of the participants were admitted to a psychiatric

unit (at least one on an involuntary basis) because of an ongoing suicidal struggle. Recovery then was not only about recovery from the suicide attempt itself but recovery from the whole suicidal episode. This was complicated however by the fact that reactions to the suicide attempt (the participant's own and/or the family's reaction, and indeed the reactions of health professionals) could exacerbate the person's state of emotional turmoil. These processes are discussed in later sections of this chapter.

6.5.1.3   Significant shifts in suicidality

Although it did not relieve their suicidality, for most participants the suicide attempt did mark a significant shift from how things had been before. This was clearly apparent for those who had sustained an ongoing impairment of function, and for many others there was a shift in life circumstances (as discussed in later sections). But for three participants who discussed their first or only attempt at suicide this shift (at least in part) concerned their experience of suicidality before and after the attempt. This shift in relation to suicidality is the focus of this section.

One participant's first suicide attempt was followed within weeks by two more attempts, followed in turn by admission to a psychiatric unit because of ongoing suicide risk. This participant had struggled with thoughts of suicide for five years before the first attempt but, consistent with Joiner et. al.'s (2009) theory of acquired capability, it seems that the first suicidal action opened the door to taking further action. In the following quote this participant was talking about experience of mental illness in general, but the image resonates in relation to that initial cluster of suicide attempts.

> *I can see* [signs of] *the illness in* [others] *but they have shut the door. I've opened the door and once you've opened the door you have to walk right through.*

Another participant described how, despite a long history of depression, it was only since her (rather impulsive) suicide attempt, that she had a recurrent and frightening struggle with suicidal thoughts. Prior to her suicide attempt,

> *I used to get very, very down and probably would think oh God I don't want to be here anymore, but never with any sort of real thoughts that I might take it beyond that feeling.*

After the suicide attempt she indicated 'it moved into a different realm'. Since then she becomes fearful, terrified when heading toward feeling suicidal because she knows it is possible for her to act on it.

> *I suppose that's what I'm struggling with now, knowing that I've been in that space and that's something that is possible. So I think the fear, that terrifies me every time I feel myself heading into that space and that's not something that I always grappled with. ... I get quite terrified since that attempt because I know the potential for where I'm headed.*

This participant made an interesting comparison of suicidality with alcoholism, referring to the idea that once one has been an alcoholic, even if recovered one has the potential to become an alcoholic again.

> *I think maybe it's possibly a bit like being an alcoholic, there's always that sense that you could end up drinking again. So even when things are OK there's that niggle for me still that this* [suicidality] *is something that I now live with and, you know, how robust am I? What will tip me over?*

This is consistent with Joiner's (2005) idea that an acquired capability for suicide may lie dormant in the absence of a suicidal emotional/cognitive state, but that a capability for suicide becomes pertinent again when there is also a psychological desire for suicide. In other words the possibility of suicide may return if the person is sufficiently distressed and distraught. This seems relevant also to another participant's account of a suicide attempt occurring after a twenty year hiatus from previous attempts.

For the third participant who described a shift in suicidality after her attempt, the shift was more to do with the nature of her suicidal thoughts. Her suicide attempt followed

a period of thoughts about suicide, but 'I guess I didn't think I'd really do it'. Whereas her attempt had been rather impulsive, afterwards her thoughts turned more towards planning. When asked about whether there was a difference in thinking about suicide before the suicide attempt and thinking about suicide since the attempt, she responded

> *Yes I think I frightened myself a bit, with doing something on impulse. Now I think more about planning, about where I would do it, who would find me and so on. I wouldn't do it where I live because I wouldn't want my housemate to find me.*

An ongoing or recurrent struggle with suicidal thoughts was part of their life experience for all participants in this study. The next section aims to characterise the nature of that experience.

6.5.2   *The experience of suicidality*

For some participants the overall experience of suicidal thoughts was often frightening, although there were significant moments of what may well be a dangerous calm. For other participants the experience was more one of obsessive, agitated preoccupation. Quotes presented in the section above have already described suicidal thoughts, and sometimes actions, as frightening, even terrifying. The frightening nature of suicidal thoughts may be linked to an ambivalence about the outcome and a struggle against the suicidal desire.

> *I've had patches ... where, you know a handful of times, I've been very much in that* [suicidal] *space but, I think it's more frightening knowing that I can, I know what the result can be, but it's also I know that this lifts and I know I can get through this as well*

Part of what makes the experience frightening is a sense that the onset of the suicidal state is not controllable or understandable.

> *What frightens me about it is that I never thought this would happen to me having worked so hard to get where I had got. I can deal with depression*

but it's scary when all the things you thought you knew were no help to you.

Because it still, it scares me, terrifies me still, but it's there, ... I don't understand why it's there. I don't think there's a reason sometimes, it just is there, so that makes it more frightening. I'm just trying to understand it better…

One participant had concluded that, rather than being frightened, he needed to learn to live with the suicidal feelings.

I used to be scared of the suicidal feelings, always pushing it away. But I made friends with it in the end, you need to learn to live with it.

Some participants identified a difference between an impulsive suicidal state and a state of planning. The impulsive state involves a spontaneous reaction to intense distress, while the state of planning is more compulsive in nature. While frightening in prospect and retrospect, at the time, the state of planning reaches a point of calmness. The person feels cut off from those around her (or him), in a kind of suicidal bubble. This was clearly articulated by a woman who contrasted her impulsive suicide attempt with subsequent experiences of being on a path toward a planned suicide.

…. and it was a spontaneous thing, it wasn't something that was planned. And I have been in that space [i.e. of planning] *which is more frightening I think even than this particular episode.*
…
The spontaneous thing is frightening because you know you can just <u>do</u> that, but the planned stuff it almost, …. there's a real calmness that comes, that comes all over me anyway … It's almost a euphoria that can come through too, and it's you've accepted this and this is a real peace that comes with that decision, and people have no sense of where you're at. They just don't have a clue. It's much different to that distress that I felt that time ...

Others also identified a sense of calmness or resolution of torturous tension that comes with making a decision to act on suicidal thoughts.

> *When you have decided to kill yourself you feel happy, not happy,*
> *relieved. You're looking forward to being dead*

For some participants the experience of being suicidal had an obsessive, preoccupied quality, which, in Shneidman's (1992) terms, involved a perceptual constriction in which the person's narrowed focus on suicide is such that he or she cannot see outside it.

> *I was obsessed with killing myself, totally obsessed, nothing else had*
> *entered my mind. ...*
> *I'd forgotten* [about a family special day]*, even though I'd known in the*
> *morning, the obsession in my head about suicide just overtakes everything.*

Perceptual constriction may be present also in the state of suicidal planning described earlier, but in contrast, the obsessive, preoccupied state does not come with a feeling of calm (not at least until the moment of actually making an attempt). There is a sense of struggle and resistance to the obsession. The participant quoted here described her life during this period as

> *I just did not have a life, it was just torture.*
> *...*
> *And I can't control how long it's going to take. I just try my hardest not to*
> *attempt suicide, just try every avenue for that life, lifeboat, to help me, and*
> *if it's not there then I'm more likely to attempt suicide.*

The experiences described here bring to mind the quote from Shneidman (1984) about 'anguish over the plight of the writhing self' (p.321). Shneidman's concept of unbearable psychological pain was manifest in participants' descriptions of their psychological state at the time of the suicide attempt and at subsequent times of feeling suicidal. The nature of this pain was consistent with conceptualisations in the

literature of the suicidal state of mind (see literature review in Chapter 3). However the core painful experience was not the same across all individuals. Where one participant spoke of hopelessness, a core feature according to Beck and Weishaar (1990), another was driven by a sense of being a burden on a loved family, as identified by Joiner et al. (2009):

> *and what I was wanting to do was alleviate that pain cos I felt like I'd been a burden for so long*

However in a different family situation, one of marital conflict and some violence, another participant spoke of escape rather than burdensomeness.

In line with Maltsberger's (1988) clinical descriptions, one participant described a sense of bitter estrangement and aloneness as well as self-hate:

> *My parents hated me and I hated myself.*

and

> *At one time I hated myself so much I wanted to kill myself in a really painful way.*

One participant spoke of self-punishment while several spoke of a painful feeling of uselessness or worthlessness.

> *… it might have been to punish myself as much as it was to kill myself, I think, because I was going through a period of feeling particularly useless*

> *One of the reasons I was so suicidal was because I wasn't myself. You feel worthless.*

Several participants spoke of feeling 'so desperate', conveying an impression of agitation or Shneidman's (1992) 'perturbation'. In contrast two participants presented images of unpleasant stillness. A woman spoke of being 'dead inside', consistent with states described by Hendin (1991). A man described his suicidal states as:

There's nothing moving inside you

and

You're empty, no spirit

Hendin (1991) argued that the feeling dead inside phenomenon came about because of efforts to block out rage and despair. His argument was that repressed (or possibly suppressed) rage and despair lay underneath the feeling of deadness. Some kind of related phenomenon may have been occurring for these two participants. While the woman partly attributed her feeling of being 'flattened' and 'dead inside' to the effects of medication, she was also describing a period of severe hopelessness and despair. The internal deadness was associated with losing hope, or perhaps with an exhausted repression of the pain of hopelessness. The man who felt 'nothing moving inside' during a persistent suicidal episode, had spoken of a tornado of feeling and a release of anger at the time of his suicide attempt shortly before. He described a 'big build-up to the suicide attempt', full of grief and trauma, a series of painful losses and an outburst of physical aggression. He concluded:

It was like a tornado building up and then bang, it came down and
thumped me.

and

It was good to get all the anger out.

However it seemed that after the anger was released, what replaced it (at least at the conscious level) was the feeling of emptiness and 'nothing moving'.

In addition to discussing the painful emotional disturbance, several participants commented briefly on a cognitive dimension, acknowledging there was an irrational element to their suicidal thought processes.

... at the time you think you are thinking clearly but you're not thinking
clearly.

I get into that space where you're not thinking particularly logically

One participant specifically referred to black and white thinking as identified by Weishaar and Beck (1992) (and perhaps discussed in her sessions with her psychiatrist).

> *... basically I said to myself, I was applying for it* [a flat of her own]*, and black and white thinking as usual, either I get the flat or I kill myself.*

Overall the participants' experience of suicidality is consistent with the literature on the phenomenology of the suicidal state. Both the literature and the participants describe a range of experiences, such that, despite some convergence, there is not just one experience of being suicidal. The element that perhaps gains greater prominence in the accounts of participants than in the literature is the frightening nature of suicidal thoughts. This brings to life more vividly and intensely an element of the struggle usually discussed in the literature in terms of ambivalence.

6.6   Inner life

This section focuses on inner life, how the suicide attempt impacts on the participants' emotional and cognitive inner world and how these internal processes or reactions may sometimes fuel further suicidality. Section 6.7 focuses on the participants' external world of relationships and daily living. The internal and external worlds are of course intimately interconnected. While acknowledging it is arbitrary to discuss them separately, the decision to do so was taken in the interests of clarity of structure and exposition. Inevitably while the focus is on inner life in this section there will be some reference to relationship context and the external world. Similarly some themes discussed here will be referred to again later when the focus is on the external world

6.6.1   Patterns of shame, humiliation and guilt

For many participants making a suicide attempt gave rise to feelings of shame, humiliation and guilt. These feelings made it difficult to face people and potentially, or actually, had the effect of increasing isolation.

... and I know it's probably the most isolating thing you can ever do is to attempt suicide, because it's such a secret and you feel so guilty about it.

It was strange going back to ___ [psychiatric hospital] because I had to face the nurses and the patients and I felt like I'd let them down.

And also I'd never gone doctor-shopping in my life, and to tell a lie like that to a doctor ... was a big deal for me, that I'd actually told that lie, to a doctor to get medication. I don't like lies, and so that was another thing that I felt guilt about.

For some the guilt was associated with feelings of self-hate and an intense feeling of being a bad person.

... and this just, the suicide attempt, the change of diagnosis, just fed into me feeling bad rather than mad really. You know, I was a bad person, and losing my job re-affirmed this, anything, everything that happened that year re-affirmed, and I just felt badder and badder ...

Mixed with the guilt were impulses toward reparation, apologising, repairing relationships, but the picture could be complicated and contradictory. One of the participants described feeling caught between a desire for reparation and a feeling she needed to justify people's concern, and her own guilt, by doing more to harm herself.

I can't imagine doing this without feeling awfully guilty afterward, but I certainly did. And I, the tension, do you know the tension was really weird, it was between feeling awful and desperately wanting to apologise to people and getting rid of some of that guilt off my back, and wanting to do more, wanting to cut myself, or wanting to overdose more, mainly to justify people's concern for me. Does that make sense? No.

Feelings of guilt often co-existed with experiences of shame, as well as feelings of badness and worthlessness. One participant described feelings of shame and humiliation:

*In fact I made two attempts last year. The first one – ridiculous, I felt
humiliated because obviously I didn't really try to kill myself.*
...
*The second attempt last year was a deliberate suicide attempt. I took a
large overdose of tablets which I calculated, wrongly, would kill me. ... I
... threw away all my identification - because you don't want anyone to
know you. ...* [In hospital after the overdose] *When I was conscious, I
wouldn't give my name. I felt very ashamed and frightened.*

While she described feeling humiliated after the action she deemed not a serious
suicide attempt, she also felt ashamed after the serious attempt some months later.
Throwing away her identification and not giving her name are actions further
reflecting her acute sense of shame. This woman felt shame and guilt not only about a
specific action but also about the state of feeling suicidal:

When you're suicidal you feel so guilty.

Lewis (1987) noted that shame and guilt are often fused, and this seemed to be the
case among participants in this study. Participants sometimes spoke of feeling guilt
about a specific action but also spoke of guilt about their overall state of mind or state
of being, similar to the experience of shame which is usually conceptualised as being
about the whole self,

A participant described how following her suicide attempt she went through a long
period of guilt-ridden depression, severe loss of confidence and overwhelming sense
of shame. She felt acutely conscious of the idea that people would know she had tried
to kill herself. Her husband shaped and exacerbated this though his own sense of
shame and need for secrecy. This woman described how after the suicide attempt she
changed:

I changed. I was oh (sigh) *so depressed after it. I just felt, this is part of
the guilt happening as well but I, any confidence I had before it, which
wasn't much, I'd lost through that, through that thing. I felt that everyone*

was seeing me through the eyes of, looking at me as though I was someone who tried to kill myself, and I got a bit paranoid. I couldn't, you know ___ [husband] *contributed to the paranoia I must say ... I used to ... drive him to* [his work] *and he used to make me park in the street behind* [his work] *so that no-one could see me.*

The sense of shame was powerful enough to lead to a degree of irrationality, in the idea that suicidality was visible, like a visible stain, and also to envelop her to the extent of being ashamed to be alive.

___ [Husband] *got really paranoid about it, really, really paranoid about it. We still had the old house then and he'd pull down the blinds so that people wouldn't see that he was living with someone who'd tried to kill herself.*
AG: It's an interesting idea that it is so visible.
How would you know? I know. I know. But he was.., and of course all of that fed into my own feeling bad about myself. I was just ashamed. Look in the end I think I was ashamed to be alive. I was ashamed that I didn't kill myself properly, and I was ashamed that I was alive, and it just was really, really awful.

As indicated in the above quotes, shame is interpersonal in that it is connected with being seen by others, but it is also about one's own view, shame in one's own eyes or shame regarding (looking at) the self. Helen Block Lewis (1987) described shame as a state of judging and devaluing the self but also as 'one's own vicarious experience of the other's scorn' (p.15). In the quotes above we can see the participant's vicarious experience of the husband's stigmatising devaluation, which exacerbates her own painful feelings of shame and guilt. This then extends to a vicarious experience of anticipated scorn from casual observers who might happen by.

The internal struggle with shame plays out against a background of stigmatising attitudes to mental illness in the general community (Corrigan, 2005) and among health professionals (Mental Health Council of Australia, 2011). Even more pertinent is the stigma specifically attached to suicide and attempted suicide (Lester & Walker,

2006; Sudak, Maxim & Carpenter, 2008) where historic notions of suicide as a crime or a sin may yet have left a subconscious echo. Stigma about suicide, and especially attempted suicide, is surprisingly under-researched. However Sudak et al., (2008) argued that while there has been some diminution in stigma associated with mental illness, this has been less evident for stigma associated with suicide.

The interplay between one's own view of self and the other's view of self was apparent in the current study. When a participant's feelings of worthlessness and shame were reflected back to him or her by others (i.e. when the person saw others, including mental health professionals, responding as though he or she was worthless), this stirred up a great sense of rejection and sometimes gave rise to a quickfire anger. In the following quote one participant described how this type of interaction increased feelings of shame and humiliation which in turn made her more suicidal. There is a circularity in that feelings of worthlessness, shame and humiliation both fuel her suicidality and are a reaction to it.

> *People treat you like this is how you always are - stupid, irrational. You*
> *are in a different state – not yourself. You're treated like you're childish;*
> *you're not listened to, made to feel ashamed, judged, punished, and all*
> *this makes you feel more like killing yourself.*

This quote echoes the words of Lewis (1987) when she wrote that in shame, and in the face of the other, 'the self feels small, helpless, and childish' (p.19). The participant's tone of voice in the above quote was an angry one, and this participant, and others, alluded to angry reactions when they felt put down, diminished or humiliated. Lewis referred to this anger as humiliated fury, triggered by shame, which is then often turned against the self (potentially increasing suicidality as indicated in the above quote).

In literature about shame reactions and the Holocaust, shame is understood as connected with witnessing the unbearable and witnessing the loss of self in the 'walking dead' (Faye, 2003). It is connected with an experience of having been stripped of one's humanity. While there are significant differences between the Holocaust and a suicide attempt in terms of the nature and scale of the events, it is

possible to wonder, tentatively, whether there are some parallels in the experience of shame. The person who has made a suicide attempt has witnessed something unbearable within the internal world and has been in a state of being 'not yourself', suggesting the connection between shame and loss of self may also be relevant here.

As in the current study, Wiklander et al. (2003) found many expressions of shame in their participants' accounts of the period after a suicide attempt. Interestingly they found that shame reactions could be exacerbated or ameliorated by staff reactions to the suicide attempt at time of admission to hospital. Unsympathetic, dismissive or punitive attitudes exacerbated shame. Shame reactions following a suicide attempt were also observed by Tzeng (2001) and by Crocker et al. (2006) in Taiwan and the U.K. respectively. The findings of the current and previous studies align in suggesting that clinicians be alert to the experience of shame after a suicide attempt. Moreover, humiliating experiences in the clinical context can exacerbate feelings of acute worthlessness, induce shame-related rage and intensify suicidal feelings.

6.6.2   Issues of control and sense of agency

For some participants the suicide attempt and/or ideation was associated with a sense of lack of control or lack of agency. The issue of control related to both the internal and external worlds, with internal struggles for control over one's state of mind mirrored by struggles over control in relationships with health professionals.

One participant made a suicide attempt in the midst of a long period of struggle about control over her treatment. She had managed her depression over the years largely without medication which in her previous experience had made her feel worse. She had then been persuaded to try new ('better') medications but was unhappy with her treatment, concerned she was spending far more time in hospital than she ever had before, felt 'patronised' by treating staff when she tried to express her views, but found herself unable to extricate herself from her treatment regime and relationships. After some months of what she termed this 'horrendous cycle' she made a suicide attempt, the sense of loss of control being a key precipitant.

I didn't have a sense of me, I wasn't in control, and I was getting
distressed. …it's all a blur; I was in and out of hospital, and people were
sort of giving me the stuff around

…

I felt like I wasn't in control anymore, because what the medication did
was take away any…, it just flattened me. It didn't help the depression but
it stopped me feeling OK, and it just flattened me so much, and then I just
completely lost hope and lost, you know, a sense of being in control and
there was no… I felt like I was dead inside.

As the above quote suggests, a sense of not being in control involves loss of a sense of
agency and is connected with loss of hope and loss of sense of self, culminating in
this instance in a feeling of being dead inside. Loss of a sense of control or agency is
closely associated with feelings of helplessness and hopelessness, long recognised as
hallmarks of depression.

In a way this woman's suicide attempt could be seen as an attempt to escape or break
the deadlock (an appropriate term given she felt caught in a struggle to the death). The
immediate effect however was that treating staff became, in her experience, more
prescriptive and controlling.

I think it made it more stuck, because then the doctors sort of said well
now you've got no choice. I'm trying to tell them that this
[medication/treatment] *was making me worse and they wouldn't believe*
me and now they definitely didn't believe me. ….. the people looking after
me, said because of that now you've got no choice and this has changed
and you know you're going to be on medication for the rest of your life.

Eventually fear, desperation and survival instinct lead her to break the deadlock and
walk out of the treatment relationship. She felt she had to make the break in order to
survive (i.e. that the situation she was in was suicidogenic).

I think at the end of that [period of] *months, I got so frightened. I just got*
so terrified that I thought I can't do this anymore. If I don't change and do

things, if I don't sort of take control and get off the medication, I won't be here...next year, let alone in 10 years. And I remember sitting in the doctor's office ... but I remember walking out in the middle, and I just said half way through the session I can't do this anymore.

While issues of control were particularly prominent in this woman's account, similar themes, including the idea that starting to take control is a step toward recovery, appeared in several interviews.

.... in the nuthouse no-one is there for you, so you have to take control. You may not take control in a socially acceptable way but [too bad].

When I was discharged from ___ [Hospital] *I was starting to realise what was happening and I was trying to take charge of my own treatment. After a certain period of depression, after a while my brain just checks back into gear; it's not immediately OK. At some point I start to think more clearly and start taking charge – it's a big thing to take control of me. When I see the possibility of starting to be in control, then I can start to get better.*

As suggested by the phrase 'take control of me' in the above quote, the issue of control is not only about control of one's own treatment or control over external circumstances, it is also about internal control.

A sense of loss of control over inner life may reflect a sense of inner turmoil. One participant spoke at some length about feeling overtaken by disturbing memories and thoughts of a damaging childhood experienced as full of loss, violence and strangeness, thoughts and memories which fuelled her suicidality. This woman seemed to be describing an unanchored, uncontained inner life swirling with disturbing thoughts & memories which co-existed with, but also disrupted, a practical life of activity and engagement with the external world.

Well each time I remember something more, I go into a deeper sort of depression, really really deep depression where I think 'nobody cares, nobody loves me, I've got no-one' and then I get so so deeply depressed

98

that I just can't cope with the world, can't cope with anything and then I just suicide.

...

I just write [in a journal] *woooo straight through and I just don't stop and then the stuff that falls out is just unbelievable, it's just … To me sometimes I think, did I make that up or did it really happen and then my sister or my older brother would say yeah it really happened.*

She described life as like a waterslide and finds she has little control over her descent down the waterslide into a state of acute disturbance

But I think life is like a, I call it a waterslide, and you climb up the steps, right up to the top, and you get to the top and you just go hnnnnnnn, you know how it goes, around in circles right, right down to the bottom, and you go so quick, and that's how quick it is to lose it. Yeah that's my little saying, you get on the waterslide, you climb all the way up, and then … and it can happen like in a few minutes, you know somebody might say something to you and I'm just gone, I'm just gone.

In contrast to this somewhat uncontained sense of losing control, there can also be an experience more like something unidentifiable exercising an insidious control from within. The following extracts from one interview suggest a sense of there being an 'it' which takes over control internally.

I get to a point where I lose control in a sense. I'm fine to a point and I can pick myself up but there gets to a point of no return, and so you just spiral…

... you know it [suicidality] *sort of gets a momentum of its own*

Because it still, it scares me, terrifies me still, but it's there, but … I don't understand why it's there.

I'm not quite sure what it is but it's ... almost like something else has taken over, it's like it's got this sort of track of its own and it's OK. It's a space of being quite at peace with, and relief, intense relief that right this is now in place and the decisions have been made and the plans are made and I'm in control, ... and the pain will go away and I won't have to think about this anymore.

The passages suggest a sense of an active controlling other, a thing which terrifies her, and threatens to take control and take her down the path to suicide. While the experience can be terrifying, it can also lead to a place of peace and relief, where decisions have been made. While she says at this point she is in control, I wonder whether this may represent unconsciously a surrender to, or a joining with, the controlling other. The process is reminiscent of Maltsberger and Buie's (1980) concept of an internal killer and this extrapolation about the unconscious would be consistent with their conceptualisation.

The findings about loss of control are broadly consistent with the findings of Crocker et al. (2006), Tzeng (2001) and Biong et al. (2008) who also identified loss a sense of control as a core experience in their participants' suicide attempts. In the (Crocker et al., 2006) study, as in the current study, regaining control in the period after the suicide attempt was associated with recovery from suicidality while a continuing sense of loss of control meant ongoing struggle. However the experiences or circumstances underpinning the loss of control varied between studies. In the Crocker et al. (2006) study, loss of control was linked to age-related changes in physical states and/or functioning. In the current study experiences of loss of control arose, as in Biong et al. (2008) and Tzeng (2001), from internal psychological processes and/or from experiences of feeling trapped in a situation of being controlled by others.

6.7 Relationships and the external world

This section focuses on what happens after a suicide attempt in the external world of relationships, work and daily living. The reactions of family and friends to the suicide attempt was an important and often complex issue. Experiences of loss and sometimes

estrangement from friends and family left participants struggling with feelings of displacement and instability, aloneness and sinking confidence.

6.7.1 Family and friends: Reactions and relationships

6.7.1.1 Suicidality is disturbing and frightening

That suicide attempts, and also suicidal thoughts, were disturbing and frightening for family and friends was a common theme. The way this disturbance and fright is expressed can vary considerably, manifesting as shock, fear, hurt, anger or avoidance.

> *The hardest, the very, very hardest thing about recovering after a suicide attempt is facing the family and dealing with their hurt and their fear and their anger. ... especially with my dad for some reason, ... he would just freak out and he wouldn't be able to come and visit me and things would be really awkward between us, and I'd feel really guilty.*

> *I told my ... brother and he came down ... and he was shocked and horrified*

Anger was sometimes the initial response, with a mix of other feelings such as hurt and fear also emerging. Speaking of waking in hospital to her husband's initial reaction, one woman said:

> *And then a phone call coming through from my husband and he was <u>so</u> angry. I don't think I've ever heard him so angry before or since.*

and

> *I just remember the tone and the anger and the.. yeah and him sounding so lost and confused and I wasn't sure he'd want to see me again. I didn't know he'd been in there all through the night.*

Anger can be understood as a response to how distressing the suicide attempt is for the whole family. When asked about her siblings' anger after a suicide attempt, a participant first responded that she didn't understand it but then ventured:

101

Well I guess my sister's angry because she doesn't want to lose a sister, so she gets angry. And I think my brother gets angry sort of ... for the whole family, like what I've put the family through, ... another crisis we have to deal with. And how it affects the whole family, I think he's concerned about that. Just the impact of me attempting suicide, just the impact it has on the family and the chaos that is the aftermath of it all.

The circumstances of the suicide attempt and the participant's psychological state at the time could also influence the reaction of family and friends. For one participant's friends an attempted hanging was much more confronting and frightening than previous attempts.

I think friends were frightened by what I did, in a way they hadn't been frightened by previous overdoses.

Another participant spoke about how frightened her friends and family (and even her support worker) were because of the depths of her distress. Even though they knew she got depressed they had never seen her as she was during this period following her suicide attempt.

In hospital [psychiatric unit]*, friends would come to visit and I'd just cry – they hadn't seen me cry before. ... It frightened my friends a lot when I was so depressed. ... It frightened my support worker and it really frightened my son. ... I was very angry with my support worker. They were frightened because I was ... angry and because in a way they couldn't recognise me. They had never seen me like that – crying, and like a zombie.*

and

My son was really frightened of me when I was really depressed. He saw a different Mum – saying you all hate me, you'll be glad when I'm dead. He saw a different person and there was nothing he could do.

This last quote alludes to one aspect of what is distressing for families, that they feel helpless to make a difference in a situation where they are frightened by the depth of despair in someone they care deeply about. However the family's intense fear, hurt and helplessness, often giving rise also to anger, could make it difficult for the depressed and suicidal family member to confide in them. Several participants felt they could not talk about suicidal thoughts and feelings because it was just too disturbing for family and friends.

> *It's not something you can talk about to people, and to be able to, I think just to be able to say how you felt, and you can't do that with your friends, or your family, because they just freak out. You can't even talk about it in retrospect because they ..it's something that's so difficult for them.*

> *You can say to a nurse 'I feel like I'm about to hurt myself and I need some help' where you can't say that to your family because it's not something they can cope with.*

A somewhat different view was the idea that people, friends in this case, were frightened of suicidality because of the self-destructive feelings it might stir up in them.

> *When I feel at my worst no-one wants to know me. ... They get very, very scared, very scared*
> AG: What do you think they're scared of?
> *I honestly don't know. Sometimes I think they're scared that they might, um, catch it. ... I think that's the biggest thing, people are scared that they're going to catch it and it's going to happen to them one day.*

This quote alludes to a sense of attempted suicide as being contagious, and at some quite fundamental level, a contagious agent that cannot be controlled or defended against. This is a frightening thought and at a subconscious level could possibly be another reason for the anger that suicide attempts can evoke.

In contrast to the experiences outlined above the participant who sustained language difficulties, thought that friends drifted away because of the communication difficulties rather than because of suicidality. This participant thought these friends were not frightened of the suicide attempt because they were familiar with suicidal feelings themselves.

I had a few friends visit me but within a few months of that they.., we didn't talk anymore. It's quite normal, [sighs] *when … you have trouble with talking or hearing it's quite, it's very hard for, to communicate, both for myself and for my friends. And it's quite common to lose friends, yes so after a few minutes, a few months I then had…*
AG: It was hard to keep those relationships going.
Yep.
AG: But you think that was to do with [the language problems] not to do with their reaction to the suicide attempt?
No they were pretty good because these friends have had attempted suicide as well, themselves, so yeah no they handled that pretty much OK.

6.7.1.2 A secret life: Painful seclusion vs strategy for managing

Because of the person's sense of shame and guilt and/or because of the potential reactions of others, a suicide attempt is 'such a secret':

… and I know it's probably the most isolating thing you can ever do is to attempt suicide, because it's such a secret and you feel so guilty about it.

Several participants commented on the need to keep secret their suicide attempts and suicidal thoughts because suicidality was so disturbing to others and because of the potential to lose friends. Secrecy is perceived as necessary to keep people close, but it is difficult and uncomfortable and also contributes at another level to feeling separate because of the façade involved.

I find if I don't tell people too much they're likely to stay around. If I put on a mask and pretend I'm OK, then they'll stay around, but I hate that

> *because it, it's lying.* [Recently] *I had all these birthdays and celebrations and I went to them and I felt like crap and I've been pretty suicidal and there I was telling everybody I was doing great, because I don't want them to leave me.*

and

> *I feel like the choice is either to lie and keep my friends or tell them the truth and risk them panicking and running.*

Where this participant spoke of putting on a mask, another spoke of a plastic smile which had a similar function.

> *… and my friends stopped coming to visit, all that sort of stuff, the social network that you normally have just went up the tubes, … So then nobody wants to see you, so then I think to myself, nobody wants to see me, I have to put on that plastic smile, you know oh I'm OK, I'm OK. And everyone thinks oh she's OK again now, it's OK to contact her … but really as I said, a plastic smile, that's what I call it anyhow. And it's the hardest thing to do.*

These quotes reflect how self-silencing (Jack, 1993) is an attempt to retain harmony in an unequal relationship. The participants are aware that, in these relationships, the friends hold the power in that they would leave or stay away if the depth of distress were disclosed. The participants' feelings of inauthenticity or pretence seem to be the 'cost' of retaining the friendships through self-silencing.

In other circumstances the need for secrecy was because of concerns that one might be discriminated against or judged in the workplace. There is a delicate balance in that one might be discriminated against if people know about your mental health issues but if they don't know and you take time off you may be seen as unreliable or irresponsible. One participant described how she dealt with some of the workplace challenges identified by Bergmans, Carruthers, et al. (2009), but then suggested that secrecy was her more usual strategy.

I guess it's, you know you've got to be careful who you trust with information about yourself, but after working with my boss ... [describes speaking to her boss about her mental health issues] *... so he knows what it is and I said that there's going to be some times when I may need some time off but that's going to be legitimate and it's not going to be a lot and I just wanted to let you know that it's a legitimate thing and I'm not just trying to get out of work. So yeah I guess, trusting certain people with that information means that I don't feel like I'm living a secret life.*

AG: Is that something you've felt in the past?

Yeah I guess yeah in a lot of ways, and just wanting to tell people I'm not unreliable, I'm not irresponsible, I just have an illness that affects me once in a while. It would be good if I could tell everyone but I don't, I tell a very few select people once I know them well enough to know they're not going to discriminate against me because of it ...

Whatever the reason for secrecy, the image of 'living a secret life' is a poignant one and the participants quoted above found this secrecy very distressing. For some others, however, a type of keeping things private and separate may have had a role in containing their distress.

Some participants who did not use the word 'secret' nevertheless spoke in a way that suggested a compartmentalising process in their lives. Their mostly private depressed/suicidal struggle was in one compartment and their everyday family relationships and competent functioning at work were in another compartment. From time to time the private struggle erupted into open sight through a hospitalisation or a suicide attempt, but as soon as possible was compartmentalised again. When talking about previous suicide attempts and consequent hospitalisations one participant stated:

The way I recovered was just to go back to work from the hospital [i.e. while still an inpatient in a psychiatric unit]. *I didn't want to take too much time off work so I would go back after two or three days, as soon as I started to feel things were getting better.*

106

While this quote attests to the role of work in recovery it also suggests a degree of sealing over and keeping the depression/suicidality separate from the rest of one's life, a kind of putting it aside. Another participant spoke of seeing an episode of depression as linked to a particular situation or life stage and then saying to herself that the situation or life stage was finished and wouldn't occur again so that experience could be put away as part of the past.

> *I think in the past that was partly what I did. I'd get through that and there's a reason for that happening and now that's finished I won't, you know, that's over. ... and there were these things so you sort of put it aside*

Feeling an imposed need for secrecy was distressing and difficult but keeping things private and separate could also function in the interests of containing distress (at least in the short term). That one of the participants who seemed to compartmentalise also lamented the difficulty of talking to family and friends, and invoked the hurt involved for both speaker and listener, suggests the complexity around the sharing of painful, suicidal experience.

6.7.1.3   Estrangement, dialogue and support

As indicated above, talking with family members about a suicide attempt or suicidal thoughts was extremely difficult. Nevertheless some participants had found dialogue with family members to be beneficial. This occurred where the various family members had been able to enter into a dialogue that was open enough to lead to increased understanding – where family members gained more understanding of the suicidal person's experience and the suicidal person gained more understanding of the family members' reactions.

Sometimes, though not always, dialogue was achieved with the help of a psychiatrist or therapist. One participant spoke about family members coming to her sessions with her psychiatrist in the period following a suicide attempt. She explained that when she is highly suicidal she is oblivious to any impact on her family but afterwards she finds the structured discussion in the therapeutic setting helpful.

It's been worthwhile having people coming to my therapy sessions, family coming and talking about how they feel and things like that. When I'm suicidal I couldn't give a damn what they're saying, but after an attempted suicide and, given time to get over that, talking to the family is quite therapeutic, to hear how everyone feels and so I can express how I feel as well which they need to try and understand.

An increased awareness of the family members' experience led her to a sympathetic assessment of their needs.

I think that families need coping strategies. Families need support at these times as much as I do. I think that's something that's lacking. ... [speaks about the family worrying at times of crisis] *... and then I end up in ICU and on all these machines and the family's got to somehow cope with that. ... And I think, there's an awful lot of responsibility and pressure on the families.*

Another participant also spoke of achieving a greater understanding with her family with dialogue in this instance occurring within the family not in therapy sessions.

... so now I've got a pretty good relationship with my family. I've spoken to them about what helps and what doesn't.
AG: What sort of thing have you said to them about that?
Just basically I said at the end of the day, if, God forbid, I ever did anything to try and hurt myself again I can understand if you'd be disappointed or angry. I can accept those responses because you're my parents and you want me to live and it's hard for you to understand, but you can't really judge me and say what you would have done in that situation, and that's what I had felt in the past.

The issue of feeling judged or blamed is significant. Where dialogue with the family was divisive and depressing rather than helpful, the experience of feeling blamed by the family was at the core. Describing an earlier interaction with her family the participant quoted above explained:

> *And then you get home* [from hospital] *and they say 'how can you hurt us*
> *this way, how can you do this, how can you do that'* [accusatory tone]*, you*
> *know, and that little bit of strength you've just built up just gets smashed in*
> *that little moment. And you just, like I've just felt how do I start again, and*
> *just really misunderstood.*

She felt misunderstood in this exchange because far from intending to hurt her
parents, she described spending long periods of time resisting the urge towards
suicide because of her 'sense of family' and not wanting to hurt them.

For a participant who was already estranged from her parents before her suicide
attempt, blame was also a significant issue. After the suicide attempt she saw a new
psychiatrist, and she described how he decided, against her wishes, to bring her
parents in and attempt a family reunion.

> *I said I really don't want to do this; it's not good for me. But he got my*
> *parents in and it was a disaster.*

This meeting was the first her parents had heard about her suicide attempt; they cried
and she felt blamed. This came on top of already feeling scapegoated by her family
for the previous history of family division and conflict. After the 'disaster' of
attempted family reunion, she ended up not seeing the psychiatrist again and also
stopped almost all contact with her family. At the time of interview she felt that she
needed to keep a distance from her family for the sake of her own mental health.

> *I'm too fragile and having my parents around is not good for my mental*
> *health at this stage.*

The experiences outlined so far in this section include two contrasting experiences of
family members attending a participant's sessions with a psychiatrist, one helpful, one
distinctly unhelpful and associated with further estrangement from family. There are
several factors that may contribute to the different outcomes. Firstly, in one instance
the family members knew about the suicide attempt and that this was to be a subject

of discussion in the session; in the other instance the session involved breaking the news about the suicide attempt. Secondly, while we don't have the full details, it is likely there were differences in how the family members approached the discussion of the suicide attempt. The third and perhaps crucial issue was the degree of collaboration between psychiatrist and patient. In one instance the family members' attendance was agreed upon, planned, and some thought given to appropriate timing. In the other instance the person who had attempted suicide was pressed to meet with the family even though she felt it wasn't good for her and this happened quickly and apparently without much time for discussion or preparation.

Experiences of support and understanding from family members were very important to participants (as were experiences of blaming, rejection and misunderstanding). Based on participants' accounts it seemed that, despite missteps, misunderstandings, strain and upheaval, some family members had provided substantial support for the person who had attempted suicide. Instances of helpful dialogue outlined above provide examples of family members' ongoing presence and efforts toward understanding. Sometimes ongoing presence and commitment were what was really important.

> *… and* [boyfriend] *stuck by me and that was really a massive boost to my belief in life because previously, other times when I got depressed or suicidal my boyfriends would freak out and leave me, understandable, it's pretty hard to deal with. But* [boyfriend] *was just was like no, no you haven't frightened me away __*[her name]; *it's fine don't worry I'm here for you. So that gave me a lot of trust that my life didn't have to be this hell, you know that really, good could come out of it.*

The type and level of support varied significantly among family members and also across time. Some family members had either come to stay with a participant at a time of particular vulnerability and risk or had invited the participant to live with them for a period. Being able to stay with family or friends for a time could provide a very important place of refuge. One participant described still feeling very depressed and suicidal in the days after her initial post-suicide-attempt medical discharge. She went

to the hospital emergency department and sat with the triage nurse before eventually finding refuge with a friend.

> *Eventually they said you have to ring a friend or family member and try to arrange to go and stay with them – we haven't got a bed …. So I rang a friend and went to stay with her, initially for a few days but ended up staying two and a half months. … I played with my friend's children and helped with cooking and so on, so I felt I was contributing, but some days I just retreated to bed and pulled the doona over my head.*

However sometimes such an arrangement broke down in an atmosphere of strain and recrimination. This could be because the participant's level of distress and unwellness put too much stress on everyone involved or it could be because family members' or friends' expectations put too much stress on the participant.

> *Then my brother came and said come up and stay with me if you want.* [So I did] *He wanted me to work, but I couldn't because my mind was churning, still depressed. So mostly I just walked around. I had an argument with my brother's friend/housemate who called me lazy and a spoilt little brat. Really hurtful, still can't talk to that* bloke *now. Thought either he had to go or I had to go, so I went.*

A practical and effective form of support in one family was family members paying for the participant's private health insurance which enabled a wider choice in accessing mental health services. Not all participants, however, had family members who would have been in a position to offer this form of support.

Friends could also be a valued source of support simply through the process of continuing friendship:

> *Good friends supported me, not in terms of running around to sit with me while I cried but in terms of doing things with me, being interested in seeing me.*

Friends joining in shared activities and being interested in seeing the person is sometimes conceptualised in the literature as 'self-esteem support', fostering the individual's sense of being a valued, capable and functioning person. However some friendships had to survive significant ruptures and cautious, tentative repairs which could take some time:

> *I knew I was hard to help but it wasn't in my control. None of it was aimed at the people purposefully. It was a reaction to how I felt. None of it is trying to be a bitch; it's aimed at trying to protect myself and it does take a while for people to get back trust in you.*

> *It took me a long time to get back my relationships with people. Not that I had really lost my friends but that was how I felt … With my best friend, we didn't speak for a while. OK now.*

Some participants spoke of losing friends. One participant lost a valued friendship when, after a suicide attempt she was taken to the hospital where the friend worked. The friend felt her work at the hospital was incompatible with the friendship with someone admitted for a suicide attempt – an incompatibility likely to be mired in issues of shame and stigma. (The friend may have felt that she would be stigmatised by association and her work identity damaged.)

> *The other thing that happened was that someone … who was quite a good friend* [worked at the hospital] *and she couldn't handle it, she couldn't handle it and after, … and that's almost the last I've seen of her. She then wrote me a letter and said 'I don't want to be your friend anymore, these things don't mix'. … and I've tried since then to try and mend bridges but no she's not interested, so. That was one of the worst things to come out of that particular episode for me.*

Another participant suggested that friends tend to drift away if they can't 'fix you', if they feel helpless to alleviate intense distress.

Friends are supportive at first but after a while some tend to go away. They feel they can't do anything to fix you and if they can't fix you they don't want to be around. I've even said to some friends, look I don't expect you to fix it, I'm the only one who can do that and I have to work on how to do it, but it's nice to have someone around who you can be yourself with and not have to pretend. I still feel very alone.

Here the participant reiterated the importance of relationship, of friendship, of acceptance and being able to 'be yourself'. In their study of attachment experience among adolescents who had attempted suicide, Bostik and Everall (2007) identified key components as finding acceptance, receiving encouragement, experiencing closeness and intimacy and the continuity of the relationship. Similarly the adults in the current study spoke about their needs for acceptance and closeness and the importance of maintaining, or restoring, significant relationships, even if that came at some cost. Sometimes however there was a tension, even apparent incompatibility, between acceptance of the true self and ensuring continuity of the relationship.

6.7.2   *Losses at home and work*

Most participants suffered losses - of work, home, relationships, in two cases even of specific memory or language functions - as a result of their suicide attempt. While loss in relationships was discussed in the previous section, the nature of other losses is the focus here. In discussing the events of loss it is important also to note the significance of the sense of loss as an internal psychological process, a part of the inner landscape. The consequences of the actual losses and the pain of the inner sense of loss and grief together made recovery after the suicide attempt much more difficult.

6.7.2.1   *Losing a foundation in work*

Freud identified the capacity to love and to work as the hallmarks of adulthood. For many people, work (of some kind, paid or unpaid) provides a foundation or scaffolding upon which a sense of capability is built and maintained. For several study participants one result of their suicide attempt, and their continuing distress afterward, was loss of work and hence a loss, at least for a while, of the foundation it provides.

Five of the ten participants were in the workforce at the time of their suicide attempt. (The others were either studying or had previously lost jobs or stopped working due to mental health problems and/or earlier suicidal crises.) Of the five participants in employment, four lost their jobs after the suicide attempt.

The participant who suffered an ongoing (anterograde) memory impairment described the suicide attempt as destroying everything, and particularly important was the impact on the ability to work and study.

> *... that* [the suicide attempt] *changed my life, destroyed everything.*
> *...*
> *I couldn't work or study. Work was very important to me and I loved study. I would like to study* [discipline area] *now but I couldn't remember what I read.*

After intensive care, brain injury rehabilitation, a period in a psychiatric unit and a mixed reception from family, this participant faced a future bereft of previously sustaining occupations and felt lost.

> *So I went home to* [place name] *and lived by myself, which I like, but at that time I just felt lost and like I didn't really belong anywhere. I felt like I had lost everything.*

Work was a significant issue for many of those interviewed. Several participants were tertiary educated. Some had held professional positions of considerable responsibility. At least two had worked in educating and training others in their professional fields. Other participants worked in positions that, while not requiring tertiary education, nevertheless required significant skill sets. Losing a job or not feeling well enough to return to work was a significant loss encompassing loss of confidence, loss of the satisfaction of making a contribution, and loss of income.

Up to the time of her suicide attempt one participant held a busy professional position with significant responsibilities. After she was discharged from (medical) hospital she

still felt very depressed and suicidal. She ended up staying at a friend's place, 'not functioning well' and could not return to work.

> *It was very busy, arranging international conferences by myself [and other complex tasks] ... it was a lot of pressure and I just couldn't do it anymore.*

Instead, in between trips to a psychiatric unit, she stayed at her friend's and:

> *I played with my friend's children and helped with cooking and so on, so I felt I was contributing, but some days I just retreated to bed and pulled the doona over my head.*

As reflected in the above quote many participants were sensitive to the issue of making (or not making) a contribution. Another participant whose work and career had been disrupted by mental health problems and previous suicide attempts spoke of feeling 'really embarrassed' about not working and indicated a clear concern about making a contribution:

> [At that time] *I wasn't working or studying or doing anything I was just helping out at home, cooking meals for the family and cleaning the house and just doing things that were contributing to the family, cos I felt funny about not working or studying so I wanted to do something that I felt was worthwhile and I knew that I was really helping Mum and Dad out by doing that because they both work.*

Losing a job or not being able to work undermined confidence and exacerbated feelings of worthlessness. Indeed because it coincided with shame and guilt about the suicide attempt, and other experiences of worthlessness, the fact of not working eroded confidence even when the job loss itself was seen as quite understandable. One participant described the circumstances of her job loss:

> *One of the results of this particular overdose was that I lost my job, but not in a horrible way. My boss at the time was really quite a nice person*

> *and I think this had been not the only suicide attempt during a fairly short period of time working with them and I understood why they just couldn't keep me going, it was just, they couldn't do it.*

Even though the job had not been lost in a horrible way, the loss contributed to a downward spiral.

> *You know, I was a bad person, and losing my job re-affirmed this …*

and

> *I could not get any work after all this happened, and I'd lost confidence so badly that I just didn't have confidence to apply for anything apart from anything else.*

Eventually this woman who had previously worked at a highly qualified professional level took some work in a related field but at a much lower level requiring no qualifications at all. She described this experience:

> *… and it was just an extraordinary lesson in humility … and I found that very, very hard but that's what happened.*

Concern about the impact that not working may have on one's future opportunities was also an issue, and was cited as a motivation to try to work even when it was difficult to do so.

> *I mean I'm back working part-time at a job that, you know it's not the ultimate job but it is* [pause] *an attempt to have something on my resume, so there's no big gap that I have to try and explain away, and maybe it will help me feel better if I'm helping others. But a lot of the time it's very hard to get to work.*

In addition to loss of confidence, loss of a sense of contributing and associated feelings of worthlessness, loss of work means loss of income. Several participants commented on the difficulties of loss of income.

> *… and sadly too, I'm working* [part-time] *and earning about as much as I would if I stayed on Centrelink* [welfare benefits].
>
> *…*
>
> *I'm working and I'm working and then I come back with $xxx a week and I'm trying to pay for a car and pay for groceries, bills and stuff, and trying to make it stretch but it doesn't.*

Loss of income also had implications for health care, for example, no longer being able to afford private health insurance. Two participants commented on the difficulties of having the money available to pay their psychiatrist upfront and then having to wait for the rebate, and also on the cost, given that the rebate is substantially less than the payment. No private health insurance also meant reduced options in relation to hospitalisation.

As discussed above, for many participants losing work was damaging, even devastating, and later, as discussed in Section 8.3, finding satisfying work was experienced as aiding recovery. For a minority of participants however the issue of work seemed to take a backseat to the issue of regaining emotional stability. This was clearly articulated by one participant who found that after enduring a period of suicidality and suicide attempts and eventual admission to a psychiatric unit, he did not feel well enough to return to work. At one point however the organisation funding disability payments pushed him to go back to work. He tried returning to work but had difficulty concentrating, had a car accident, and he felt that trying to work was detrimental to his mental health.

> *I went back into my shell and it brought all the pressures back and* [family member] *had to come and stay with me again. … *[The organisation]* pushed me back into work and it highlighted I'm not fit enough to work and look after my health.*

The family member had come to stay with him when he was suicidal so the implication here is that feeling forced to return to work, and the difficulty he experienced with it, led to a return of suicidal feelings. At the time of the interview he was focused on finding a way to live his life, not on finding a way to go back to work.

> *I'm not after rehabilitation to get back to work. I'm rehabilitating my whole life.*

Another participant while linking working with being a useful person, thought that it was necessary to resolve trauma-related symptoms and regain emotional stability before contemplating a return to work.

> *... basically if we could* [get] *treatment for my post-traumatic stress disorder, if that's fixed up then there would be no need for me to ... attempt suicide, and, hence I wouldn't have depression, hence I wouldn't have anxiety, in which case I would be a useful person and I could work and everything.*

The participant who was rehabilitating his whole life described feeling a sense of loss. It was one of feeling lost within himself, of having lost a sense of who he is.

> *But I was lost, like you don't know who you are. I needed to find who I am. It's like you're walking along a line and then you veer off the line. When you have a breakdown you can't just hop back on the line, you have to sort through all the shit.*

The statement 'I was lost' is reminiscent of a statement quoted at the beginning of this section, when the participant with memory impairment said 'I just felt lost'. The sense of loss or 'lostness' seems to be ubiquitous regardless of the particularities that underpin it.

6.7.2.2   Losing a home

Losing one's home was another major blow and of course losses could be cumulative.

> *... if I had been able to keep my own home that would have made such a big difference.*

and

> *I think having gone that far that I attempted suicide, I lost my home, I lost my job, I lost my family. I just feel like there should have been some intervening steps. Somebody should have stepped in before then with something for me.*

A suicide attempt that precipitates this accumulation of losses has a devastating effect on a person's life. As suggested in the above quote some participants felt a bitter sense of regret that although they had tried to access help, the help available was not sufficient to ameliorate their distress and thus avert the suicide attempt and the consequent losses.

Several participants discussed an instability in living arrangements, precipitated by hospitalisations which were in turn precipitated by suicide attempts. Fragile mental health together with loss of work and hence income were also contributing factors. One participant owned a house (a very helpful asset in the long run) but initially after a year in and out of hospitals, was judged not well enough to live in it.

> *All that year I was in and out of hospital, had suicidal thoughts. In the end they wanted to put me in a boarding house and I went along with it to get out of hospital.*

This was followed by living with one family member after another. These initially, or potentially, supportive arrangements often ended with the participant moving on after feeling pushed or expected to do things too difficult to manage at the time. Discussing similar living arrangements another participant stated:

> *I actually lived with* [sibling's family] *for a year, and I was too ill, and they couldn't cope with me.*

It was often very difficult to find a suitable place to live. One participant described experiences of living in supported accommodation. While it may have been the only place she could go, she found it very difficult, saying that the chaos of the house mirrored the chaos in her own mind at the time.

> *…. it's quite draining. I was too ill to live on my own but we were all too ill to be living together basically.*

and

> *Whereas a* [supported accommodation house] *was just chaos, so if you're trying to cope in chaos, when you feel chaotic in your head, a hospital doesn't look so bad.*

Subletting or house sharing in the open market also had its difficulties.

> *The person I sub-let from is not very sensitive to how you're feeling or else she just ignores it, for example if I come home from counselling with my face all marked with tears. Or she says you bring it on yourself, you just need to go out more and socialise, which is the last thing I want. And she's the sort of person who intrudes on your space. I have to shut the door to stop her coming in all the time if I need to think things through.*

In some instances staying with friends was very helpful but it was usually only an interim measure.

6.7.2.3   Concluding comments about loss

The literature acknowledges loss as a significant contributing or precipitating factor in suicide. Interpersonal loss is widely cited as a contributing factor in suicide, with a recent relationship break-down often reported as the most common precipitant. In their review of coroners' files on completed suicides, Stack and Wasserman (2007) found economic strain, and associated loss, was a contributing factor in approximately 10% of cases. Loss of a job was a precipitant in 33 of the 62 suicides where economic strain was a factor. Loss of a home occurred in 10 of these 62 suicides, with anticipated loss of home a factor in another 9 cases. However the current study is focused on consequences rather than antecedents, and provides evidence, albeit on a small scale, of loss as a consequence of a suicide attempt. It seems that at the very time when a person is trying to recover from a suicide attempt he or she is also likely to be grappling with experiences of loss, whether interpersonal or economic - in the form of loss of job, home, and/or level of income. These external losses may be linked

with an internal loss of a particular version or image of the self. A sense of being lost occurs when the person is not able to feel oriented in relation to purpose and meaning in life.

Chapter 7 Experiences with clinical services

This chapter focuses on findings concerning experiences of clinical services. The term 'clinical services' is used here as a generic term to encompass health professionals' contact with patients/clients whether in an inpatient, outpatient or community setting. The first theme discussed, 'Respect and being taken seriously vs humiliation, blame or indifference', is an overarching one which recurs through all the other themes in this section. It could be considered a lens through which all interactions with clinical services can be viewed. It is also perhaps worth noting at the beginning that while overall perception of clinical services may lean toward either the positive or the negative for individual participants, all participants identified instances of both helpful and unhelpful interactions.

7.1   An overarching theme: Respect and being taken seriously vs humiliation, blame or indifference

The principles of respect and active (attentive) listening are espoused in all textbooks and training courses for health professionals. These are seen as basic building blocks of clinician-patient relationships. However the complexities of implementing these principles, given the emotions that may be aroused by a suicide attempt and in the context of a busy (perhaps under-resourced) workplace, may be underestimated and insufficiently explored (Michel et al., 2002). In any case participants in this study provided accounts that suggest the implementation of a basic principle such as respect is distinctly uneven and variable.

Where respect was given, this was recognised and appreciated by participants. Feeling respected was linked to being listened to and being able to express a point of view and have it taken seriously.

> AG: You said [you are] now seeing Dr C and he's been much more helpful. What does he do?
> *He pays attention to what's going on and I can talk to him.*

Similarly another participant stated:

> *I have a psychiatrist I like better.*
> AG: In what way better?
> *I can disagree with him.*

Another participant elaborated on the importance of a collaborative approach to treatment decisions. The phrase 'and he lets me feel in control of it all', in the quote below, conveys the participant's recognition that the psychiatrist is ultimately in control of the decision to take a collaborative approach. This does not however negate the sense of trust and safety which the approach engenders.

> *…. the doctor I've got now … He's just incredibly respectful and he lets me feel in control of it all and so when I went into hospital the first time* [under his care] *he just gave me a whole lot of options, like these are your options and he rattled off six or eight and said the only thing that's not an option is to do nothing. … It was just the most incredibly respectful and, you know just made me feel that I, that he wasn't going to take over and do things that were horrible.*

Respect shown toward family members was also noted and appreciated, as in the following quote about a psychiatrist's approach to appointments.

> *… and I'd like to meet your husband, when would he be able to come in, not I'll see him tomorrow at 10 o'clock.*

The participants quoted above were all drawing a contrast between experiences with a current psychiatrist and previous experiences where they had felt disrespected, not listened to and/or where their views had been ignored or overridden. An example of the latter was reported in section 6.7.1.3 above where a psychiatrist insisted on bringing parents to a session against the wishes of a (young adult) participant, and when the participant felt not ready for this. Most participants spoke about experiences of not being listened to, and in some instances about feeling that suicidal feelings are

not treated with respect despite their potential seriousness. Speaking about clinicians one participant said:

> *You tell people how you feel and they just look at you. ... If you have a life-threatening* [physical] *illness you are treated with respect; you can talk about it.* [You're] *not treated with respect when you're suicidal.*

This participant thought it counted against you if you were articulate, in that suicidal thoughts were less likely to be taken seriously, and suggested that health professionals take more notice of suicidality if the person is obviously psychotic or can't talk. The participant noted however that, at the time of being suicidal, being articulate and even having 'a bit' of insight did not help her.

One of the male participants thought that men's distress is often not recognised, or underestimated, because their expression of emotions is more restrained or inhibited.

> *... in my situation generally guys aren't very good at talking ... guys don't talk about much so they don't cry, during the session, so therefore the case manager doesn't think that the guy is in a bad state ...*

This comment echoes the statements made by suicidal men in Strike et al.'s (2006) study. Similar to the men in that study, this participant felt he had been unable to find the sort of treatment that would be helpful for him. He spoke of going home and cutting his arms to manage his emotional upset after seeing his case manager.

Sometimes not being taken seriously extended to contravention of legally mandated rights. One participant spoke of being ignored despite repeated requests to see the participant's own (mental health agency) file, an entitlement under Freedom of Information legislation. This was contrasted with a prompt and respectful (and legally appropriate) response by another mental health worker:

> *Well put it this way, when that worker finally left that organisation, the day that I got a new worker I said please can I get a copy of my file please. She left .. the room, went to her own office, got a copy of a FOI* [Freedom

of Information form], *gave it to me and asked me to sign it. ... Bang done. So I was not upset.*

Beyond a lack of respect some participants spoke of experiences that were more actively blaming or punitive. One participant spoke of contrasting experiences with case managers, first describing one whom she experienced as negative and blaming:

... when I came home [from hospital] *Mum and Dad confronted me, and apparently my case manager, who I didn't have a good relationship with, had said to them that I was not being co-operative, that I wasn't trying, that I was doing this to myself and that I was just doing it deliberately basically.*

The participant was devastated that her parents initially accepted the case manager's version of her efforts:

... I kind of shut down for a while. .... at the time I thought I don't care anymore, I've tried so, so hard to beat this and my parents, at the word of this woman, believe that I haven't tried.

A subsequent experience with another case manager was quite different, the difference inspiring hope and perhaps even a degree of idealisation:

I ended up getting a new case manager and I've got a beautiful case manager now and it's working, it's actually having a difference in the way I cope because she's there for me and if I start to slide she'll say well come in and see me and we'll talk about it, and she's just so positive and caring, it actually makes a difference. Good case managers can make a difference which is nice cos I hadn't really experienced that before.

The impact of a clinician's dismissive or judgmental attitude is magnified when this connects with the suicidal person's own struggles with feelings of shame and self-condemnation. The following quote was presented earlier, noting how shame can

intensify (and increase suicidality) when feelings of worthlessness are reflected back via clinicians' attitudes.

> *People treat you like this is how you always are - stupid, irrational. You are in a different state – not yourself. You're treated like you're childish; you're not listened to, made to feel ashamed, judged, punished, and all this makes you feel more like killing yourself.*

A sense of hopelessness and emptiness can also follow from a clinician's negative judgments, perhaps especially when these are passed on to significant others. In the instance above where the case manager conveyed negative judgments to parents, the participant reacted by shutting down, and going into such a severely withdrawn state ('I felt I had nothing left in me') that she was re-admitted to hospital.

As well as intensifying feelings of shame, worthlessness and/or hopelessness, negative judgments conveyed by clinicians can also spark anger when something inside the suicidal person protests against the feeling of being diminished.

> *I do have a survival instinct in there and I want to live long enough to say 'fuck you all'.*

> *Years ago when I was first admitted to hospitals, when people treated me badly I was violent. I have in me a powerful rage, a result of being treated very badly* [in childhood] *– it's not needed in daily life.*

The anger which is not needed in daily life erupts as a survival mechanism at moments of extremity – to ward off blaming/dismissal/condemnation by others that threatens to undermine one's own internal struggle against feelings of shame and self-condemnation.

7.2   Trauma and traumatisation

Chapter 1 of this thesis raised the issue of whether a suicide attempt could be seen as a traumatic event. Certainly a suicide attempt meets the DSM-IV definition of a

traumatic event as one involving 'actual or threatened serious harm to self or others' (American Psychiatric Association, 2000), the difference being that in this instance the person is both victim and perpetrator of the violence. The participants in the study did not specifically talk about their suicide attempt as a traumatic event, although they sometimes spoke in ways that would be consistent with a conceptualisation of trauma, for example using terms such as 'torture' to describe their experience.

> *They ask what brings you to hospital - and how can you tell them - feeling like you're tortured.*

Speaking of her life over a period of years when she was frequently suicidal, another participant said:

> *I just did not have a life, it was just torture.*

Where some participants did speak explicitly about trauma, however, was in discussing potentially, or actually, traumatising experiences with clinical services. One participant spoke of seeking help for an episode of depression only to find the doctor went behind her back to tell her husband he was planning an involuntary admission to hospital. Although the involuntary admission was averted, the participant described this experience as traumatic to the extent that, when she came across the same doctor years later, she had a physical reaction to seeing him.

> [That period of] *depression was a real shock because I was almost certified at that stage. A particular doctor rang my husband and said this is what I am going to do, don't tell her, and I'd gone to ask for help! So, I mean that's still quite traumatic and* [on seeing that doctor] *I just have a physical reaction.*

This physical reaction is consistent with the DSM-IV trauma symptom of physiological reactivity to a cue symbolising the traumatic event, a symptom listed under the PTSD diagnostic cluster of re-experiencing the event (American Psychiatric Association, 2000).

Another participant spoke about an involuntary hospitalisation in which he was physically held down. His tone of voice and emotional engagement in the telling suggested a heightened vividness to the memory and that he was still hurt and angry about this experience some years later. This was again suggestive of a element of re-experiencing the event.

> *…. and I was blackmailed into another hospital. They kept it a secret; I walked in and they grabbed me. I had an interview with doctor then he said do you want to go to* [get something to eat]. *I walked through the door and they grabbed me.* [The participant was furious and several people held him down] – *holding my legs, holding my arms and sitting on my back. And they syringed me and put me in solitary.*

The two experiences described above did not occur immediately after a suicide attempt indicating that the potentially traumatising impact of a clinical intervention is not specific to a post-suicide-attempt context. Another participant however described the traumatic impact of an experience that was specifically related to her suicide attempt.

> *And I remember this woman, this really strong memory of this nurse and it was just as I was coming to, and I was absolutely covered in black tar* [from charcoal given to induce vomiting up the pills she had taken] ... *and I was projectile vomiting so there was just black everywhere, all around, and I came to, and I know I was covered in black and I know that I must have been extremely horrible-looking, ugly, dreadful, ghastly, but this, I opened my eyes and this woman who was a nurse said to me, I went to reach out to her, and she said 'don't you dare touch me'. and I remember that so well, it was just such a vivid, that's just such a vivid memory.*

This incident occurred in the context of a set of difficult and distressing interactions with staff in a hospital Emergency Department. These included the nursing staff physically restraining the participant during a period where she was in a highly agitated state ('*they jumped on me and did all sorts of horrible things to me*') together with a number of later staff actions which can be characterised as either dismissive or

punitive. The participant acknowledged that her behaviour (for part of the time - at the height of her agitation) had been difficult. However the reactions of nursing staff, then and later, were such that

> *I am still recovering from* [that] *now, it's years later…*

The participant reported that her psychiatrist (at the time of the interview) regarded some of her current difficulties as a post-traumatic disorder following on from her experiences at the time of this particular suicide attempt. In particular a voice saying 'don't you dare touch me' is re-experienced by the participant in a vivid and disturbing way:

> *… and one of the things that my present psychiatrist is working on at the moment, one of the most debilitating things when I get stressed and not looking after myself and not having the right medication, one of the most debilitating things is that I've got a voice that says 'don't you dare touch me'. And it comes directly from what happened to me after that suicide attempt, and I find it extremely frightening.*

This sounds very like the vivid sensory images that occur post-trauma, images which evoke intense emotional reactions (fear and horror) and often remain unprocessed and unintegrated (Gordon, 2007).

What the participant found most 'overpowering' (her word) in her post-suicide-attempt experience were staff attitudes and communications indicating she was selfish (by implication blameworthy and undeserving). The 'don't touch me' comment carries with it echoes of others historically considered untouchable, lepers, and those of lower caste whose job it is to collect, and hence touch, the dead. The participant said 'that particular comment just said what I was already thinking about myself'. This reprises the idea outlined above that clinician attitudes can have a particularly potent impact when they mirror internal self-denigration, in this instance potent to the extent of being traumatising.

7.3   Sites of intervention

This section considers experiences with clinical services that take place in particular contexts, namely in crisis and emergency situations, in hospital, and in psychotherapy or counselling.

7.3.1   In emergency

Face to face crisis or emergency services for suicidal states essentially consist of Crisis Assessment and Treatment Teams (CATT) and hospital Emergency Departments. In some instances a person in a suicidal crisis may also phone his or her psychiatrist, therapist or case manager or phone a Lifeline service. In this section experiences in Emergency Departments and acute medical care will be discussed first followed by experiences with CATT teams and other crisis contacts.

Participants had varied experiences of Emergency Departments and acute medical care in the immediate aftermath of a suicide attempt. Most however tended to see the positive experiences as the exception rather than the rule. What separated a good experience from a bad or horrible one was again respect, acceptance and empathy rather than blame, denigration or indifference. For example, one participant, in praising one experience of acute medical care after a suicide attempt, compared this with other experiences of acute or emergency care:

> *With my experiences, and I had many of going into Casualties and being on a hospital ward after attempted suicide, the people at ___ Hospital were great. They made me as comfortable as possible and were very empathetic, and helpful, which I don't often come across.*
> AG: What's the usual experience?
> *That I'm wasting people's time, and energy. By doing this sort of thing it's wasting nurses' hours and you're attention seeking anyway. Things like that.*

For another participant parts of the experience were 'reasonably OK' but the unpleasant part was expressed in much stronger terms:

> *The nurses at ___ [acute medical] Hospital treated me reasonably OK –*
> *except the psychiatric triage nurse and the Psych Registrar.*

But

> *The [triage] nurse came to see me and made me feel like shit.*

Several participants recognised that at times of suicidal crisis their behaviour could be difficult, but hoped for clinicians to recognize that this was not typical of how they were all the time. They hoped that ruptured relationships could be repaired. One participant spoke of her effort the next day to apologise for suicidal actions and disturbed behaviour and how important it would have been to her to have her apology acknowledged.

> *I felt incredibly guilty about what I'd done, incredibly, incredibly bad, so my attempts to apologise were just, landed on deaf ears, which I found really, really hard. I tried to say to people 'look I'm sorry I've caused you all this problem', I'm sorry you know and ...*
> AG: Was this to the hospital staff or …
> *To the hospital staff, and of course they're busy Casualty people. They weren't the slightest bit interested in me apologising but it actually would have made a huge difference if they'd said 'oh thankyou, yes you did cause a problem last night but thankyou for apologising'. Something just as simple as that would have made a huge, would have made a huge difference really.*

Some actions of hospital staff seemed punitive. After a night and day in the Emergency Department one hospital decided to admit a participant to a psychiatric unit some distance away and 'summonsed' a family member (against the participant's wishes) to provide transport:

> *They wouldn't give me my clothes back, so I just had one of those hospital gowns on which is you know completely open at the back ... and I was still incredibly groggy, so, and he [the family member] was cross, really cross. So it was just, it was just awful. I mean [pause] just remembering it, it was*

awful, like people could see me, it was really obvious what had

happened… And so, anyway and poor ___[family member] was trying to

drive and I was leaning all over him because I was still [groggy]. *Now why*

they didn't provide an ambulance for that I've got no idea.

Another participant had been taken to hospital unconscious in an ambulance. She did not remember anything about her hospital stay, but described how she was discharged alone and without support:

Next thing I remember is waking up at home and I had a single memory of

coming home in a taxi. I was sent home from hospital in a taxi in my

dressing gown. I lived on my own and had no-one to help me.

One participant expressed the view that Emergency Department staff just want to hear that the person who has made a suicide attempt is OK to go home.

They wanted to hear it was OK. But you need to be able to acknowledge

that you feel like people hate you, like you're alone; then people say that's

not true. You need to acknowledge how you feel. People don't let you say

how you feel. You always know what you're supposed to say: [that] *I*

should not have done such a stupid thing; it was really stupid, and I

should see my psychiatrist and if I feel this bad I will ring someone and let

them help me. They want you to go.

The perception here is that staff don't want to hear how badly the person feels or whether he or she is still at risk, suggesting perhaps a collusive effort between staff and patient to minimise the seriousness of the suicide attempt and/or the person's current state (McGinley & Rimmer, 1992).

It seems likely that initial experiences in the Emergency Department function to shape the pattern of interactions to come. Wiklander et al. (2003) found that patients' experiences in the Emergency Department, and through the process of admission to care, had significant implications for the patients' reactions to their own suicide attempt. Unsympathetic, disrespectful or punitive reactions from staff exacerbated the

patients' initial sense of shame. On the other hand, more accepting responses from staff helped patients to be more accepting of treatment.

In addition to experiences immediately after a suicide attempt some participants also spoke of seeking help at Emergency Departments as they continued to struggle with suicidal thoughts and feelings. The theme of recognising an emergency and being taken seriously was reiterated by a participant who had returned to the Emergency Department several times while still distressed and suicidal in the days after discharge from post-suicide-attempt medical care.

> *It would be good if health professionals treated you better, for example in*
> *Emergency.*
> AG: How could they be better?
> *I'd go into emergency looking for help. I guess I'd like an understanding*
> *from the professionals that this is an emergency, that I often have nowhere*
> *else to go or feel I have nowhere else to go and that if I'm expected to sit*
> *for hours, and I'm curled up in this fetal position and I'm shaking like a*
> *leaf and I'm physically sick and I probably haven't eaten for days and I'm*
> *a mess and there are people all around me who are also a mess, that the*
> *longer I sit in the waiting room the worse I'll get too. And I guess just to*
> *be taken seriously.*

Some participants acknowledged under-resourcing of services but emphasised the significance of care and concern and recognition of distress and disturbance, even if a hospital bed could not be offered. Care and concern was contrasted with being told to learn to cope or with feeling that staff just wanted to be rid of you.

> *So they can say look we haven't got any beds …, and if they say that and*
> *they go 'but we're really going to keep an eye on you and we know you're*
> *going through a hard time and we really wish that we could give you the*
> *bed right now', I would feel as if they've recognised and acknowledged*
> *that I was feeling unwell and that, I don't know, that they weren't going to*
> *just send me off and go 'oof we got that one out of our hair'.*

I know that they're under-resourced and that's a big part of why they don't have enough time to spend with you, that you have to wait for hours and hours and hours in Emergency, and there aren't many beds so a lot of the time they can't admit you even if they think you could probably be admitted, but I think between all of that they could at least show a little bit of care, a bit of concern, because when you're really down, you really want someone to go, 'mm it sounds like you're going through a really hard time', but they never acknowledge that. They're just like 'well you've just got to learn to cope with this, it's an illness, and other people have illnesses and they cope with theirs and so..' and it's just the last thing you need to hear.

The narrative of not being taken seriously was also present in participants' accounts of experiences with a CATT team or other emergency contacts. This alternated however with health professional responses that were perceived by some participants as over-reaction or panic. Neither indifference nor panic was helpful.

Participants described feeling increasingly distressed, and in some cases angry, when CATT teams were perceived as indifferent or unconcerned about their suicidal feelings.

And I'd feel really crushed because I had done what I considered to be the right thing, when you're feeling really low and you think you're going to hurt yourself you call the CATT team, and they'd fob me off, like they didn't care, I told them I was thinking of ending my life and they're like well whatever.

Another participant spoke in similar terms about another crisis service:

Well they are just useless. They say oh well take a cup of milo, and hop into bed and take your tablets and you know they treat you like a child, they treat you like a child.

An apparently unconcerned response and a lack of action from crisis teams could be equally distressing for family members:

> *My son said you must call the CATT team. I said they won't listen, and he made me call them. I spoke to the CATT team and they wouldn't listen and my son got on the phone and said he was very concerned, and he didn't want to go to work and leave me, but they said she's OK. Then my son rang one of my friends and I went and stayed with her for the night. My son was stunned because he thought when he said he was too worried to go to work ...*

On the other hand some participants also thought that clinicians or crisis services over-reacted at times.

> *... and you don't want to tell the professionals because most of them react, and then you end up bearing the brunt of the system instead of getting through it therapeutically or whatever. I think now with the doctor I've got that's not such an issue but it's taken a long time to get to that.*

Similarly,

> *... and, because you learn, if you ring up someone and you say oh I need a bit of help, I've got all this stuff out and I don't know what to do, and they panic and they, right, send the cops around or something like that.*

Two participants spoke of feeling humiliated by being taken to hospital in the back of a police 'divvy' (divisional) van. In one instance this felt particularly humiliating because it was witnessed by a friend. Another participant described being placed barefoot in a van where vomit from a previous occupant was still on the floor.

One participant spoke of emergency services coming to her home as a kind of invasion and a stigmatising one.

> *I don't want the CATT team coming into my home. This is my home …*
> *This is my safe place. It's not a hospital or a madwoman's place.*

and

> *So the ambulance and police came. I let the ambulance in. Told the police*
> *I'm not a criminal or a madwoman - wouldn't let them in.*

Despite the above mainly negative accounts, some participants did report instances of a CATT team facilitating a hospital admission. Interestingly the most positive and valued experience with a CATT team came not in the form of an emergency response, but rather a planned intervention supporting a discharge from psychiatric hospital and helping the participant make a transition to living in her own accommodation.

> *… in the early days in the flat I had some suicidal feelings and I worked*
> *with the CATT team. … I've had some very mixed experiences with them*
> *over the years, but in this flat they were great. They understood what I was*
> *trying to do, stay at home, and cope and everything. … They administered*
> *my medication, and just talked about strategies to get through the night. I*
> *had phone calls with them during the night if I needed to phone them, and*
> *I had times to see them. We arranged for three days at a time, for a period*
> *of three days they'd do this, this and this, and they monitored me to see*
> *whether I had to go into hospital, and I didn't. I could cope at home.*

The contrast between this and many of the other experiences partially reflects the greater difficulty, for both parties, of achieving a helpful and collaborative outcome in the heightened emotional states characteristic of crisis. However the pressures of the CATT teams' gatekeeping role (with expectations of keeping people out of hospital wherever possible) very likely also play a part, perhaps creating a barrier to listenng empathically to someone's distress.

7.3.2   Hospitalisation

The majority of participants were admitted to a psychiatric unit soon after their suicide attempt. Some went straight from medical care (or rehabilitation) to a psychiatric ward or unit. Perhaps more commonly the pathway was discharge from

medical care to a period living out of hospital while struggling with ongoing distress and suicidal feelings, followed by admission to a psychiatric unit. Whether or not a psychiatric admission followed directly after the suicide attempt discussed in the interview, all had been in a psychiatric unit at some stage.

The over-arching theme of respect and being taken seriously vs humiliation, blame or indifference was once again relevant to interactions with staff in psychiatric settings. Acceptance, kindness and being treated humanely went a long way toward characterising a good experience.

> *And I remember a really nice thing happening after I was ... [admitted] …, I remember that this very nice nurse, very capable nurse took me in and gave me, I was still really groggy, but could take me and gave me a bath and got all the black crap off me, and she was just a very skilful nurse, and that made a huge difference, in that she wasn't at all judgmental and she was kind and it was a good experience.*

It was also a good experience when there was someone who could listen calmly to disturbing thoughts, feelings and memories and, importantly, not be frightened by what they heard.

> *The psychologist in ____ Hospital was very helpful during the [x] weeks. It became frightening because things were coming back from the past. She listened to me and seemed to understand. She just let me talk and she was comforting in a way. She wasn't frightened of it, didn't try to steer me away from it. There should be more psychology in hospitals.*

However participants reported varied experiences of staff attitudes and responses. One participant illustrated this in speaking about being 'specialled' (where a nurse was assigned to stay with one, or sometimes two, patients who were deemed to be at risk).

But my experience with specialling is that it depended totally on the calibre of the people doing the specialling. It wasn't always intrusive and awful. Sometimes it just made me feel secure…

… some of the people were awful and some just … took no notice of you and there were some good ones as well, so there was a real mixed bag of people and I think that you'll probably get that in any profession.

AG: What made a good one?

A good one, a good one talked to me, … was there if I needed to talk and I did talk to some of them. … A good one acknowledged that I was a person and … didn't just read the newspaper … which a lot of them did, bloody hopeless. A good one didn't hit the toilet door open to make sure that you weren't doing anything in the toilet. A good one would say something like 'now you're not going to do anything in the toilet are you' and I'd go 'no I'm not' and I'd feel like I've got a responsibility to her not to do anything. You know that's, it felt like I was given responsibility and then I was able to take that.

There are a number of points here about what makes for a 'good' nurse or a good interaction with staff: communicating a readiness to talk and listen if the person needs to talk, but without being intrusive; acknowledging the person rather than ignoring him or her and thus signalling indifference; respectfully negotiating around responsible behaviour rather than an intrusive policing of behaviour.

Being treated disrespectfully (or worse) in front of visitors was particularly humiliating, as illustrated by one participant's account of what happened when her boss visited her in a psychiatric unit:

But he [boss] *came in … to see me which was really good and* [a hospital staff member] *decided to search me, whilst he was there, and search my cupboard and search everything, looking for contraband, in front of him, and he was my boss! You know that was an awful experience, … that I could have been made to feel so awful in front of someone who was not even a close friend or relative.*

Staff attitudes to suicide attempts and suicidal feelings had a significant impact. Some participants felt they had been 'told off' or criticised for their suicide attempt.

> *… so I'd do something like attempt suicide, and then I'd be in hospital and the hospital staff would tell me off and say I had to stop doing it, and I was like 'why is everyone against me'.*

Perceived indifference to, or dismissal of, suicidal feelings could be experienced by some participants as permission to act on the feelings. Because of the person's vulnerable state and emotional volatility, this could occur even where the overall context included a sense of alliance and caring connection with most (but not all) nursing staff.

> *I told the nurse at lunchtime that I felt suicidal, She told me she didn't have any time, it was lunchtime, which I took as like oh well it doesn't matter if I kill myself, because you know nothing's important like lunch.*

> *… and I remember a nurse once telling me I wasn't suicidal, and it actually made me think, well I've got permission to kill myself because they don't think anything of it.*

Despite some distressing experiences (usually with individual staff), several participants felt that a stay in psychiatric hospital was helpful. In these instances being in hospital felt safe, removed the person from everyday stresses, provided support from staff, enabled recognition that others were also struggling, and relieved the person from concerns about worrying the family.

> [Being in hospital was] *Just taking the stresses away. It was a good break.*

> *Something about hospital, I don't know what it is, maybe it's just the comfort of being around other people who struggle with the same types of problems, having staff there who respect the fact that you are going through a hard time, well most of the time they do, as long as you don't act up or anything, being away from families and knowing that, even though*

they know that I'm not well that they don't have to worry so much because
I'm in a safe place, because I hate worrying my family.

It was just that sense of I'm in a place where it's alright to be unwell and
I'm going to do my best just to cope.

It was working though it, I wanted to work through things … But also it
was the surrounding, it was like everybody in there is like a big family…

However some participants thought that psychiatric hospital had only provided time
out and that this wasn't really enough, that there had been no treatment. One
participant described the experience as follows:

They said it was to review medication but no-one did that. The nurses were
too busy for me to talk with them. They couldn't spend time with me. So
nothing happened really. I got to see that there where other people in the
same position as myself. But hospital was really just time out, no
treatment.

As discussed below in the section on negotiated control, participants thought it was
important that they have a significant say over when they go to hospital and how long
for. As noted by one participant hospital is 'a really unusual environment', which can
be helpful but only when you really need it:

But I found I can only really recover in hospital if I really needed to be
there. Otherwise I'm kind of looking around going 'what am I doing here'
you know, there's all these people and they're really quite wacky and I'm
feeling very normal so I think I want to go home now.

7.3.2.1 Borderline Personality Disorder as an accusation

As mentioned in section 6.2.2, several participants contested a current or former
diagnosis of borderline personality disorder (BPD), with some describing the
diagnosis as 'contentious' and 'judgmental'. Discussing her diagnostic history, one

participant quoted her psychiatrist as saying 'you were <u>diagnosed</u> with [name of disorder] but <u>accused</u> of having borderline personality disorder'.

Several participants reported that a diagnosis of borderline personality disorder had implications for how they were treated in psychiatric hospitals and other mental health services. This was presented most starkly by a participant who had formerly been diagnosed with schizophrenia, but after the suicide attempt that was the focus of the interview, found her diagnosis changed to borderline. In the following quote the participant (whose current diagnosis was not BPD) is speaking about her post-suicide-attempt stay in a psychiatric unit.

> *... one of the things that happened is* [that] *it was during that stay, where my diagnosis changed from late* [onset] *schizophrenia to borderline personality disorder. And that was really horrible, like we have a strange mental health system, that as horrible as schizophrenia might be, it's legitimate, seen as real, seen as something that needs treating, seen as, and borderline is the exact opposite. You're just seen as evil, attention-seeking evil person, and so what happened, as that diagnosis changed, I got treated more and more and more badly basically. ... and it was almost like I needed to be punished because they had now determined that I was this evil, bad person, rather than someone suffering from an illness.*

If a diagnosis of borderline personality disorder could be experienced as an accusation then this was also true of other labels associated with self-harm. A participant who had scars on her arms from when she was self-harming twenty years earlier, spoke about attending hospital for a blood test as part of an investigation for a medical condition. The doctor saw the scars on her arm and said 'oh you're a cutter', at which she burst into tears. The tears were a response to the implied accusation and to her sense of hurt and injustice that the pejorative label could not be escaped even after 20 years.

Some participants spoke of how the diagnosis of borderline personality disorder regulated the amount of time they were allowed to stay in hospital, or indeed the possibility of being admitted to hospital.

Sometimes when I go through a really long bad patch I need to be
admitted for a week or something, but they only keep me in for two or
three days, so I come out too quick, and then I'm back in within a couple
of weeks because I never actually recovered, I never actually got myself
together. But because of my borderline diagnosis, they don't like to keep
anyone with borderline personality disorder in hospital for a long time, a
long time being a week or two weeks, so I've always just been, it's been
assumed that within two or three days of being admitted I'll be gone,
which is better than what some people get, but still, sometimes I think they
could be a little bit more flexible and a little bit more realistic about the
length of stay ...

Another participant, who described a long period of distress and depression after her
suicide attempt, felt that recovery would have been facilitated by a stay in psychiatric
hospital following her time in a medical ward. She reported that this was denied her
due to her diagnosis.

If they had taken me to [psychiatric] *hospital, worked things out with me, I*
think it would have been much quicker and better. But instead if you've got
the label personality disorder they think 'out'. Yeah, you're not coming
into the hospital…

A BPD diagnosis could also affect access to private psychiatrists, with one participant
reporting that a psychiatrist, whom she had seen before, refused to see her again after
she received the diagnosis. The participant was informed that the psychiatrist did not
'treat people with borderline'.

7.3.2.2 Returning to the ward after an inpatient suicide attempt

Two participants made suicide attempts while they were inpatients in a psychiatric
unit. One participant, who had absconded from the hospital in order to make the
suicide attempt, spoke at some length about her return to the unit after a period

receiving medical care. This was interesting as it is a topic not often discussed in the literature.

On her return to the psychiatric unit the participant found that her fellow patients had not been told anything about what had happened, but they assumed she had attempted suicide. She had not anticipated how difficult if would be 'having to face the people in the hospital' and also to deal her own feelings about what she had done. She was concerned that other patients might follow her example and also felt she had let the staff down, even that she had insulted them.

> *But when I got to __ [psychiatric] Hospital, and people obviously knew*
> *that I had attempted suicide. To the patients, those who were in the same*
> *position, I felt like I'd done something that was over the line, something*
> *that they wanted to do, and I didn't want to encourage anyone else to do*
> *what I did. I didn't want to encourage anyone else to commit suicide, just*
> *because I had tried. And with the nurses, personally I felt like it was an*
> *insult to them, that they couldn't care for me and it was only a few*
> *particular nurses I felt didn't care. I mean most of them do care a lot, and*
> *I felt like I had sort of slapped them in the face, by nicking off.*

The patients had a range of reactions. They hadn't known whether she was alright. Some thought she might have died.

> *The patients were upset, because I had gone for so long they didn't know*
> *that I was alright, so they were quite concerned and upset. And some of*
> *them were telling me off for what I'd done…. They were telling me off*
> *because I'd tried to kill myself. They, different patients for different reasons,*
> *but these weren't people who were suicidal, these were people who had*
> *other problems, and they were telling off for what I'd done and how much*
> *I'd scared them and… I really got a very confronting reception when I went*
> *back, and it was very difficult to deal with.*

> *And some people were quite relieved to see me, and as I said some people were quite angry; others you know wished they had come with me or to do it together.*

This situation raises complex questions about what, if anything, hospital staff should tell other patients on a ward when someone goes missing and has attempted suicide. The participant felt she had to try to explain herself because there was such a strong reaction from the patients. In the research interview she was asked whether she thought the staff should have given out more information.

> *Well I felt like I had to explain myself to the patients because they were so confronting to me about what had happened and how they felt about what had happened. And as I said they didn't know whether I was dead or alive, no-one had told them anything. .... The staff knew through my doctor but they didn't tell the patients.*
>
> AG: Do you think they should have?
>
> *I think they should have told the patients that I was alright, but for confidentiality reasons they, because I snuck out, they* [the patients] *knew I was missing but they had no idea from that point on what had happened.*

This is a complex issue with the staff having to consider confidentiality and privacy for the patient who has gone missing and yet also respond to the anxiety that has been stirred up in the other patients. The participant's suggestion was that the patients should have been told that she was alright. In the particular circumstances described this would seem a sensible suggestion, as it would be possible to say that the person was alright without saying anything about what had happened to her or whether she had attempted suicide. It leaves open the question, however, of how the staff could proceed if they knew the person was not alright. These issues could be further complicated in some hospital settings, for example in a private hospital where each patient may be under the care of a different psychiatrist, and there may be different views among the psychiatrists about what patients should hear.

As mentioned in one of the above quotes the participant was also concerned about how the nursing staff would feel about, and react to, her suicide attempt. However

because she had known some of the nurses for a long time she felt more comfortable talking to them about it. It was harder to respond to patients' sense of betrayal.

> *If I felt I was getting a cold response from nurses that I've known quite a long time, I'd discuss it with them. It was patients I found the hardest because some felt betrayed, that I'd leave them, I'd do that, you know we're all suffering, how dare you take your life. I found it most hard to rationalise with the patients. ... in hospital we sort of group up and look after each other, sort of that mentality in hospital.*

7.3.3   *Psychotherapy*

Participants generally regarded psychotherapy or counselling as helpful or at least potentially so. However some participants complained about the difficulty of accessing therapy/counselling, while others compared their varied experiences of therapy and held that some approaches had been found wanting (or at least not suited to their needs at the time). Psychiatrists provided psychotherapy for a minority of participants, but more commonly psychotherapy was provided by, or sought from, psychologists (and sometimes from other health professionals or counsellors).

One participant thought that psychotherapy had rescued her from a life completely without prospects:

> *When you're depressed your* [earlier] *life comes back, past issues of sexual abuse and so on. I had three years of psychotherapy, which got me from being a nutcase to someone who could function. ...*

In a quote presented above (section 7.3.2), a participant spoke about seeing a psychologist in hospital and how important it was to have someone listen and not be frightened by what he or she heard. Similar processes were central to an ongoing helpful (and life-supporting) therapeutic relationship, including the clinician being able to hear and acknowledge suicidal feelings.

> *I wouldn't have got though it without my psychiatrist. ... her support and listening to me after the whole experience helped tremendously, just to ventilate what I was feeling and that I was still feeling suicidal, having her acknowledge those feelings, was very, very useful.*
>
> *...*
>
> *But the way my doctor works with me she's just spot on, she's really clued me in, really listens and makes a lot of sense in her answers. ... we have a really good rapport, even though when it comes to suicide we're completely opposite thinking.*

Participants saw therapy/counselling as being about trying to understand themselves better and/or about coming to see things differently (including their valuing of themselves). As several participants found, this process could take some time and was facilitated by a long-term therapeutic relationship:

> *I've had some great counselling for a couple of years and you know it took me a long time to find that, and that's separate from my doctors. They're for the crisis, sort of planning and support, but I'm starting to understand more about me, and recognise, I didn't realise that I didn't cope with distress, so you know learning about me has also been something that's been really helpful and, I thought I might do this for a couple for years; it's been two years now and I think I'm only just starting to hit the work, so it's probably going to be another couple of years, and, it will be time-limited. But it's been, I think, something I've never done before, never really understood me. Don't know if I ever will completely, but I'm trying to.*

As indicated in the above quote, it could take a long time for participants to find or access (helpful) therapy or counselling. Sometimes this was because of a lack of knowledge of the service system and of the differences among the services offered.

> *I'm learning a bit more about the system and what is out there, cos I didn't realise that there were two types of psychiatrists. When you're out there someone says go and see a psychiatrist and the first couple I saw weren't*

really into this. I think they wanted to fill me up with pills or they just sat and stared at me. ... [Since then I started] *to recognise and learn that there were different approaches.*

However several participants spoke about access being restricted by the very limited availability of psychotherapy though public mental health services and/or the cost in the private system (even acknowledging the rebates available).

I guess I feel that if I'd been provided enough support before my suicide attempt, if I'd been able to access more than one counselling session every 5 weeks maybe I wouldn't have ended up in this state.

I know at the clinic I go to there's psychologists, who work there, and I've asked them, cos I know that I need to have a psychologist, ... and they won't let me have a psychologist.

Despite the overall positive evaluation, experiences of psychotherapy were not altogether unproblematic. One participant described how she felt her counsellor 'wasn't as present in the room as she had been before' and that the counsellor had indicated she may have to stop the sessions. The participant understood that this was because of issues to with 'transference and countertransference':

I thought that was something that just happened and you sort of worked with it but .... The counsellor is about the same age as my mother, she doesn't look like her or anything, but ... I think when I go there I often think about what I'm missing ... [in her relationship with her own mother]. *I think I see the counsellor as a sort of idealised mother figure, but I just thought that was part of it. But she said she'd run it past her supervisor but we might have to stop.*

Two participants spoke of helpful approaches to therapy/counselling and contrasted these with experiences that were not helpful. One participant found an approach that was focussed around supportive sympathy less helpful than one that was more actively challenging and engaging her in discussion and exploration.

> *I was seeing the old one* [previous clinician] *and she was fantastic but all she kept doing was saying was 'oh* [big sigh] *you poor thing, oh* [big sigh]*..' And it was like patronising me, you know, not giving me answers. The one I've got now sort of turns it round and throws it back on you and says 'hey how are feeling now?' and 'I'm getting this from you; this is what I'm getting'. But the other one was just sort of 'oh you poor darling' and all this sort of stuff, and it wasn't what I needed.*

and

> [The clinician] *that I'm seeing at the moment, she feeds back to you what you've said, which means you're not just saying it and it's just going out of your mouth and just never coming back again. I say it and she feeds it back and then we talk about what's gone wrong ..., whatever it was that happened.*

For another participant the crucial difference between therapy experiences was how the therapist dealt with the participant's sense of responsibility, guilt and self-hatred. One therapist framed the issues in terms of the participant needing to take responsibility for her actions, an approach that exacerbated feelings of guilt and self-hate:

> *Well she was using methods that were about me supposedly taking responsibility for things, but the issue was never that I didn't. ... I'd take too much responsibility if anything. ... So she was trying, we were having this ... therapy about growing up, being mature , taking responsibility, doing those sorts of things and all it was doing was feeding this terrible, terrible hate I had for myself. The public mental health system was stretched. I saw her for an hour a week and was told that I was really lucky to get that time, and I shouldn't stuff it up, and that made me feel guilty. Look anything that fed into my guilt was powerful stuff for me cos that was my most obvious way I was in the world, at that point in time.*

This contrasted with a therapy that framed the suicide attempt in terms of the participant's experiences in childhood and within her family as an adult:

I'd completely closed up and closed in and I was you know almost beyond repair and that therapeutic relationship didn't last to be what I needed forever, but at that time it was really important, and it pulled me through. … she framed the suicide attempt very differently, do you know what I mean? She enabled me to get some of the guilt off my [back]*, because she framed it, she framed it in terms of my family, and she framed it in terms of what I'd been through as a kid, and she framed it in terms of* [significant relationships and losses in adult life]*.*

This approach aimed to place the suicide attempt in context, understanding it as a response to painful life experience, rather than as (only) a product of mental illness or personal failure. This reduced the participant's self-condemnation and helped her to emerge from a closed up, withdrawn state and to engage more with everyday life. In saying that this therapeutic relationship 'didn't last to be what I needed forever', the participant was indicating the therapy did not address all her problems, but it was very important in her recovery from the feelings of guilt (and shame) that gripped her in the aftermath of the suicide attempt.

7.4   Medication for better or worse

Participants had varied experiences of the effectiveness of medication but experiences converged in relation to the interpersonal process around the prescription of medication. In terms of the therapeutic (or anti-therapeutic) effect of medication, experiences ranged from seeing it as a foundation for recovery or staying well, to feeling significantly worse while on medication.

For some, after a long history of recurrent suicidal episodes and repeated hospitalisations a change of medication or more careful monitoring of medication could make a significant difference. Discussing how she emerged from periods of feeling suicidal one woman said:

It just goes. I think it's starting to get better over a couple of days and suddenly boom it's just gone. Sometimes, a lot of the time it's just been

given time, over time it just goes, but with my last hospital admission I
changed medications and it had such a big effect.
[After discussing other factors contributing to recovery] *And then being put*
on Clozaril, just, things fell into place.

This change in medication was an important (though not the only) factor in enabling her to remain out of hospital, live independently and return to satisfying (part-time) work. Similarly another participant with a history of multiple suicide attempts saw medication as a key factor in maintaining equilibrium. She described how her psychiatrist managed her depression by adjusting her medication before she herself even recognised a change in her mental state:

I still get depressed but it's managed much better now. … if I go to see Dr
K and I'm not my usual self - usually I go in there cracking a joke and
kidding around - he'll say I'm putting your medication back up, and I'll
say why? Because you're depressed. OK am I? So he gets in early.

For another interviewee it was getting onto a medication regime that adequately controlled epilepsy that made a significant difference to the participant's psychological state. This followed a prolonged period of depression, distress and suicidal feelings while doctors were trying to change the treatment from one epilepsy medication to another.

In contrast some participants felt that being on medication made them feel worse. One woman first became suicidal while on medication (fluoxetine) which she experienced as flattening her sense of self and leading to a loss of agency and hope. She had 'always maintained that medication makes things hellishly worse' for her, but went on medication again after a decade or so off it when medical staff convinced her there were new and better medications now.

I felt like I wasn't in control any more, because what the medication did
was take away any, it just flattened me. It didn't help the depression but it
stopped me feeling OK, and it just flattened me so much, and then I just
completely lost hope

……

I could identify, especially now that it's past, that the patches when I was on medication I just got sicker, so that I never felt like, I didn't have a sense of me, I wasn't in control, and I was getting distressed.

This participant found herself in something of a catch-22, when her efforts to argue that medication didn't help were met eventually with the response that 'well the medication's not working because you don't want it to work'.

Another participant had been initially persuaded to try a range of medications, somewhat against his will.

I felt some of the medication increased the feelings of depression, made the flashbacks [of painful memories] *more intense.*

At the time of interview he was not on medication, but his doctor had made him aware of a proviso:

I've found out that I've got 3 strikes. It's 3 strikes and you're out. I have to get into trouble 3 times before the doctors can get a treatment order saying that I have to take medication.

Sometimes however the doctors themselves concluded medication wasn't helping. One participant described being tried on lots of different medications while finding that none really helped and they had a lot of side-effects. Medications interfered with her sleeping patterns and with her eating patterns and she put on a lot of weight (which she had since lost again). Eventually the doctors decided that hers 'wasn't a biological depression but more situational, to do with things that had happened' and took her off all medication.

Going off medication was better – I felt sharper, mentally clearer.

Those who saw a place for medication nevertheless often had mixed experiences.

[During a hospital admission] *They put me on new medication which made me very angry.*
Then I came home and went off the medication that was making me angry and the anger [subsided] *and I put myself back on the medication I had been on before.*

This participant thought that her depression 'is mostly reactive, a bit chemical, but mostly reactive' and her preference was to go on medication when depressed and go off it after a couple of months, and in the past this had been with agreement from her doctor. Now she felt that doctors pressured people to stay on medication.

Side-effects and health consequences were also an issue.

… and because you're on so many tablets you put on weight and then when you put on weight you get diabetes, Type 2, and it's just a never-ending circle. And then every couple of years or year or so the medication that they've got you on, for anti-depressants and all that, they start not to work so they try you on a new one, so as I said, a vicious circle.

Nevertheless, despite complaining about medication because of side-effects such as weight gain, those who saw medication as helpful or necessary to their mental stability, thought it was important to stay on it.

However when health professionals resorted to medication instead of a more nuanced, interpersonal response, this was resented even by those who acknowledged medication as having a role.

I would be really depressed and I would call the CATT team and say 'I'm really depressed, I feel suicidal, I don't know what to do' and they would kind of just fob me off and say …'take your medication' or whatever. And I'd feel really crushed
And after being sent by her GP to the hospital to be seen by the CATT team:

> *And again the CATT team would say 'oh just take your medication and go home' and I would've been taking my medication, it wasn't that,…*

A similar experience was expressed in even stronger terms by another participant:

> *They* [doctors] *don't listen; they just want to jam medication into your throat.*

These varied experiences again highlight the importance to the person that he or she be listened to, and listened to about medication as well as other aspects of their experience.

> *And I was on just all these horrible doses, quite horrendous high doses of different things and different combinations and things that were supposed to be anti-depressants and stabilise mood and you know do this and that, and all sorts of things. And I just kept getting sicker and sicker and I kept telling them it was the medication, and I was patronised: well if you're this sick now dear, imagine how sick you'd be on nothing. So they weren't hearing and I said well in the past when I've been on medication it's made things worse*

The experience of being shut out of decision-making and treated with disdain can occur equally when being taken off medication:

> *I mean it's just, … even taking me off medication. Like I complain about the medication now because it makes me fat, but they used, they pulled off absolutely everything, told me that they thought my private psychiatrist was a fuckwit, virtually, not in those words. …… They kind of bad-named him, in front of me, and pulled me off everything, and it was like that was a symbolic act of, the meaning of the changing of the diagnosis* [to personality disorder] *was you don't even deserve pills*

Participants recognised that decisions about medication could be complex and that there could be a basis for differences of opinion between doctor and patient, even that they may have seen instances where a patient didn't want medication but might need

153

it. However they wanted their experience to be listened to, and they recognised that this was more likely to happen in the context of a long-term relationship with a doctor who had known them when well and not only when unwell. Consistent with this they wanted to find a doctor whose judgement they could work with and trust and not see a rotation of doctors each with potentially a different idea about what medication was best.

7.5 Discrimination and disadvantage

7.5.1 Discrimination based on suicide attempt or mental health status

One of the participants who was admitted to a brain injury rehabilitation centre described an instance where discrimination on the basis of a suicide attempt was being actively considered. Two nurses came to a medical hospital to assess the participant for suitability for the rehabilitation program and part of their discussion concerned whether the suicide attempt meant rehabilitation was a waste of time.

> *When I was at __ hospital two nurses came from* [the rehabilitation centre]*, and they came to check out whether I'm a good enough case … So those two were talking about it and the senior nurse originally said no it's not worth spending a long time, so not even to go to the* [rehabilitation] *hospital because I was a suicide attempt person so why waste that time. But the more junior nurse, who's got a lot more experience though, she eventually told the senior nurse that it is worth to check me out, and let me go to that brain unit.*

Writing the context of surgery, post-operative care and rehabilitation, Wirbel, Olingar, Karst, and Mutschler (1998) noted that patients who attempt suicide are often considered to be unreliable and uncooperative during treatment and this is seen as likely to compromise functional outcomes. However their follow-up of surgical patients who had attempted suicide found that these pre-conceptions were not borne out.

The researcher asked the participant quoted above how it felt to be listening to this discussion of worthiness for rehabilitation. The participant described several phases of reaction: being stunned, recognising discrimination as a systemic mental health issue and then arguing for fair and equal rights.

> *I was stunned originally to be talked* [about] *that way, to even not originally give me a chance for treatment … then secondly I thought well OK yes this is the same sort of situation as what they do in the mental health system, that we're second hand people so we don't get much decent treatment, so.. and then in my third stage I started to express my opinion that I do have some rights and yes I'm worth enough to be checked, to be treated.*

In the above quote this participant suggested mental health patients are systemically discriminated against, in a systemic way, through insufficient and inadequate (or inadequately funded) mental health services.

Several other participants expressed concerns about discrimination in relation to general medical/physical health care. The issue was how professional/medical staff knowledge of a suicide attempt or psychiatric diagnosis will impact on future treatment for unrelated problems. One participant avoided hospitals and Emergency Departments where she had been after a suicide attempt:

> *Emergency Departments are really dangerous places for people who have* [previously] *tried to kill themselves because the assumption is that it's psychological. I've got a pain – oh it's psychological.*

Others were concerned that a particular psychiatric diagnosis would lead, or had led, to the same assumption being made, i.e. that physical symptoms would be regarded as psychological in nature.

> *… also the fact that they said I had borderline personality disorder, every time I go to the hospital for something else they'll say oh it's psychosomatic.*

The participant quoted above reported that after several years of 'going through all this agony' and presenting with pain symptoms that were seen as psychosomatic, she was recently diagnosed as needing urgent gall bladder surgery.

Consistent with participants' concerns, large scale studies have provided some evidence of differential medical treatment for people with psychiatric diagnoses. Sullivan, Han, Moore and Kotrla (2006) found differences in rates of hospitalization for diabetes among persons with diabetes who did or did not have co-occurring mental illness. In this U.S. study, persons with diabetes and a psychiatric diagnosis (especially a non-psychotic diagnosis) were less likely to be hospitalized after presenting to an emergency department. Sullivan et al. recommended further investigation of the reasons for the disparity. Understanding and addressing such disparities becomes even more important with proposals for developing a centralised electronic system of medical records which medical practitioners could access no matter where the patient presents.

7.5.2   *Living in a regional township*

The one participant who lived in a regional township (as distinct from a major city) thought that this entailed a number of disadvantages. One issue was the very limited choice of mental health practitioners and services. If one had a bad experience with one service, there was nowhere else to go.

> *You have no choice. You have no-one else to go to. And if you go and see your doctor, and tell your doctor about what's going on, they instantly ring* [the service where you had the bad experience]
> *…*
> *So it's like if I want to see a psychiatrist I go all the way to Melbourne* [state capital] *and see a psychiatrist in Melbourne. But once I went down there, all the way down there by car, drove all the way and he saw me for 10 minutes …*

As well as the effort of driving to the city, the cost of petrol was a significant issue to be weighed up against a ten minute appointment.

This participant's experiences are consistent with other reports of the restricted nature of mental health service provision in regional areas. Stephenson (2003) found that psychiatric patients from non-urban areas had fewer mental health visits in a calendar year than their urban counterparts. Fortney, Rost, Zhang, and Warren (1999) reported that, among those seeking treatment for depression, longer travel time to a preferred provider was associated with making fewer visits.

For the participant in this study, another issue was the lack of privacy in a regional township:

> *There's no privacy in a country town. Everybody knows everything about*
> *you ...*

and

> *And like you don't have any privacy, everyone knows because they see*
> *you at the hospital, or they see you talking to one of the psych nurses, or,*
> *and it just gets around*

This lack of privacy made it more difficult to manage the boundaries abound sharing experience with others, and to make one's own decisions about who to confide in.

7.6   Negotiated control

Participants felt that being able to exercise some autonomy within the treatment relationship was very important. As discussed in section 6.6.2, the sense of being controlled by clinicians and having treatment decisions imposed against one's will was experienced as frustrating at best and 'horrendous' and unbearable at worst. This extended well beyond formal involuntary hospitalisation to heavy pressure to, for example, take medication, stay in hospital longer, leave hospital sooner, meet with family etc (in some cases with termination of the treatment relationship as an outcome of refusing to comply). Similarly participants who felt their needs were denied and their safety neglected (for example by emergency services) reacted with hurt and

157

anger. Here participants were concerned about denial of services which they felt were needed.

When one's judgment, experience and knowledge of oneself is dismissed, sense of autonomy or agency is undermined and trust in treating professionals can be severely damaged. At the same time participants acknowledged that, at the time of feeling suicidal, they weren't always thinking clearly and in at least one instance a participant denied ongoing suicidal intent in order to be allowed to leave hospital. In such circumstances collaborative decision-making can become complicated. Participants spoke of two factors or processes which facilitated what might be termed a negotiated control – where participants/patients could exercise autonomy and control in relation to their treatment but where this takes place through a process of negotiation with the treating professionals. These factors were over and above the basic pre-requisite of respect for the patient and for their knowledge and experience (as discussed in section 7.1.). Firstly participants thought that clinicians were more likely to respect their views about treatment if the clinician had known them during periods when they were well. The second facilitating process concerned putting treatment plans in place ahead of time.

7.6.1   *Knowing the well self and the sick self*

Several participants thought that clinicians' dismissal of the participants' own perceptions about their needs and thoughts about treatment was connected to the fact that clinicians only knew them when they were unwell. Thus clinicians did not see participants' strengths or their capacity for decision-making.

> *So they weren't hearing and I said well in the past when I've been on medication it's made things worse, but they didn't know me, you know the doctor had met me for the first time when I was particularly low, and so he didn't have a sense of who I was and what I was saying and whether or not that was true.*

The following quote refers to a participant's experiences with hospital staff and the CATT team.

I really felt that I was seen as a nuisance because every few months the same thing would happen, and they would only see me when I was really unwell, so they kind of saw me as this really kind of depressed and not able to cope person, whereas in between depressions I'd be quite well and I'd be coping really well and I'd be achieving things, and so they just didn't seem to care and they didn't respond.

This experience led to a reciprocal lack of respect for, and trust in, the clinical services:

… so now I never ever call the CATT team and I hate being seen by them. I really have no respect for the CATT team.

In contrast participants found they could enter into decision-making when the clinician knew the well self and not only the sick self.

… but I think what really helped [was] *that I got to know him when I was well, and he got a sense of me.*

Meeting the clinician when the participant was well meant he or she could, in essence, negotiate an approach to treatment or 'interview the doctor' about how the clinician was likely to proceed in certain circumstances.

I don't think I was saying anything different then to what I say now, but now the doctor I've got I met while I was well. I said this is what works for me, and this is what I'm looking for, are you willing to be part of that and he said yes. I was: if you're not, then I'm moving on.

7.6.2   Treatment plans

One way a participant could have some control over what happened in a suicidal crisis was to engage in a planning process in advance. This involved clinicians and the participant working together on how to identify early signs of becoming

unwell or heading toward a crisis and developing a plan for what to do. One participant spoke about a treatment plan that enabled her to have brief admissions to hospital without needing a CATT team assessment:

> *… and so I have dips still but they tend to be caught earlier and they've* [clinicians] *been working on my management plan, my treatment plan, and I have planned admissions so that if I start to feel unwell and I think it's heading in the wrong direction and that I need to kind of have some time out, I get admitted to hospital for usually two or three days, and I just rest there and try and turn things around for myself, but I don't have to go through all the rigmarole of the CATT team, which I hate the CATT team cos they've really been terrible in the past, so having that there is a kind of a safety net.*
>
> *…*
>
> *so it's about for them, and for me, recognising the early warning signs and acting before it becomes a major problem. I tend to crash pretty quickly …*

Another participant described a plan for support and intervention which facilitated adjusting to living independently after discharge from hospital. In this instance the CATT team was the collaborating partner. Sometimes the plan may be more like a set of principles, for example one participant had developed in-principle agreements with her psychiatrist around such matters as her role in decision-making, and only going to hospital if the participant really thought it was necessary and leaving as soon as she felt ready.

One participant raised the concept of advance directives:

> *… and I love that whole notion of advance directives, … I'd never heard that term, but what I had done was put letters in my files about, you know, I'm not happy for medication. It was pretty negative actually when I think about it; … but that was just my fear about don't ever do this to me again.*

7.7   Psychological safety in mental health services

Many of the themes and experiences discussed in this chapter can be drawn together through the concept of psychological safety (or the lack of it) in mental health services. Seager (2008) argued that psychological safety emerges from a relational context characterised by attachment and containment. To be psychologically safe is to be held in mind and thought about in an empathic way by someone in whom there is a basic level of trust and with whom there is regular contact. The overarching theme of this chapter, respect and being taken seriously vs humiliation, blame or indifference, points to experiences of safe versus unsafe psychological environments. Seager maintained that mental health services have focused on physical safety but have paid very little attention to 'the relational and social context that gives rise to dangerous feelings, thoughts and acts' (p.211). Participants quoted in this chapter described how clinicians' attitudes conveying blame and negative judgements, or actions that humiliated and diminished, led to a downward emotional spiral and/or a resurgence of suicidal feelings. In other words, breaches of psychological safety lead to risks to physical safety. Significantly Seager went on to make the point that clinicians also need a psychologically safe working environment, i.e. need the containment provided by a 'good enough' (sufficiently nurturing) system of supervisors, managers and meaningful policies and procedures.

Chapter 8 Toward recovery

Within the overall aim of investigating experiences following a suicide attempt, one of the initial intentions of this study was to explore what was helpful and what was not helpful. During the process of data analysis, themes concerning what was helpful, or not, were largely reconceptualised in terms of the processes of moving toward recovery. It is these themes and these processes that are the focus of this chapter. The chapter is entitled 'toward recovery' in recognition of recovery as a dynamic process, and because, at the time of their interview, participants in this study found themselves at different places in relation to this dynamic. After discussing themes about recovery that emerged from the interviews, the chapter concludes with a comparison of these recovery themes and Judith Herman's model of recovery from trauma.

8.1   Recovery as process

The concept of recovery is complex and open to a range of understandings. The literature on recovery from mental illness has noted varying emphases on symptom remission, level of functioning (social, occupational and in relationships), establishing a positive sense of identity, and living a satisfying, meaningful life perhaps while managing a chronic condition (Andresen, Oades, & Caputi, 2003; Ralph & Corrigan, 2005). The literatures on recovery from grief (Worden, 2002) and trauma (Herman, 1992) recognise that there is no clear and complete end-point to recovery, that the experiences of grief and/or trauma continue to reverberate in some way throughout life. Furthermore recovery is not a matter of returning unchanged to the person and the life that existed prior to trauma or mental illness. Experience changes all of us, creating scars but also developing strengths, as recognised in the literature on post-traumatic growth. In view of this complexity recovery may best be thought of as a process, the process of being 'in recovery' (Corrigan & Ralph, 2005).

Not all participants in the current study used the words 'recover' or recovery' during their interviews. However all participants spoke about whether their life (internal and external) felt better than it had at or just after the time of the suicide attempt and about

the extent to which they continued to struggle with suicidal thoughts and urges. A common experience was that:

> *It takes a long time before the effects of people attempting suicide really goes away.*

Nevertheless several participants reported that the level of meaning and satisfaction in their lives, their sense of inner strength and/or ability to cope were significantly improved, even though they were still actively engaged in managing their psychiatric condition with its attendant vulnerabilities and periods of distress.

> *I just feel like, I feel like I've got a lot more hope in my life and a lot more to look forward to in the future. I'm a lot stronger than I used to be as well, and the depressions when they come don't last as long. I guess I've got more good things in my life.*

For another participant the sense of hope was more tentative:

> *… but it does seem to dissipate a little with time, that certainty that that's going to be where things finish. Other things seem possible finally, you know that it is possible that I may be OK.*

On the other hand some participants felt very much immersed in a painful, and consistently difficult, struggle, still searching for a way to feel better:

> *I am working hard to keep going.*

and

> *I'm still trying to find a pathway to how to feel better.*

Other participants described a fluctuating experience, with some happier times interspersed with highly distressing episodes of suicidality. Overall the experience of suicidality had significantly diminished for some participants, but was still a central issue for others.

In the interviews the discussion of factors or experiences that were helpful in recovery or in feeling better ranged across a) recovery from the specific suicide attempt and its aftereffects, and b) recovery more generally in terms of the underlying mental health problems and life circumstances that were associated with suicidal thoughts and actions. These two aspects of recovery, the specific and the more general, were not always clearly distinguished in the interview conversation. In addition some participants spoke about factors that were relevant to preventing or reducing the likelihood of further suicide attempts. This section of the thesis provides an account of the factors and processes that participants identified as significant in relation to recovery. The researcher does not contend that this is a full account of the processes of recovery but argues that the factors and processes identified here are significant leads toward a greater understanding.

8.2   Home as secure base

Several participants reported that finding, or retaining, a home provided a necessary foundation for recovery. This was identified particularly by those who had lost their home after the suicide attempt and those who had faced instability of accommodation over a substantial period (as discussed in section 6.7.2.2 above.) Those who had retained a stable home base were less likely to mention this factor, perhaps because lack of something foundational impacts more noticeably than its presence. One participant described getting a home of her own in terms of moving from a kind of ghettoised position to being part of the community:

> *I found a place to live, the flats I still live in. … And this is after* [many]
> *years of special accommodation, living with other people with psychiatric*
> *illnesses, I got my own flat. And as soon as I got the flat… because I saw*
> *the flat as a way to escape, get out of the cycle of being with people with*
> *psychiatric illnesses and the drama of everyday living in that situation and*
> *a way of getting myself back into the community, which is really important*
> *to me. … I got the flat and it helped enormously.*

This participant had moved into her own flat on discharge from a psychiatric unit where she had spent some weeks following her suicide attempt. She recognised that a

change in medication soon afterward played a role in helping her to be well enough to live on her own. Having her own home then provided a foundation that facilitated engagement with other people and activities, and was associated with reduced levels of depression:

> [Since then, things have been] *a lot better. I have a great relationship with my family, good friends, part-time work. I do voluntary work. I feel part of the community .... I have times, short times of depressions and flashbacks and things like that but nothing like I used to experience every day of the week. I might go through a slump for two weeks then I get out of it, not three months long.*

Having a home obviously has important material functions. However participants spoke about having a home in a way that suggests a home also functions emotionally as a secure base, in attachment theory terms. Bowlby's (1988) original concept of a secure base concerned the sense of security engendered in an infant by a secure attachment to a primary caregiver (usually the mother). The mother provided a kind of anchor point from which the infant could safely venture out and explore the world. For Bowlby a secure attachment not only provided a mental model of relationships, but underpinned curiosity, learning and engagement with the world. Importantly, when faced with strange situations, potential threats and disequilibrium, the infant could scurry back to the safety of the secure base (mother). For the adult participants in this study a home provided a place of emotional safety, a place of retreat and a springboard for engagement with the community. This was articulated also by a participant who did have a stable place of residence when she spoke of her home as 'my safe place'.

8.3   Activity, work, contribution

As discussed in section 6.7.2.1 many participants lost a job or felt unable to return to work in the aftermath of their suicide attempt. For most, loss of work entailed loss of confidence and damaged the person's sense of having something worthwhile to contribute, further exacerbating feelings of shame and guilt. Starting work again was associated with reversing these effects. There is a circular process here in the sense

that the person needs to feel well enough and/or confident enough to look for a job or attempt a return to work, but once working, this tentative confidence is expanded and strengthened.

> *So having a job in something I like, I guess builds my self-esteem a bit again, cos for a while it was a bit down there, and knowing that I can do a good job. Yeah just that sense of doing something and I'm not beat by this illness, you know, I can still do things.*

> *Dr X suggested this* [type of work]*, thought I would be good at it and I love it.*

> *And then finishing that* [study] *and starting work in something that I believed in was another thing, that I thought well my life can be OK, it doesn't have to be just this cycle of depressions and failures and stuff like that, it can be, I can manage this and still have a meaningful life.*

As indicated in the above quotes, the affirmation and sense of meaning, and indeed enjoyment, that can come with work also engenders a sense of hope, that there is a future and a life worth living. As Beck et al. (1975) established many years ago, a sense of hopefulness is associated with a decline in suicidal ideation:

> *… although now even when I get quite depressed I don't really get suicidal and I think that's probably to with* __[relationship with partner] *and also with the fact that I'm in a career that I like and that I've built for myself.*

When a person is struggling with feelings of worthlessness and shame and has lost sight of his or her own capabilities, affirmation from others can be very significant. One participant told a story of affirmation having an impact even when she did not get the job she had been interviewed for:

> *I didn't get the job but, this is a really good example of a little bit, it doesn't take much of an effort, just a little bit of white paper,* __ [person who is now a colleague] *who was part of the interview panel, wrote me, and I didn't*

know her at all then, wrote me this little thing that said 'sorry you didn't get the job but I thought you were terrific, we've got some voluntary work at __ [organisation], are you interested in doing something?' And I jumped at the chance …

This participant went on to explain that, although at that point she was still not really well, and doing voluntary work was challenging even within a supportive organisation, this affirmation of her value was the start of developing the confidence for a full return to the workforce. There may be a fine line however between affirmation and unrealistic expectations. As outlined in section 6.7.2.1 one participant related how unrealistic expectations and the associated pressure to return to work was unhelpful and exacerbated mental health problems.

In addition to, or instead of, working, other forms of activity may build a sense of agency and achievement. One participant described how art and craft sustained her during lengthy periods of depression, and said that even when feeling depressed enough to have suicidal thoughts, a conversation that put her back in touch with a sense of achievement through her craft, could act as a counter (even if temporary) to those self-destructive feelings:

I'm into craft in a huge, huge way and for months last year, I just sat there; I knitted, I crocheted, I did some pictures.
…
Somebody will say 'oh what have you been making today?' and I'll say 'oh yeah I did this and I did that, and I did the other thing' and because I'm so crafty, I have done those things and I feel really good about it, oh not really but (laughs) *you know what I mean.*

For some participants, being active and involved was in itself experienced as helpful. Forms of activity included involvement in community organisations, participation in exercise, sport or dancing classes, as well as creative pursuits such as art and craft. Some of these activities also provided an opportunity to develop and strengthen sustaining relationships, which are the focus of the next section.

8.4 Sustaining relationships and mending ruptures

8.4.1 The significance of relationship

Several participants nominated family and/or friends as an important factor in the recovery process. Critically important was the continuation of valued relationships: that '[boyfriend] *stuck by me*'; that friends were '*interested in seeing me*'; that although '*I wasn't sure he'd want to see me again*', a husband had been at the hospital all night; that a father responded caringly to a desperate plea:

> *If you're my Dad, you'll work this through with me. I'm your son; I'm your blood.* (Q response?) *Dad was good.*

The significance of relationship is always multi-faceted but some elements are discernible in the above examples. That friends were '*interested in seeing me*' conveys an affirmation of worth and value as a friend and a person. That a husband is there at a time of crisis and a father responds to a plea for help affirm an ongoing attachment bond with its inherent promise of support and containment. In addition to these elements, the fact that '[boyfriend] *stuck by me*' carries implications for the future and generates hope:

> *He's completely non-judgmental about what happens when I get depressed and he doesn't get freaked out by it. ... So I feel safe with him and that's really nice because prior to that I thought I'll never have a relationship with anyone, I'll never get married or have children because no-one will ever stick around if I get depressed.*

Some instances of helpful relationships are not so much about the future of that relationship per se but about what the person internalises and carries with him or her into the future. This is true of therapy relationships and can be true of other relationships also:

> *I used to go dancing. I love music so much I thought I'd try dancing. There was this dancing instructor, she gave me the courage to look again, to go*

again. I fell for her; she's married and so on now, but she's still inside me,
like a light inside me. … In the end it turned out the friendship was based
around work and it couldn't go anywhere, but [it] *still helped me.*

As well as being important in recovery, the experience of interpersonal connections can sometimes function to disrupt a suicidal process. One participant spoke about how an accumulation (and she emphasised the accumulation) of instances of connection with others and being valued broke through an inner state of suicidal separateness and diverted her from a suicide plan. It can be argued that re-connection with her own feelings was also a significant part of this process.

I wanted to see [friend] *and I wanted to see her new baby, and so you*
know .. I'd booked a hotel,… it [the suicide plan] *was all in place, nobody*
had a clue. But that particular morning [at work]*, somebody who I*
thought didn't value me at all asked for my input for something and
indicated they valued it. Somebody else … came up and was really
appreciative of something I'd done. I think, my friend … I think just
something she said, I don't remember if it was a particular thing but I just
remember us both crying together, and I think.. she didn't know, she had
no sense of what was happening, but I remember us both crying and
hugging and me having a sense then that it was over and that it was OK.

In addition to the significance of relationships per se, some participants described a range of practical supports provided by families and friends in the period after a suicide attempt: coming to stay with the person; providing a place to live for a time; helping the person set up in his or her own place; reclaiming and moving furniture from previous rentals; paying for private health insurance.

Sometimes the importance of relationship was, in essence, about shared activities, companionship and not being alone. As indicated in section 6.7.1.2 it was important to maintain relationships with friends even when this could only be done by hiding one's true emotional state. Isolation was to be avoided at all costs, and indeed the literature on suicide suggests that isolation is dangerous. The significance of sustaining relationships in the recovery process is consistent with a large body of

research that has identified both social isolation in general and the loss of, or breakdown in, a significant relationship as risk factors for suicidality (Joiner, 2005; Maris, 1981).

Risk factor research is based on research designs involving quantitative measurement of emotions, thought patterns or behaviours in order to investigate the links between them. Such designs are less suited to the study of process and reciprocity, but the study of what is happening in the reciprocal relationships within families and among friends seems a core issue in understanding reactions to and recovery from a suicide attempt.

8.4.2   *Reciprocity: Recoil, protective silences and re-connection*

Qualitative research designs may provide more access to process, although the picture may be partial as it is dependent on what informants can and do speak about. In the current study, investigation of reciprocity in relationships is also limited by the fact that the study has access to only one informant perspective. We have the perspective and perceptions of the person who made the suicide attempt and not directly those of family members. Nevertheless the study suggests some leads or insights.

As discussed in section 6.7.1, the participants' suicide attempts gave rise to a range of intense emotions in those close to them. A suicidal crisis is painful to see, invoking terror at potentially losing a loved one, a sense of profound helplessness, and/or fear of being contaminated or infected by unbearable despair. Family members may be angry as it seems the family is being asked to bear something unbearable. At the same time it is just this 'something unbearable' that the person who made the suicide attempt is also struggling with. Immediately after a suicide attempt the person may be still in the grip of the suicidal crisis and/or experiencing intense feelings of shame, guilt and helplessness, bereft of any sense of agency or control. Often family members and friends can't bear to see this. They may recoil and avoid the person – a pattern that some participants reported (or feared) in their friends, '*my friends stopped coming to visit',* and in intimate partners: '*boyfriends would freak out and leave me, understandable, it's pretty hard to deal with'*. Family members may use avoidance mechanisms such as denial that the person is or was seriously suicidal. A belief that

the person could get out of the suicidal crisis if they 'really try' can also be understood as a kind of denial. The following quote notes the range of reactions that can occur within one family:

> *My dad doesn't believe I ever intentionally want to kill myself, and that's very difficult, because I do. That's his coping mechanism, so he doesn't believe I'm going to die. That's the way he copes. Mum acknowledges that I want to die and how much she doesn't want me to die.*

In recognition of how difficult it is to look at the suicidal crisis, many participants tried to protect family and friends by not talking about their suicidal feelings:

> [If] *I tell them this too, and what are they going to do with it, and it's just going to stress and terrify people*

However these feelings become shockingly apparent at the time of a suicide attempt - unless the suicide attempt itself is hidden from the family. One participant, in seeking support from family after a suicide attempt, spoke of depression but did not tell of the suicide attempt. Another participant kept the suicide attempt and subsequent hospitalisation in a psychiatric unit hidden for some time, motivated partly by protective instincts:

> *I went right through that period and didn't talk to my, my mum is still upset about it. I didn't tell her. And she would have been a good ally if I had, really. But I didn't tell her, she still can't understand it but I didn't tell her for a number of reasons. One is that she had already been through* [family history of suicidal crisis], *so I felt that I was protecting her a bit ...*

In most instances however the participant's suicide attempt was known to the family, who reacted with shock, fear and horror. Moreover at the time of most acute crisis, in a state of cognitive constriction and narrowed awareness, the suicidal person may be oblivious to family feelings and impacts, something the family may sense and react to with hurt and anger.

All in all, the time of suicidal crisis and/or suicide attempt can produce significant ruptures in relationships, whether through recoil from the anguish of the suicidal crisis, though distance created by protective silences, or through difficulties inherent in a jungle of intense and volatile emotions. The process of recovery then is partly a process of repairing these ruptures.

Overall participants reported mixed levels of success in the endeavour to repair ruptures. Where ruptures were repaired, heightened emotions settled, conflict decreased and/or communication re-established, this occurred gradually, and sometimes painstakingly, over a substantial period of time. The process seemed to be facilitated by the participant being in a less suicidal state. As the suicidal crisis passed or suicidal thoughts became less insistent, it seemed more possible for family and friends to share in the person's current experience, i.e. the current non-suicidal or less suicidal experience. The previous 'toxic' suicidal experience and the suicide attempt itself could then be dealt with in one of two ways. Establishing sufficient distance from the events enabled some families to talk about what had happened, their feelings and reactions (with or without the assistance of a clinician), as outlined in section 6.7.1.3. Alternatively in some families there seemed to be a mutual agreement not to talk about the suicide attempt, but rather to leave it in the past. In these instances, there was a sense that it is better not to stir up old hurts.

> *I still haven't really spoken about it with him* [husband]. *He says that he lets them* [the children] *know what's happening but I've never really been game to even ask that question, if they know quite where I was at.*

Just as being less suicidal seemed to enable re-connection, some participants described how they resorted to simulation of recovery (keeping suicidality a secret) in order to retain friendships.

While repairing ruptured relationships involved family members dealing with their horror, fear, hurt and anger, so too the person who made the suicide attempt is attempting to resolve or contain intense emotional states. Many participants were struggling with sometimes overwhelming shame, guilt, and feelings of worthlessness. Some were fighting back in anger when their feelings of worthlessness were reflected

back to them by others. These feelings could affect their confidence to be with others (hiding in shame) and their trust in other people (projection of their own negative self-evaluations and/or sensitivity to stigmatising judgments made by others). Some participants spoke about recognising their need to work through these feelings as part of the process of repairing ruptured relationships.

> *I made a huge effort to ignore some of the negative feelings about people I knew. I used to get incredibly angry – when I felt this coming on I had to try to do something about this earlier. I had to recognise that anger if left would really magnify. I had to trust myself a bit more. I felt I'd been really bad so I had to say I am OK, I'm not a terrible person.*

and

> *I have this thing that people don't like me, yet I know they do like me.*

While some ruptured relationships could be mended, some could not survive the impact of the suicide attempt. In some instances this may reflect a different pattern of reciprocity, where problems in the relationship fuelled suicidality and then the suicide attempt hastened the relationship's ending. One participant who made a suicide attempt in the context of a deteriorating long term relationship said:

> *… you might have underlying psychiatric, psychological stuff but what's happening in a day to day basis in your life is also absolutely fundamental to your ability to stay alive I think*

Then after the suicide attempt:

> *That was the start of the end in terms of our relationship. We kind of lingered on a little bit. We kept going for a little bit, tenuously, after that, but he was, absolutely could not handle, and I'm not being totally judgmental here, I think it's a hard thing to ask someone to handle … but he wasn't, but I don't want to make him out to be a saint either.*

Reviewing the material in this and previous sections it is evident that experiences with family and friends were not the same across all participants. Indeed there was a good

deal of variation in how these interactions played out and/or in how they were perceived by participants. Family and friends varied in their reactions to the suicidal crisis and in their willingness or capacity to mend relationships when ruptures had occurred. Participants too varied in their reactions and feelings about family and friends. Moreover participants in the study were at different stages in their recovery. If it is the case that re-connection with family and friends is facilitated by recovery from suicidality, as well as recovery being facilitated by re-connection, then for many participants this was an ongoing process at the time of the interview.

8.4.3   *Thinking, and re-thinking, about burden*

For one participant, an important restraint on acting on suicidal feelings came from being forced to reconsider the issue of being a burden. This woman's suicide attempt had been, at least partly, connected with feeling she was a burden on her family and they would be better off without her. Subsequently a doctor worked at getting her to see that, even though she might believe this, her family didn't believe it.

> [When I'm suicidal] *you won't convince me otherwise, that my children would be better off with my husband, and I believe with it every fibre of my being, but I also believe now with every fibre of my being that <u>they</u> don't believe that. And so I've got that struggle to reconcile that now, … and it was that doctor who actually put some fighting words into my head … and so that comes back ever since that time*

The doctor's words were reinforced by her husband's reaction to her suicide attempt, which had clearly indicated that he didn't think the family would be better off without her. Even so, it was a real struggle to go reconcile this with her own instinct.

> *… that was always the thing that was too hard to reconcile, you know, even though I didn't believe that, I didn't agree with that, that they couldn't be better off, they had to be better off, you know because I'm, the distress I'm causing now. But there was just enough of a tension, an uncertainly in my head, well what if I've got this wrong and the last thing I want to do is hurt my family, and so I cannot take that chance*

The participant initially made a promise that she would get through to a period when her children were older. She saw the promise as not only something for her family but 'something for me'. As time went by, with other changes and with psychotherapy, she began to feel her future might, but at that stage still only might, stretch beyond that. While this process involved only one participant, it illustrates another dimension of the ways in which family, and thinking about family, has a significant influence on suicidal behaviour, a dimension which Joiner (2005) has particularly emphasised in his writing about sense of burdensomeness.

8.5   Disclosure of the real self

8.5.1   *Acceptance vs secrecy and avoidance*

A theme running though the interviews was that it was (or would be) helpful to have an avenue for disclosure of the real self. Implied was the desire not only for disclosure but for acceptance. This theme was clearly present in the discussion about the need for secrecy. A suicide attempt is '*such a secret*' and participants spoke of having to put on a mask or a plastic smile, keeping suicidality and depression hidden, in order to retain friends. One participant concluded:

> *… but it's nice to have someone around who you can be yourself with and not have to pretend. I still feel very alone.*

When she said 'it's nice to have someone around', the context indicated she meant 'it would be nice'. She was saying she does have to pretend and this leaves her feeling very alone, because although friendship is retained, the friendship is experienced as being based on presentation of a false self.

This theme also runs through the discussion of the need for respect and the desire to be listened to within clinical services. Participants wanted their real self, real emotional state and the seriousness of their situation to be recognised and acknowledged, and it was helpful when this happened. This will be raised again in the discussion of recovery and clinical services in section 8.7.1 below.

While Goffman (1969) and others have identified presentation of a false self as, in varying degrees, a ubiquitous feature of social life, this takes on a special significance when one's sense of self is infused with shame. When disclosure of a shame-infused real self is met with acceptance, this serves as an antidote to shame.

Some participants yearned to be able to disclose and find acceptance with friends, some hoped for more recognition and acceptance of their experience from family members. Some had found a level of acceptance from friends and family and this had been significant in their progress toward feeling better. It is worth noting, however, that participants wanted to exercise some control over when and where to disclose their experience of suicidal anguish and associated feelings and thoughts. They didn't want to feel they were constrained into hiding and keeping secrets, but did not necessarily feel the need to tell everything. It is perhaps the difference between freedom to tell and telling.

Some participants looked for an avenue of disclosure away from family. Included in this were some who tended to compartmentalise their suicidal experience and keep it rather separate from their work and family life, seeming to find this a helpful form of containment. One avenue for disclosure away from family was therapy or counselling, but also valued was the opportunity to speak to others who had had similar experiences:

> *So to learn about it was important and to meet other people who, you know, oh my god this is the first person I've ever heard that's said that.*

> *… and really the only people who understand it are other people who have been in the same situation*

Another avenue, not so much for disclosing but for connecting with the experience of others, was through reading. Reading was raised by two participants who valued the opportunity to see one's own experience mirrored in the experience of others:

... and then I started reading some of the biographical stuff, and even though the people are different ... but there was stuff that I'm thinking 'yes that's it, that's what I..', you know, so it was actually connecting with other people's stories. And I'm a reader so that helped... I couldn't read much when I wasn't doing well, I couldn't read more than a paragraph and remember what I'd read, but to have a sense of other people's stories would have been, I think that would have been really, really helpful.

Another participant spoke about looking, without success, for a book that mirrored her experiences.

... even just a book about people's experiences or something, anything, would be good because ..., there's not a lot of understanding out there from the general community and also in psych services, they don't really understand, unless you've been through it I don't think you understand. Yeah so I think that would help recovery as well if there was some kind of group or book or something where people talked about what it was like for them. I went to the library and just looked up suicide and I saw all these books you know how to stop your teen if they're suicidal and stuff, and I'm like what if it's the daughter looking for, so there wasn't anything out there.

Listening to music performed a somewhat similar function for another participant who found comfort in connecting with experiences of depression expressed in song. While not involving an actual disclosure to others, these experiences of music and books provide a sense of recognition of the real self, that there are others out there who would recognise what one is going through.

8.5.2   Writing the self

Three participants spoke about writing as something they felt was helpful. However the manner of writing and its function may have differed somewhat among the three. One participant spoke of writing journals almost like free association, as a form of expression but also as though to find out the contents of her unconscious:

Writing in my journal is like the best therapy anyone could give me,
because I don't just write, scribble, scribble, scribble, I just write whooo
straight through and I just don't stop and then the stuff that falls out is just
unbelievable …

Her journals were extensive and carefully looked after, and she read some excerpts to the interviewer, mainly concerning memories of her early life. This participant also wrote poetry.

A second participant spoke of getting up when he couldn't sleep and writing about his past and how he's feeling. The writing seemed to function partly as a form of expression of the real self, but also as a form of comfort and way to calm his mind. There was some sense of a possible audience in that he said he didn't know if anyone would be interested in his writing; he has wondered about this but '*it is risk to show anyone*'.

The third participant made the point that she had written about her life experience not as therapy but as a literary endeavour or a 'creative novel exercise'. While not conceived as therapy, writing about her experience has enabled her to gain some distance from it.

One of the reasons that I can distance myself a bit from this and talk about
it, is that I have written about it … one of the major ways that I've dealt
with it is that I've written about it.

Although the writing included suicide themes, there was also humour:

… but there is a bit of humour in it as well. And I think that being able to
see the humour, and I can now see it round the suicide attempt even. I can
see the humour in it as well, and I think that's a very healthy thing to be
able to do really.

Lester (2004) has raised the question of whether writing is helpful for someone struggling with mental anguish and suicidal feelings. He suggests that writing provides emotional expression, the possibility of reflection and some distancing from emotional content. It may calm the mind, reduce desperation or enable a structuring of potentially chaotic emotional experience. However, according to Lester's admittedly rather speculative analysis, writing is not always helpful. When writing is repetitive and does not involve any reflection, structuring or attempt to make the writing communicable to a potential, if not actual, audience, it is less likely to be helpful.

8.6 Managing psychological pain: The idea of suicide as insurance

One of the challenges the participants faced was managing pain. Some of the ways they did this are encompassed within other themes. However there is one way of managing psychological pain that remains singular and requires separate mention. Two of the participants spoke about the idea that having the option of suicide there (in the back pocket so to speak) actually makes it more possible to manage:

> *In a sense that's freeing, I know it sounds back-handed, but it is. It's almost like well if I know that I've got that* [suicide] *as an option I can manage. Like if you take my options away and if I get so distressed that I can't manage anymore, and that's not an option, I can't cope. But if I know that's an option, I know it doesn't… when I say it, it sounds awful*

One participant spoke of this as being like an insurance policy:

> *It's an attraction, some people have an attraction to that* [ie to suicide]. *It's like Plan B, like an insurance policy. If things get too bad then I know what to do – and sometimes that helps you to cope with things.*

Knowing there is a way out means one can keep going at present.

8.7 Clinical Services: Helpful and not helpful

Participants' experiences with clinical services are presented and discussed at some length in Chapter 7. In the context of thinking about recovery processes, the aim in this section is to summarise what was experienced as helpful, or not helpful, in participants' encounters with clinical services.

8.7.1 Clinical encounters

Participants' shared views of what was helpful did not centre on identifying a particular type of treatment. Some participants found medication helpful, or indeed essential, while some felt distinctly worse when on medication. While some thought they would have benefitted from a stay, or a longer stay, in a psychiatric unit, others were concerned about being kept in hospital for longer than was helpful. Most found psychotherapy or counselling a valuable experience, but occasionally it wasn't. This variation in experience is consistent with the heterogeneity among people who make a suicide attempt. The challenge for clinical services is to recognise, understand and work with individuality – in emotional resources, mental state, diagnosed condition, family circumstances and life context. Participants' areas of agreement about what was helpful and unhelpful centred on the interpersonal clinical encounter and the processes that underpin clinicians and patients working effectively together.

Firstly, it was helpful to participants when they were treated with respect, listened to and believed, and when their distress was taken seriously and acknowledged. Participants appreciated clinicians who had the capacity to listen and not be frightened by intense emotions and disturbing thoughts. In a sense this is about disclosure of the real self, of the anguished self, and acceptance by the clinician. Beyond acceptance, participants found it helpful when they felt understood (when the clinician was in tune with their individuality) and when they felt the clinician cared.

This was contrasted with experiences that were the opposite of helpful: being dismissed, fobbed off, patronised and spoken to like a child, or exposed to blaming and punitive staff reactions. Such responses were experienced as hurtful and humiliating; they broke trust and increased feelings of hopelessness and/or shame.

Some participants reported that they were more likely to be subject to these negative experiences when they were identified as having borderline personality disorder compared to times when they had been diagnosed with other conditions.

The second group of interpersonal processes that participants identified as helpful concerned having a say about what happened in treatment. In addition to being listened to about their distress, they wanted to be listened to about their treatment preferences. A collaborative approach to treatment in which the power relationships were such that a participant felt able to speak up and disagree, was experienced as helpful. This not only implied respect for the participant's point of view but it developed and supported the participant's sense of agency, confidence and control. This contrasted with unhelpful or damaging experiences where participants felt their sense of control was undermined or where treatment decisions were made against the participant's wishes. (Examples include being heavily pressured, while in a vulnerable state, to stay on medication despite the participant's experience that she had always felt worse on medication, and the decision to proceed with a family meeting against a participant's wishes, resulting in further estrangement from family members.)

However one incident reported by a participant provides an illustration of how collaborative decision-making can, at times, be complicated. This participant, having regained consciousness after a suicide attempt, told doctors that she was no longer suicidal and wanted to be discharged, when in fact she was still suicidal and was thinking about making another attempt. During the research interview, in response to a question about what staff at the hospital could have done better following her suicide attempt, she said:

> *Nothing really. But what should have happened is not to listen to me saying I am OK.*

At first sight, this appears to contradict the theme of participants wanting to be believed and to have their views about treatment taken seriously. However the participant went on to say:

They wanted to hear it was OK. But you need to be able to acknowledge that you feel like people hate you, like you're alone …. People don't let you say how you feel. You always know what you're supposed to say: [that] *I should not have done such a stupid thing; it was really stupid, and I should see my psychiatrist and if I feel this bad I will ring someone and let them help me. They want you to go.*

In saying that she wasn't suicidal the participant was complying with what she felt the clinical staff wanted to hear, so they could discharge her from hospital. There may be a number of factors operating here. On the one hand the participant may have difficulties with trust as part of her own personal dynamics, and she is also reacting on the basis of previous experiences with clinicians who have been indifferent, dismissing or demeaning. For clinical staff, hearing that someone is still suicidal may be disturbing and places additional demands on their personal and professional resources. Furthermore clinicians may well be operating in the context of bed shortages where they are feeling pressured to discharge patients. The basic point, however, is that the clinical staff had not managed to establish an alliance in which the participant felt she could say how she really felt.

It seemed clear from participants' accounts that it was more difficult to establish a collaborative decision-making process when clinicians and patients met or came together at a time of crisis. Participants reported a number of difficult emergency encounters with CATT teams and other crisis contacts. An ongoing relationship where the clinician saw the participant when they were well and not only when they were unwell was helpful in facilitating a collaborative model of working together. Treatment plans worked out in advance allowed for a more collaborative way of preparing for, or acting in anticipation of, crises.

As mentioned above, participants reported a range of experiences in relation to treatments. Most participants seemed satisfied with, or saw benefit in, the actual medical treatments and/or physical rehabilitation received after a suicide attempt. However their overall feeling about the medical hospital or brain injury rehabilitation experience was very much coloured by the quality of the interpersonal encounters as discussed above. Most (though not all) had found a psychiatric hospital stay helpful at

some stage. Helpful aspects were when the hospital provided a sense of safety and/or a break from stress, and when staff were respectful and also ready to listen without being either intrusive or frightened. Some participants expressed relief that a hospital stay protected families from having to worry about the participant harming him or herself at home. Unhelpful aspects of hospital were when interactions with staff were characterised by indifference, rejection, humiliation or blame. It was also unhelpful to be discharged too soon (while still suicidal) or to be kept in hospital when the person felt no need to be there any longer.

Participants who found psychotherapy or counselling helpful spoke of developing an increased understanding of themselves, and making sense of their feelings, thoughts and actions in terms of their past experiences and current circumstances. For some a more immediate need and benefit was help in developing coping strategies to manage and get through the day.

Family members entered into post-suicide-attempt clinical encounters in a number of ways, either in person or through the thoughts and concerns of participants. Family members meeting with the participant and the clinician could be either helpful or unhelpful. Based on the experience of this sample, such meetings could be helpful when the patient and the clinician both thought it was a good idea, prepared for the meeting together and thought carefully about the timing. It was unhelpful when family members were involved against the wishes of the participant, either in family meetings or in being called in to offer support or take responsibility when pre-existing strained relationships made this difficult. In relation to family members in the thoughts of participants, section 8.4.3 describes a helpful intervention in which the clinician spoke with a participant about how, although she thought her suicide would relieve the family of a burden, this was not how the family saw it, an important insight. One participant put forward a strong argument that there should be more support provided for families, an argument that addressed a concern expressed by several participants about the impact of their suicide attempt or suicidal crises on the family. Participants expressed concerns about the worry and distress of families at the time of a suicide attempt and also about families being left to somehow cope when a person was discharged from hospital while still suicidal.

Another issue concerning a suicide attempt and its impact on others was raised by the experience of a participant who returned to a psychiatric unit where she had been prior to her suicide attempt. For reasons of privacy other patients had not been told anything and facing up to their varied reactions was very difficult. The participant thought the other patients should have been told that she was alright.

Some participants had found it helpful to hear about someone else's experiences of being suicidal and how they managed, and one suggested a support group might be helpful (with guidelines advising talking about emotions and not about suicidal behaviours). Some had found reading about such experiences helpful and suggested reading material be made more readily available (although one participant said that, when suicidal, she could hardly manage to read at all). One of the younger participants reported that when she went looking for books to read, all she could find were books for parents of suicidal young people, while she needed a book written for a suicidal young person about how to deal with parents.

8.7.2   Systemic issues

The interpersonal issues raised in the previous section could be regarded as systemic issues in that addressing problematic interactions may well require a systemic approach. However in the course of discussing their experiences with clinical services, participants raised a number of other systemic issues. Sometimes these were raised by several participants; sometimes they pertained to one particular participant's experience. The issues listed below may concern availability of resources, policy and systems within organisations, or professional education, judgement and attitudes.

a)   Staff turnover in public mental health agencies. Where turnover was frequent this tended to undermine working alliances and consistent treatment plans, with new staff having their own ideas about how to proceed. Monitoring the effect of medication became difficult when it was not the same doctor doing the monitoring. Countering this, however, there were times when participants benefitted from new staff with different approaches.

b) Limited access to psychotherapy in public mental health. Several participants were concerned about this and at least one participant thought that access to psychotherapy might have prevented problems spiralling to the extent of making of suicide attempt.

c) Bed shortages in inpatient psychiatric units. Participants thought, and sometimes had been told, that they were denied admission to hospital, or were discharged early, because of bed shortages.

d) Difficulty accessing information about services that would permit informed choices. Examples of helpful information include knowledge about differing approaches within psychiatry and among psychotherapists.

e) Costs associated with seeing a private psychiatrist, psychotherapist or counsellor. Even when a rebate was available, paying upfront was difficult on a pension or a part-time wage and the rebate does not cover the whole cost.

f) Limited access to, or choice of, clinical services in regional areas.

g) Being treated differently in relation to one's general health because of identified mental health problems or history of suicide attempt. The issue of differential treatment was also raised in relation to access to brain injury rehabilitation.

8.8   Comparison with Herman's model of recovery from trauma

In considering the relevance of trauma to the conceptualisation of a suicide attempt (or a suicidal crisis), it is interesting to compare the ideas about recovery process emerging from this study with Judith Herman's (1992) influential model of recovery from trauma. The model focuses on recovery from trauma inflicted by humans as distinct from natural disasters. Herman began by identifying the core experiences of trauma as disempowerment and disconnection and argued that the process of recovery necessarily centres around empowerment and reconnection. These broad themes also emerged from the current study. A suicide attempt is at some level an attempt to assert agency in a context of feeling otherwise disempowered and participants spoke of further experiences of helplessness, worthlessness and loss of a sense of agency after the attempt. Recovery themes included re-establishing a sense of agency and capacity

to exercise some control over one's situation and to make a contribution (for example through work). The theme of disconnection is reflected in participants' experiences of ruptures in their relationships with family and friends, and reconnection through repairing ruptures is seen as a significant part of the recovery process. Experiences of shame, and recovery from shame, can be understood as connected with both disempowerment (I'm bad or useless) and disconnection (hiding from the gaze of others).

Herman (1992) went on to discuss three fundamental stages or central tasks of recovery: establishing safety, reconstructing the trauma story and restoring connection between survivors and their community. In relation to the first stage, issues of sense of safety also arose in the current study. One difference in the post-suicide-attempt situation, compared to post-trauma, is that the issue is not so much about establishing physical safety from an external perpetrator or predator. However other safety processes discussed by Herman, such as developing capacity for self-care and knowing whom one can rely on for support are very relevant. Establishing a sense of safety post-suicide-attempt may involve being in a protective environment (such as hospital) for a time, having a safe place (home) in which to establish oneself in the community, security and safety within relationships (family, friends, therapist), and developing capacities to manage distress and to protect oneself from external psychological attacks (blaming and humiliation, actual and anticipated).

In the second stage of recovery from trauma the focus is on remembrance and mourning, achieved through 'speaking the unspeakable' (Herman, 1992). The core process is reconstructing the trauma story, moving from fragmented snapshots and images to a narrative of what happened. Reconstruction is undertaken with a therapist who acts as a witness to the truth, and truth-telling can also occur through testimony. The idea of a detailed reconstruction and retrieval of the trauma (suicidal) experience was not spoken about, in those terms, by participants in this study. The overarching idea of 'speaking the unspeakable' does, however, resonate with the themes of the suicide attempt as a shameful secret, as something so painful and frightening that it disrupts relationships, and with the wish for disclosure and acceptance of the real self. Herman emphasised that the traumatised person must have control over the timing and pacing of reconstructing the trauma, and that uncovering must always be balanced

against safety. This is consistent with study participants' assertion of the need to be in control of disclosure, how much, to whom and when. Herman's idea that recovery involves transforming traumatic memory, for example, from a story about shame and humiliation to a story about dignity and virtue, touches on the need, post-suicide attempt, to find a way to deal with shame and stigma and to integrate the experience into one's whole mental life, sense of self and life history. Some study participants had made progress in this by working with a therapist to re-frame or understand the circumstances of the suicide attempt. Whether recovering from trauma or suicide attempt, it seems that the core ideas of finding a way to speak the unspeakable, at one's own pace, in the context of a healing relationship, are similar, but the precise mechanisms and processes by which this is achieved may be somewhat different.

The third stage of recovery from trauma is about reconnection with ordinary life, a process Herman (1992) described as moving from stigmatised isolation to restored social connection. This process is apparent in the current study in the repair of relationships, and/or deepened connection, that participants sought with family and friends (when it felt safe to do so), and also in their reconnection with the wider world through work and community activities. For Herman this stage is also about reconciling with oneself, and re-forging identity, discarding or repudiating aspects of identity that were formed by the trauma. Following a suicide attempt, reconciling with oneself can be understood as developing compassion for the anguished self (or the memory of the anguished self) and for the actions that came from that anguish. Compassion and understanding can come to replace shame, guilt and self-condemnation. Some participants in the current study spoke about being engaged in a process of re-building the self. Finally Herman wrote about a minority of trauma survivors transforming the meaning of personal tragedy though 'finding a survivor mission' (p.207), engaging in social action. Participants in the current study were recruited though support and advocacy groups, and some were engaged in advocacy on behalf of consumers of mental health services. Furthermore, participants saw their participation in the current study as a form of social action, contributing their experience, or bearing witness, for the benefit of others.

Chapter 9 Conclusion

This chapter aims to summarise the findings and situate them, concisely, within the context of the existing literature. The chapter also considers limitations of the study and implications for research, theory and practice.

9.1 Experience of a suicidal state

Participants described their experiences of suicidality as frightening and torturous but also encompassing periods of calm, where the person was on a suicidal pathway and no longer struggling against it. Suicidal feelings arose in the midst of experiences of self-hate, profound worthlessness, hopelessness, aloneness, burdensomeness and/or emptiness and feeling dead inside. In some cases the build-up to the suicide attempt included experiences of grief, trauma or intensely conflicted family relationships. Some participants also noted a cognitive aspect to their experience, identifying not thinking clearly, black and white thinking or obsessive preoccupation that excluded all other thoughts. These descriptions of the experience are consistent with the clinical literature on the phenomenology of the suicidal state, as discussed, for example by Shneidman (1993a), Maltsberger (1988) and Hendin (1991). Participants varied, however, in terms of which of the above experiences were prominent in their account. The experience of suicidality was intensely painful, and often frightening, but the feelings underlying it were not always the same.

9.2 Change and continuity after a suicide attempt

For the participants in this study, their suicide attempt seemed to represent a crisis point within an ongoing episode of suicidality, experienced as a continuing struggle with suicidal thoughts, preoccupations, impulses or compulsions. The suicide attempt did not provide a catharsis or a resolution of the suicidal crisis. After the suicide attempt some participants remained actively suicidal, while some described feeling suicidal without any sense of how to go about it, and others felt forced to focus on finding a way to go on living.

With many of the participants having made multiple suicide attempts, only three participants described their first and/or only suicide attempt. These participants experienced some shift in suicidality after the suicide attempt, with two participants describing an increased susceptibility to either suicidal thoughts or suicidal actions and the third participant describing a shift within suicidal thoughts toward more planning. One participant described recurrent episodes of suicidal thoughts that had not been experienced prior to the suicide attempt. These shifts toward increased, or more planful, experiences of suicidality could be seen as consistent with Joiner's (2005) theory that capacity for suicide is acquired, and that an initial suicidal action is like a rehearsal that reduces the fear and sense of prohibition that act as a barrier to suicide. However increased struggles with suicidal thoughts after an initial suicide attempt could equally be explained as a consequence of trauma. As both a victim and a perpetrator of violence, a person who survives a suicide attempt has experienced a traumatic threat to the self, which is likely to result in increased susceptibility to self-attack and/or feelings of disintegration (Maltsberger et al., 2011).

At the time of the interview (eight months to eight years after the suicide attempt) some participants reported significant improvement in their psychological state and life circumstances, to the extent in some cases that suicidal thoughts were rare. However other participants were still engaged in an intense, painful struggle with suicidal thoughts and feelings. For some the suicidal thoughts were fluctuating and episodic, but intense and 'terrifying' when present. Several participants spoke of living with the idea of suicide, in the sense that even in happier times, there was an awareness, on the edge of consciousness, that suicidal thoughts could return. One drew an analogy with alcoholics and the potential for relapse, noting the need to watch out for triggers that might evoke suicidal thoughts. In the literature the concept of 'chronic suicidality' tends to be seen as associated with personality disorder, but in the current study, the 'potential for relapse' was not limited to those who had at some time had a personality disorder diagnosis.

In addition to the issue of suicidality per se, the participants' suicide attempts had other consequences, some of which have received little attention in the literature. These consequences are discussed in the following sections.

9.3   Shame, control and sense of self

Issues of control and shame were central to the experiences of participants in this study. Feeling out of control internally, feeling controlled by an unidentifiable 'it' within, or feeling trapped in a situation where control has been wrested away by external others (including treating professionals) were all experiences reported as being associated with a suicidal state. These experiences preceded, or accompanied, the suicide attempt but frequently continued in the period after the attempt (and often recurred later at times of renewed suicidality). The sense of loss of control was associated with feelings of helplessness and hopelessness and an experience of anguished and overwhelming turmoil, or in some instances, emotional deadness. It was also possible, however, for the sense of being controlled by an insidious, internal other to lead to a sense of no longer having to struggle, of being drawn inexorably toward (a mirage of) suicide as a place of peace. This description indicates that loss of control may be associated with feelings of compulsion and well as with experiences of anguished helplessness. Starting to feel in control of oneself and/or one's life was associated with the possibility of psychological recovery after the attempt. Loss of a sense of control was also identified as a core experience in participants' suicide attempts in studies by Crocker et al. (2006), Tzeng (2001) and Biong et al. (2008). These accumulating findings are consistent with Maltsberger's (2004) conceptualisation of helplessness in the face of uncontrolled and unbearable affect leading to hopelessness and impending disintegration in the suicidal self (as in a participant's statement that 'I didn't have a sense of me').

Experiences of shame, guilt and humiliation were prominent in participants' accounts of their experiences following a suicide attempt. Experiences of guilt were sometimes related to specific actions (e.g. telling lies to get medication to use in a suicide attempt). More often shame and guilt seemed to be fused (Lewis, 1987) and both were spoken of in relation to the whole self. The state of being suicidal, and the fact of being a person who had made a suicide attempt, were experienced as shameful and guilt-inducing. These feelings were often associated with intense feelings of badness or worthlessness and with a sense of one's suicidal history as a visible stain which could be seen by others. Shame is interpersonal in that it is connected with an intense

consciousness of how others see us, but it is anchored intrapsychically in our own view of the self. Lewis (1987) argued that shame originates in our own self-devaluation, but is also a vicarious or empathetic experience of the other's scornful rejection of the self. Both these aspects were discernable in the participants' accounts. Furthermore these experiences were isolating in nature. For some participants a suicide attempt was isolating because of the need to keep the attempt (and/or subsequent suicidality) a secret, a shameful or guilty secret which entailed an inability to be one's authentic self with others. For other participants a sense of overwhelming shame induced isolation through a painful sensitivity to, and withdrawal from, the anticipated derision of others. In the latter experience the shameful self was experienced as visible and easily seen despite efforts to hide oneself away.

While the links between feeling states were not fully articulated by participants, there are some indications that the experience of shame was connected with the sense of loss of control, helplessness and disintegration (loss of) self. When suicidal 'you are in a different state – not yourself'. This being 'not yourself', a 'lost self', or not having a 'sense of me', seems to be a central aspect of the self that is vulnerable to shame. However, perhaps as a function of the fusion of shame and guilt, an overwhelming sense of badness or worthlessness also pervades the consciousness. When this sense of worthlessness is reflected back by others, those whose attitudes are rejecting, dismissive or punitive, this increases the sense of shame and humiliation (as reported also by Wiklander et al., 2003). This then exacerbates suicidality, perhaps through triggering humiliated fury which Lewis (1987) suggested induces further guilt and is then turned against the self.

Some of the inferences drawn here are tentative and await further investigation. However it seems clear that a continuing sense of loss of control or loss of self and experiences of shame and guilt are matters that warrant particular attention in psychotherapy following a suicide attempt. Feelings of shame and guilt or fear of being overwhelmed and out of control were among the experiences identified by McGinley and Rimmer (1992) as present in the immediate aftermath of a suicide attempt (at the time of initial assessment in hospital). The current study suggests that, for some people at least, these experiences persist for many weeks or months.

9.4   Connection: Impact on relationships with family and friends

Reactions of family members to a suicide attempt and subsequent interaction with the family are, in many or most instances, central aspects of the experience of having made a suicide attempt. It may be surprising then that very few studies could be found that examine this experience. The few studies identified (Sun & Long, 2008; Sun et al., 2008, in Taiwan; Kjellin & Östman, 2005; Magne-Ingvar & Öjehagen, 1999, in Sweden) approached the issue from the perspective of family members. Other than Dorer et al.'s (1999) brief reporting of immediate reactions, and with the partial exception of the research in Taiwan, no studies were found that investigated family reactions and interactions from the perspective of the person who had made a suicide attempt. In this respect then the current study is breaking new ground. The ground is complex, however, as families differ in their membership, structure, systems and in the psychological make-up of the individuals within them. Participants' accounts thus contained both commonalities and differences.

Family members reacted to the suicide attempt with a mix of profound shock, anger, fear, hurt and avoidance. These reactions could be hard for participants to bear, especially when they detected an element of reproach or blame. However participants also recognised how intense and disturbing these feelings were for family members and often reacted by refraining from talking about the suicide attempt or about subsequent suicidal feelings (in at least one instance even refraining from telling family members about the attempt). The silence seemed to serve a dual protective function. Although intense suicidal preoccupations may have crowded out such concerns at the time of the suicide attempt, there was a strong desire afterward to protect the family from further hurt and disturbance. In addition the silence also protected the participant from exposure to the full force of the family's pain, and in instances where the suicidality has diminished, from re-visiting the anguish of the suicidal crisis. Interestingly, and consistent with the current findings, in Magne-Ingvar and Öjehagen's (1999) study of family members, nearly half reported they had not talked to the suicidal family member about the suicide attempt. These patterns of reaction have been discussed in this thesis in terms of reciprocal recoil from the horror of the suicidal crisis and mutual silences aimed at protection of self and other.

The suicide attempt could nevertheless result in significant ruptures in relationships with family and with friends, whether through the initial intense and volatile emotions (inherent in the participant's suicidal state and in family reactions) or through distancing associated with the patterns of recoil and silence. Participants reported mixed levels of success in subsequent attempts to establish re-connection or mend ruptures. Overall it seemed that as the participant became less suicidal it became more possible to mend fractured relationships, perhaps because it became more possible for family and friends to once again share in the person's, now less toxic, experience. There was variation, however, in the approaches to mending ruptures in relationships and in the outcomes. Some families were able, with or without the assistance of a therapist, to discuss the suicide attempt, or the possibility of future suicidal feelings, and come to a greater understanding. (This process was assisted if a clear plan was in place about how to deal with future crises.) On the other hand, an attempt by a clinician to bring a family together against the wishes of the person who had made the suicide attempt, resulted in greater estrangement. In some families, ongoing relationship seemed based on a tacit mutual agreement to consign the suicide attempt to the past and not discuss it. Some ruptured friendships were re-established through a slow and painstaking re-building of trust, while some proved to be unrecoverable. In other instances participants felt it necessary to maintain a pretence, covering up any suicidal feelings that might drive friends away, but which left the participant with an underlying feeling of being alone.

Despite the difficulties outlined above, and consistent with Bostik and Everall's (2007) findings for adolescents, many participants reported on the significant role that relationships played in their recovery process (or at least in supporting them as they sought equilibrium). Sustained relationships affirmed the person's worth and value and generated hope. Some families and friends also offered substantial practical assistance including having participants live with them for lengthy periods. Sometimes these co-living arrangements provided a protected space and safety at a critical time. However such arrangements could also falter over the longer term, either because the participant was, in his or her view, too unwell, or because the family had difficulty understanding and responding to the participant's needs.

This study investigated family interaction following a suicide attempt from the perspective of the person who had made the attempt, and also considered relationships with friends, often of particular importance for those whose family members are estranged or live far away. Previous studies (Kjellin & Östman, 2005; Magne-Ingvar & Öjehagen, 1999; Sun & Long, 2008; Sun et al., 2008) focussed mainly on family members' experience as carers, their own needs for support and their experience of contact with mental health service providers, with limited attention to the patterns of interaction within the family. There is a strong case for further study of all these aspects, ideally in studies interviewing both the suicidal person and the family members (or significant friends). There has been, in recent times, significant, and much-needed, attention to the experiences of family members (survivors) who have been impacted by a family member's suicide, but family interactions in the wake of a suicide attempt have not received the same attention.

9.5   Loss

The findings suggest that loss is a significant consequence of a suicide attempt and not only an antecedent precipitating factor. The loss could be a loss of relationship (estrangement within families, or boyfriends, girlfriends or friends stepping away), but it could also take the form of loss of work, loss of home and/or loss of income. For two of the study participants, life after the suicide attempt meant living with a significant loss of memory or language function. Losses of relationships, work, home and/or function tend to increase isolation and aloneness, potentially undermine feelings of self-worth, and leave one adrift without a sense of home base. These losses have a significant impact on the person's sense of identity and feelings of safety and security, at the very time when he or she is trying to recover from a suicide attempt. However this post-suicide-attempt pattern of loss is rarely, if ever, mentioned in the literature. Moreover, as loss is also a contributing factor to suicidality, these losses may create a spiral of increasing risk.

9.6   Experiences of clinical services

While participants spoke about a wide range of experiences with clinical services, a theme running through many of these accounts was that of staff attitude or stance

within the clinical encounter. It needs to be acknowledged that we are talking about perceived staff attitude or stance. For everyone, whether client/patient or clinician, experiences are filtered through a perceptual lens, with light and shade influenced by emotions, fears and desires. As McGinley and Rimmer (1992) observed, after a suicide attempt, a person may be sensitised to, and half anticipating, negative judgements and condemnation. Nevertheless, as the same authors argued, the actual staff response matters, and makes a difference. Participants' descriptions of experiences ranged from very helpful, through middling, to very unhelpful or damaging, indicating that positive experiences registered as well as negative ones. Nor were experiences all seen as either extremely good or extremely bad, which might have suggested an idealising-devaluing polarisation. While specific perceptions may have been coloured by psychological state, the overall characterisation of what is helpful and what is unhelpful is consistent and meaningful. Furthermore it reflects what is already widely accepted as good practice. According to participants in the current study, helpful (or at least potentially helpful) clinical encounters are those where the person is listened to, treated with respect, where distress is believed and acknowledged (even if sometimes what the person wants cannot be provided) and where kindness prevails over punitiveness. Encounters that are dismissive, devaluing, humiliating or punitive are not only unhelpful but they exacerbate distress and may at times increase suicidality. On occasion, intensely negative encounters can be traumatising. Similar views about what is helpful or unhelpful have been reported in other studies (Samuelsson et al., 2000; Taylor et al., 2009).

Since the principles of listening, respect and empathy are widely accepted as a foundation for clinical practice, the question arises as to how these principles can be quite often not adhered to, as indicated by the negative experiences reported by participants. This was not a question that was asked of participants in this study, but it has been addressed in the literature in terms of countertransference reactions to suicidality (Maltsberger & Buie, 1974), with self-inflicted violence experienced at some level as an insult to clinicians' ideal of healing. McGinley and Rimmer (1992) described defensive splitting by clinicians in the face of the intense feelings (aggression, despair, fears of abandonment) stirred up by the suicidal act. This splitting is such that the suicide attempter is seen either as a cruel aggressor (and responded to with hostility) or as a passive victim (eliciting a kinder response but also

195

insufficient attention to significant aspects of the suicidal state). Michel et al. (2002) argued that these emotional challenges can lead to avoidance by the clinician, but also that the empathetic or humanistic aspect of initial assessment has been somewhat lost in the emphasis given to risk factor and diagnostic-based decision-making in the context of time pressures. The result is 'empathetically remote' clinical encounters (Michel et al., 2002).

Also very important to participants was involvement in decisions about their treatment. This issue connects with the experiences of loss of control and the need to regain a sense of agency in the aftermath of a suicide attempt. Participating in decisions about treatment, even, as one participant said, being able to disagree with the clinician, are steps toward empowerment and resurrection of the self. While involvement in decision-making was partly dependent on the attitudes of the clinician, in the participants' experience there were some processes or circumstances that were enabling. Collaborative decision-making was facilitated when the health practitioner knew the participant at times when he or she was well and so could see his/her strengths and capacity for judgement. Working out a plan in advance for how a suicidal crisis would be managed was also recommended as decisions were in place before the crisis disrupted clear thinking.

Other issues of concern were discrimination in physical health care based on history of suicide attempt or mental health status, differential treatment and negative staff attitudes based on borderline personality diagnosis, inpatient bed shortages which were seen as preventing needed admissions, and staff turnover and limited availability of psychotherapy services within the public mental health sector. Psychotherapy or counselling was experienced as helpful in most, but not all, instances.

9.7   Recovery processes and suicide attempt as trauma

McGinley and Rimmer (1992) described post-traumatic sequelae seen in the immediate aftermath of a suicide attempt, identifying the attempt as a traumatic experience of violence, albeit self-inflicted violence. More recently Maltsberger, Goldblatt and colleagues (Briggs, Goldblatt, Lindner, Maltsberger, & Fiedler, 2012; Maltsberger et al., 2011) have discussed a traumatic dimension to the suicidal crisis,

pointing out that trauma and suicidality are both states in which intense affective experience threatens to overwhelm regulatory capacities or injure psychic functioning. In the current study participants' accounts of their experiences following a suicide attempt are supportive of, or at least consistent with, a conceptualisation of suicide attempt as trauma. They described experiences of loss of control, helplessness and disconnection from others, together with shame and humiliation, all of which have been identified as core elements of post-trauma reactions (Gordon, 2007; Herman, 1992). Avoidance and difficulty processing and integrating the experience are also noteworthy.

A comparison of recovery processes emerging in this study with Herman's (1992) model of recovery from trauma identified significant commonalities. Fundamental to both was a movement from helplessness and disempowerment toward a sense of agency and control, and from disconnection and aloneness to restoring connection. Establishing a sense of security and psychological safety, finding a way to deal with shame and stigma and 'speaking the unspeakable', while maintaining control of the process, were important elements. Mending ruptured relationships and developing compassion, rather than condemnation, for the anguished self of the suicidal crisis were crucial aspects. Some of these processes were facilitated by psychotherapy, some through finding a home or returning to work. Finding ways to manage distress and/or live with mental illness - for some medication played a part - and to establish a sense of equilibrium laid the groundwork. Transforming suffering into social action was a possibility, and in a sense this is what participants were doing when they volunteered for the study.

9.8   Limitations of the study

This is a retrospective study and hence subject to potential limitations associated with a) memory lacunae, and b) the reforming or recolouring of recollections over time. Many of the events and experiences that participants spoke about seemed very vivid and present in their minds, perhaps in the way very intense or traumatic memories are preserved. Nevertheless it is certainly possible, even likely, that some aspects of their experiences had been lost or not remembered. It was clear, for example, that some participants had difficulty recalling the time periods associated with certain events. In

relation to the second source of limitations, there is a sense in which our memories are always being reworked in the light of subsequent experience and present day context. Events and experiences can be seen in a different light or their meaning modified. This is not peculiar to the kind of experiences explored in this study, but a basic facet of the human search for meaning. While this is a limitation of the study in some respects, it can be argued it is not always a limitation. People's current thoughts, feelings and actions, for example sense of hope or seeking help when suicidal, are influenced by their current perspective on, or recollection of, previous experiences. From the point of view of (preventive) psychological intervention in the months or years after a suicide attempt, meaning and memory at the time of intervention are what is significant.

Apart from issues of memory, it is also possible that some aspects of experience may simply not have surfaced as sufficiently central to the interview conversation on the day. This is a potential limitation of all interview studies, although the counter-argument is that the interview process allows the participant to talk about whatever seems most salient or significant to the participant.

Ideally in qualitative studies the sampling process is such that recruitment of participants continues until saturation of data is achieved, that is, until no new information or no new themes are emerging in the interviews. Saturation was not reached in the current study. This partly reflects the limited avenues available for recruiting more participants, but also the wide range of circumstances and experiences likely to be found among those who have made a suicide attempt. It cannot be claimed then that the study has explored the whole set of experiences following a suicide attempt. However an important function of qualitative research is to begin to cast light on areas than have been relatively little explored. It is argued that the current study fulfils this function. While not necessarily covering the whole field of experiences, there are sufficient commonalities, as well as some differences, in the participants' accounts to identify significant themes and to begin to consider the implications.

The participants in the study were young adult to middle-aged, with a significant history of struggles with mental health, and still in contact with some type of mental health service provider. This places some limitations around the scope of the study. It

is not looking at the experience of adolescents or the aged, nor of those who may have made a suicide attempt at some time but made a good recovery and no longer feel the need to continue contact with a mental health professional. The study also does not represent the experience of those who have made a suicide attempt but never presented for medical care in connection with the attempt. In addition men are under-represented in the sample, as are people from non-English speaking backgrounds.

9.9   Implications for theory and research

The study findings support, or are consistent with, the theorisation of a suicide attempt (or suicidal crisis) as a trauma (Briggs, et al., 2012; Maltsberger et al., 2011; McGinley & Rimmer, 1992) with loss of control, helplessness, disconnection from others, shame and humiliation described as core features of the suicide attempt experience. Moreover analysis of post-suicide attempt recovery processes revealed significant commonalities with Herman's (1992) model of recovery from trauma.

This study also offers an analysis of interactions with family and friends in the aftermath of a suicide attempt, identifying a pattern of reciprocal recoil from the horror of the suicidal crisis and mutual silences aimed at protection of self and other, followed by efforts at rapprochement and repair of ruptured relationships. Despite, or in the midst of this pattern, sustained relationships and practical assistance were important in supporting recovery or in regaining some level of equilibrium. Despite the wide recognition of relationship and connection as significant for mental health, exploration and conceptualisation of family (or friendship) dynamics following a suicide attempt are largely absent from the literature.

Another finding, with implications for recovery and for prevention, concerns the range of losses experienced in the aftermath of a suicide attempt. A previous focus in suicidology has been the occurrence of loss prior to a suicide attempt, with loss seen as a significant precipitating factor. Recognising loss as occurring both antecedent and consequent to the suicide attempt, highlights the potential for a dangerous cycle of elevated risk.

The processes of recovery, or continuing struggle, following a suicide attempt have received only limited attention in theory and research to date. The current study is one of only a very few studies using qualitative, interview-based methodology to explore experiences following a suicide attempt during the life stages of early to middle adulthood. There is a strong case for further experience-near research to extend the findings of the current study, to focus on specific aspects of the post-suicide-attempt experience (e.g. overcoming shame, family interactions, experiences of psychotherapy), and to encompass more fully the experiences of a wider demographic (e.g. greater representation of men and of people from non-English speaking backgrounds). It would be interesting also to study the experiences of those who have made a suicide attempt but are no longer, or never were, in contact with mental health agencies or support organisations.

Problematic interactions between clinicians and those who have made a suicide attempt, particularly in the context of emergency or inpatient care, is one area that has received some attention in the literature. Here studies that aim to understand these interactions from the perspectives of both the person struggling with suicidality and the clinician would be valuable. Studies investigating the most effective ways to train clinicians to engage empathically with their own and the patient's experience when working with a recently or currently suicidal person would also be very worthwhile.

9.10   Recommendations and implications for clinical practice

Study findings reinforce the position that relationships and empathy are fundamental to clinical care, even in short term contacts in emergency settings. Furthermore, to be helpful to people in suicidal crisis, or recovering from a suicide attempt, clinicians need to be able to bear to listen to their intense, painful and overwhelming experience. While recognising the limitations of the study, including sample size, the experiences reported by participants are suggestive of some recommendations for clinical practice. These recommendation are presented here:

Training beyond risk assessment

1. Health professionals' training (and professional development) in relation to suicide should be broadened out from the current focus on risk assessment to encompass an

increased focus on understanding and engaging with suicidal patients/clients. This should include:

a) understanding the role of shame and humiliation and how these may underpin anger and withdrawal,

b) recognising the potentially traumatising nature of a suicide attempt and the need to work toward restoring a sense of agency and empowerment and repairing ruptures in relationships,

c) reflecting on health professionals' own emotional responses to patients' suicidal thoughts and behaviours, and how these emotional challenges may lead to non-empathic and non-therapeutic stances and actions.

Increasing collaborative decision-making

2. Increasing collaborative decision-making should be an active focus in clinical practice with people recovering from a suicide attempt or struggling with episodes of suicidality. It is important that this goes beyond written principles and policy and into daily practice.

3. Where feasible, collaborative decision-making should extend to forward planning, i.e. working with a person while (relatively) well to develop, collaboratively, a plan about what to do at the time of a suicidal crisis.

Keeping the family in mind but with choices about family involvement

4. Following a suicide attempt, the suicidal person's wishes and choices about family involvement should be respected. This decision-making may constitute a process over time, and should involve working collaboratively with the person about readiness for, the timing of, and preparation for any agreed family involvement.

5. Following a suicide attempt, and where the family knows of the attempt, consideration should be given to the family's need for support. If the person does not want family involvement in his or her care at that time, family support may be offered separately and independently, with due respect for confidentiality.

After a suicide attempt in, or while absconded from, hospital

6. In the case of a suicide attempt in, or while absconded from, hospital, staff should attend to concern and speculation among other patients on the ward, and consider giving some limited information to these patients, for example indicating the person is 'alright' without providing further confidential detail.

7. When a person returns to the same ward following an inpatient (or while absconded) suicide attempt, staff should offer support and assistance to the person returning in coping with the reactions of other patients, as well as responding directly, where appropriate, to the concerns and emotional reactions of the other patients.

Attending to losses following a suicide attempt

8. When working with someone following suicide attempt, clinicians should keep in mind the impact of losses – of work and income, of home, of relationships – that commonly occur following a suicide attempt.

Access to shared experiences

9. Clinical services should give consideration to the potential benefits of access to shared experiences of suicidality, the underlying emotional states and ways of managing these states, either through written accounts or through support groups. There may be advantages to such sharing of experiences taking place within a therapeutic context.

Increasing availability of psychotherapy

10. There is a need for increased availability of psychotherapy, including longer-term psychotherapy, for those struggling with suicidal thoughts and actions. While acknowledging resource implications, there is an argument that increasing the availability of psychotherapy should be seen as a preventive measure which has the potential, not only to alleviate distress and assist recovery following a suicide attempt, but also to reduce future suicidal behaviour. This recommendation is relevant both to public mental health and to issues of duration of affordable psychotherapy in the private system.

Differential general medical treatment for those with suicide attempt history

11. Hospitals and other large medical services should establish a monitoring system to assess and evaluate medical treatment (for general medical symptoms/conditions) that is provided to those with a history of suicide attempt or psychiatric disorders. Where differential treatment with potentially negative consequences is identified, this should be a focus of specific medical and nursing training.

References

Alvarez, A. (1971). *The savage god*. London: Weidenfeld & Nicholson.

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders.* (4th ed., text revision ed.). Washington, DC: Author.

Andresen, R., Oades, L., & Caputi, P. (2003). The experience of recovery from schizophrenia: Towards an empirically validated stage model. *Australian and New Zealand Journal of Psychiatry, 37*, 586-594.

Arensman, E., Corcoran, P., & Fitzgerald, A. P. (2011). Deliberate self-harm: Extent of the problem and prediction of repetition. In R. C. O'Connor, S. Platt & J. Gordon (Eds.), *International Handbook of Suicide Prevention*. Chichester UK: Wiley.

Asch, S. S. (1996). Suicide and the hidden executioner. In J. T. Maltsberger & M. J. Goldblatt (Eds.), *Essential papers on suicide* (pp. 379-396). New York: New York University Press. (Reprinted from International Review of Psychoanalysis, 7, 51-60, 1980).

Australian Bureau of Statistics. (2012). Suicide in Australia 2010 Retrieved 17 Nov 2012, from www.abs.gov.au/AUSSTATS/abs@.nsf/mf/3309.0/

Bancroft, J., Hawton, K., Simkin, S., Kingston, B., Cumming, C., & Whitwell, D. (1979). The reasons people give for taking overdoses: A further enquiry. *British Journal of Medical Psychology, 52*, 353-365.

Beautrais, A. L. (2001). Suicide and serious suicide attempts: Two populations or one? *Psychological Medicine, 31*, 837-845.

Beautrais, A. L. (2004). Further suicidal behavior among medically serious suicide attempters. *Suicide and Life-Threatening Behavior, 34*(1), 1-11.

Beautrais, A. L., Joyce, P. R., & Mulder, R. T. (2000). Unmet need following serious suicide attempt: Follow-up of 302 individuals for 30 months. In G. Andrews & S. Henderson (Eds.), *Unmet need in psychiatry: Problems, resources, responses* (pp. 245-255). Cambridge: Cambridge University Press.

Beautrais, A. L., Joyce, P. R., Mulder, R. T., Fergusson, D. M., Deavoll, B. J., & Nightingale, S. K. (1996). Prevalence and co-morbidity of mental disorders in persons making serious suicide attempts: A case-control study. *American Journal of Psychiatry, 153*, 1009-1014.

Beautrais, A. L., Wells, J. E., McGee, M. A., & Oakley Browne, M. A. (2006). Suicidal behaviour in Te Rau Hinengaro: The New Zealand Mental Health Survey. *Australian and New Zealand Journal of Psychiatry, 40*(10), 896-904.

Beck, A. T., Brown, G., Berchick, R. J., Stewart, B. L., & Steer, R. A. (1990). Relationship between hopelessness and ultimate suicide: A replication with psychiatric outpatients. *American Journal of Psychiatry, 147*, 190-195.

Beck, A. T., Kovacs, M., & Weissman, A. (1975). Hopelessness and suicidal behavior: An overview. *Journal of the American Medical Association, 234*, 1146-1149.

Beck, A. T., & Steer, R. A. (1989). Clinical predictors of eventual suicide: A 5- to 10-year prospective study of suicide attempters. *Journal of Affective Disorders, 17*, 203-209.

Beck, A. T., Steer, R. T., Kovacs, M., & Garrison, B. (1985). Hopelessness and eventual suicide: A 10-year prospective study of patients hospitalized with suicidal ideation. *American Journal of Psychiatry, 142*, 559-563.

Beck, A. T., & Weishaar, M. E. (1990). Suicide risk assessment and prediction. *Crisis, 11*, 22-30.

Bergmans, Y., Carruthers, A., Ewanchuk, E., James, J., Wren, K., & Yager, C. (2009). Moving from full-time healing work to paid employment: Challenges and celebrations. *Work, 33*, 389-394.

Bergmans, Y., Langley, J., Links, P., & Lavery, J. V. (2009). The perspectives of young adults on recovery from repeated suicide-related behaviour. *Crisis, 30*(3), 120-127.

Berman, A. L. (1991). Child and adolescent suicide: From the nomothetic to the idiographic. In A. A. Leenaars (Ed.), *Life span perspectives of suicide: Timelines in the suicide process* (pp. 109-120). New York: Plenum.

Berman, A. L. (2012). Suicide research: Knowledge gaps and opportunities. In R. I. Simon & R. E. Hales (Eds.), *The American Psychiatric Publishing textbook of suicide sssessment and management* (2nd ed., pp. 621-634). Washington DC: American Psychiatric Publishing.

Bibring, E. (1953). The mechanism of depression. In P. Greenacre (Ed.), *Affective disorders*. New York: International Universities Press.

Biong, S., Karlsson, B., & Svensson, T. (2008). Metaphors of a shifting sense of self in men recovering from substance abuse and suicidal behaviour. *Journal of Psychosocial Nursing, 46*(4), 35-41.

Blatt, S. J. (2004). *Experiences of depression: Theoretical, clinical, and research perspectives* Washington DC: American Psychological Association.

Borges, G., Nock, M., K., Haro Abad, J. M., Hwang, N., Sampson, N. A., Alonso, J., . . . Kessler, R., C. (2010). Twelve-month prevalence of and risk factors for suicide attempts in the World Health Organization world mental health surveys. *Journal of Clinical Psychiatry, 71*(12), 1617-1628.

Bostik, K. E., & Everall, R. D. (2007). Healing from suicide: Adolescent perceptions of attachment relationships. *British Journal of Guidance and Counselling, 35*(1), 79-96.

Bowlby, J. (1988). *A secure base: Clinical applications of attachment theory* London: Routledge.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*, 77-101.

Brent, D. A., Johnson, B., Bartle, S., Bridge, J., Rather, C., Matta, J., . . . Constantine, D. (1993). Personality disorder, tendency to impulsive violence, and suicidal behaviour in adolescents. *Journal of the American Academy of Child and Adolescent Psychiatry, 32*, 69-75.

Brent, D. A., & Perper, J. A. (1995). Research in adolescent suicide: Implications for training, service delivery, and public policy. *Suicide and Life-Threatening Behavior, 25*, 222-230.

Briggs, S., Goldblatt, M. J., Lindner, R., Maltsberger, J. T., & Fiedler, G. (2012). Suicide and trauma: A case discussion. *Psychoanalytic Psychotherapy, 26*(1), 13-33.

Cantor, C. H., & Slater, P. J. (1995). Marital breakdown, parenthood, and suicide. *Journal of Family Studies, 1*, 91-102.

Carter, G. L., Page, A., Clover, K., & Taylor, R. (2007). Modifiable risk factors for attempted suicide in Australian clincial and community samples. *Suicide and Life-Threatening Behavior, 37*(6), 671-680.

Charmaz, K. (2003). Grounded theory: Objectivist and constructivist methods. In N. K. Denzin & Y. S. Lincoln (Eds.), *Strategies of qualitative inquiry* (2nd ed., pp. 249-291). Thousand Oaks, CA: Sage.

Charmaz, K. (2009). Shifting the grounds: Constructivist grounded theory methods. In J. M. Morse, P. N. Stern, J. Corbin, B. Bowers, K. Charmaz & A. E. Clarke (Eds.), *Developing grounded theory: The second generation* (pp. 127-154). Walnut Creek, CA: Left Coast Press.

Charmaz, K. (2011). A constructivist grounded theory analysis of losing and regaining a valued self. In F. J. Wertz, K. Charmaz, L. M. McMullen, R. Josselson, R. Anderson & E. McSpadden (Eds.), *Five ways of doing qualitative analysis: Phenomenological psychology, grounded theory, discourse analysis, narrative research and intuitive inquiry* (pp. 165-204). New York: Guilford.

Chesley, K., & Loring-McNulty, N. E. (2003). Process of suicide: Perspective of the suicide attempter. *Journal of the American Psychiatric Nurses Association, 9*(2), 41-45.

Clandinin, D. J., & Connelly, F. M. (1994). Personal experience methods. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 413-427). Thousand Oaks, CA: Sage.

Clark, D. C., & Fawcett, J. (1992). Review of empirical risk factors for evaluation of the suicidal patient. In B. Bongar (Ed.), *Suicide: Guidelines for assessment, management and treatment* (pp. 16-48). New York: Oxford University Press.

Corrigan, P. W. (Ed.). (2005). *On the stigma of mental illness: Practical strategies for research and social change*. Washington, DC: American Psychological Association.

Corrigan, P. W., & Ralph, R. O. (2005). Introduction: Recovery as consumer vision and research paradigm. In R. O. Ralph & P. W. Corrigan (Eds.), *Recovery in mental illness: Broadening our understanding of wellness* (pp. 3-17). Washington, DC: American Psychological Association.

Crocker, L., Clare, L., & Evans, K. (2006). Giving up or finding a solution? The experience of attempted suicide in later life. *Aging and Mental Health, 10*(6), 638-647.

Croll, N. (1995). Community mental health policy. In H. Gardner (Ed.), *The politics of health: The Australian experience* (2nd ed., pp. 493-509). Melbourne: Churchill-Livingstone.

Curran, S., Fitzgerald, M., & Greene, V. T. (1999). Psychopathology 8½ years post parasuicide. *Crisis, 20*(3), 115-120.

Curtis, C. (2006). Sexual abuse and subsequent suicidal behaviour: Exacerbating factors and implications for recovery. *Journal of Child Sexual Abuse, 15*(2), 1-21.

Cutcliffe, J. R., Joyce, A., & Cummins, M. (2004). Building a case for understanding the lived experiences of males who attempt suicide in Alberta, Canada. *Journal of Psychiatric and Mental Health Nursing, 11*, 305-312.

De Leo, D., Burgis, S., Bertolote, J. M., Kerkhof, A. J. F. M., & Bille-Brahe, U. (2006). Definitions of suicidal behaviour: Lessons learned from the WHO/Euro Multicentre Study. *Crisis, 27*(1), 4-15.

De Leo, D., Cerin, E., Spathonis, K., & Burgis, S. (2005). Lifetime risk of suicide ideation and attempts in an Australian community: Prevalence, suicidal process, and help-seeking behaviour. *Journal of Affective Disorders, 86*, 215-224.

Denzin, N. K., & Lincoln, Y. S. (Eds.). (1994). *Handbook of qualitative research*. Thousand Oaks, CA: Sage.

Denzin, N. K., & Lincoln, Y. S. (Eds.). (2000). *Handbook of qualitative research* (2nd ed.). Thousand Oaks, CA: Sage.

Devries, K., Watts, C., Yoshihama, M., Kiss, L., Schraiber, L., Deyessa, N., . . . Garcia-Moreno, C. (2011). Violence against women is strongly associated with sucide attempts: Evidence for the WHO multi-country study on women's health and domestic violence against women. *Social Science and Medicine, 73*, 79-86.

Diekstra, R. F. W., & Garnefski, N. (1995). On the nature, magnitude and causality of suicidal behaviors: An international perspective. In M. M. Silverman & R. W. Maris (Eds.), *Suicide prevention: Toward the year 2000* (pp. 36-57). New York: Guilford.

Dieserud, G., Røysamb, E., Braverman, M. T., Dalgard, O. S., & Ekeberg, Ø. (2003). Predicting repetition of suicide attempt: A prospective study of 50 suicide attempters. *Archives of Suicide Research, 7*(1), 1-15.

Dorer, C., Feehan, C., Vostanis, P., & Winkley, L. (1999). The overdose process-adolescents' experience of taking an overdose and their contact with services. *Journal of Adolescence, 22*, 413-417.

Durkheim, E. (1966). *Suicide: A study in sociology*. New York: The Free Press (Original work published 1897).

Everall, R. D. (2000). The meaning of suicide attempts by young adults. *Canadian Journal of Counselling, 34*(2), 111-125.

Everall, R. D., Altrows, K. J., & Paulson, B. L. (2006). Creating a future: A study of resilience in suicidal female adolescents. *Journal of Counseling and Development, 84*, 461-470.

Everall, R. D., Bostik, K. E., & Paulson, B. L. (2005). I'm sick of being me: Developmental themes in a suicidal adolescent. *Adolescence, 40*(160), 693-708.

Everall, R. D., Bostik, K. E., & Paulson, B. L. (2006). Being in the safety zone: Emotional experiences of suicidal adolescents and emerging adults. *Journal of Adolescent Research, 21*(4), 370-392.

Farberow, N. L., & Shneidman, E. S. (Eds.). (1961). *The cry for help*. New York: McGraw-Hill.

Favazza, A. R. (1996). *Bodies under siege: Self-mutilation and body modification in culture and psychiatry* (2nd ed.). Baltimore: Johns Hopkins University Press.

Fawcett, J., Scheftner, W. A., Fogg, L., Clark, D. C., Young, M. A., Hedeker, D., & Gibbons, R. (1990). Time-related predictors of suicide in major affective disorder. *American Journal of Psychiatry, 147*, 1189-1194.

Faye, E. (2003). Being Jewish after Auschwitz: Writing modernity's shame. *Australian Feminist Studies, 18*(42), 245-259.

Fitzpatrick, S. (2010). *My father's daughter: Memories of an Australian childhood*. Melbourne: Melbourne University Press.

Fortney, J., Rost, K., Zhang, M., & Warren, J. (1999). The impact of geographic accessibility on the intensity and quality of depression treatment. *Medical Care, 37*(9), 884-893.

Freud, S. (1917). Mourning and melancholia. In J. Strachey (Ed.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. XIV, pp. 239-258). London: Hogarth.

Freud, S. (1923). The ego and the id. In J. Strachey (Ed.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. XIX, pp. 3-66). London: Hogarth.

Goffman, E. (1969). *The presentation of self in everyday life*. London: Allen Lane.

Gordon, R. (2007). Thirty years of trauma work: Clarifying and broadening the consequences of trauma. *Psychotherapy in Australia, 13*(3), 12-19.

Hassan, R. (1995). *Suicide explained: The Australian experience*. Melbourne: Melbourne University Press.

Hawton, K., & Catalan, J. (1987). *Attempted suicide: A practical guide to its nature and management* (2nd ed.). Oxford: Oxford University Press.

Hendin, H. (1981). Psychotherapy and suicide. *American Journal of Psychotherapy, 35*, 469-480.

Hendin, H. (1991). Psychodynamics of suicide, with particular reference to the young. *American Journal of Psychiatry, 148*, 1150-1158.

Hendin, H., & Haas, A. P. (1991). Suicide and guilt as manifestations of posttraumatic stress disorder in Vietnam veterans. *American Journal of Psychiatry, 148*, 586-591.

Herman, J. L. (1992). *Trauma and recovery*. New York: Basic Books.

Hollway, W. (2001). The psycho-social subject in 'evidence-based practice'. *Journal of Social Work Practice, 15*(1), 9-22.

Hollway, W. (2006). Paradox in the pursuit of a critical theorization of the development of self in family relationships. *Theory and Psychology, 16*(4), 465-482.

Hollway, W. (2009). Applying the 'experience-near' principle to research: Psychoanalytically informed methods. *Journal of Social Work Practice, 23*(4), 461-474.

Ide, N., Wyder, M., Kolves, K., & De Leo, D. (2010). Separation as an important risk factor for suicide: A systematc review. *Journal of Family Issues, 31*(12), 1689-1716.

Jack, D. C. (1993). *Silencing the self: Women and depression*. New York: Harper Perennial.

Jensen, V. W., & Petty, T. A. (1996). The fantasy of being rescued in suicide. In J. T. Maltsberger & M. J. Goldblatt (Eds.), *Essential papers on suicide* (pp. 131-141). New York: New York University Press. (Reprinted from Psychoanalytic Quarterly, 27, 327-339, 1958).

Johnston, A. K., Pirkis, J., & Burgess, P. (2009). Suicidal thoughts and behaviours among Australian adults: Findings from the 2007 National Survey of Mental Health and Wellbeing. *Australian and New Zealand Journal of Psychiatry, 43*, 635-643.

Joiner, T. E., Jr. (2002). The trajectory of suicidal behavior over time. *Suicide and Life-Threatening Behavior, 32*(1), 33-41.

Joiner, T. E., Jr. (2005). *Why people die by suicide*. Cambridge, MA: Harvard University Press.

Joiner, T. E., Jr. , Conwell, Y., Fitzpatrick, K. K., Witte, T. K., Schmidt, N. B., Berlim, M. T., . . . Rudd, M. D. (2005). Four studies on how past and current suicidality relate even when "everything but the kitichen sink" is covaried. *Journal of Abnormal Psychology, 114*, 291-303.

Joiner, T. E., Jr., Van Orden, K. A., Witte, T. K., & Rudd, M. D. (2009). *The interpersonal theory of suicide: Guidance for working with suicidal clients*. Washington, DC: American Psychological Association.

Kidd, S. A., & Kral, M. J. (2002). Suicide and prostitution among street youth: A qualitative analysis. *Adolescence, 37*, 411-430.

Kienhorst, I., & de Wilde, E. J. (1995). Suicide attempts in adolescence - "self-report" and "other-report". *Crisis, 16*, 59-65.

King, R. A., & Apter, A. (1996). Psychoanalytic perspectives on adolescent suicide. *Psychoanalytic Study of the Child, 51*, 491-511.

Kjellin, L., & Östman, M. (2005). Relatives of psychiatric inpatients - do physical violence and suicide attempts of patients influence family burden and participation in care? *Nordic Journal of Psychiatry, 59*, 7-11.

Kvale, S. (2003). The psychoanalytical interview as inspiration for qualitative research. In P. M. Camic, J. E. Rhodes & L. Yardley (Eds.), *Qualitative research in psychology: Expanding perspectives in methodology and design* (pp. 275-297). Washington, DC: American Psychological Association.

Laufer, M. (Ed.). (1995). *The suicidal adolescent*. London: Karnac.

Lester, D. (2004). Final thoughts: Did writing a diary help or harm Katie? In D. Lester (Ed.), *Katie's diary: Unlocking the mystery of a suicide* (pp. 189-202). New York: Brunner-Routledge.

Lester, D., & Walker, R. L. (2006). The stigma for attempting suicide and the loss to suicide prevention efforts. *Crisis, 27*(3), 147-148.

Lewis, H. B. (1987). Introduction: Shame - the "sleeper" in psychopathology. In H. B. Lewis (Ed.), *The role of shame in symptom formation* (pp. 1-28). Hillsdale, NJ: Lawrence Erlbaum.

Li, Z., Page, A., Martin, G., & Taylor, R. (2011). Attributable risk of psychiatric and socio-economic factors for suicide from individual-level, population based studies: A systematic review. *Social Science and Medicine, 72*, 608-616.

Liamputtong, P. (2013). *Qualitative research methods* (4th ed.). South Melbourne, Vic: Oxford University Press.

Linehan, M. (1986). Suicide people: One population or two? *Annals of the New York Academy of Sciences: Psychobiology of suicidal behavior, 487*, 16-33.

Linehan, M., Goodstein, J. L., Nielsen, S. L., & Chiles, J. A. (1983). Reasons for staying alive when you are thinking of killing yourself: The reasons for living inventory. *Journal of Consulting and Clinical Psychology, 51*, 276-286.

Litman, R. E. (1996). Sigmund Freud on suicide. In J. T. Maltsberger & M. J. Goldblatt (Eds.), *Essential papers on suicide* (pp. 200-220). New York: New York University Press. (Reprinted from The psychology of suicide, pp. 565-586, by E. S. Shneidman, N. L. Farberow, & R. Litman, Eds., 1970, New York: Science House).

Magne-Ingvar, U., & Öjehagen, A. (1999). One-year follow-up of significant others of sucide attempters. *Social Psychiatry and Psychiatric Epidemiology, 34*, 470-476.

Maltsberger, J. T. (1988). Suicide danger: Clinical estimation and decision. *Suicide and Life-Threatening Behavior, 18*, 47-54.

Maltsberger, J. T. (1993). Confusions of the body, the self, and others in suicidal states. In A. A. Leenaars (Ed.), *Suicidology: Essays in honor of Edwin S. Shneidman* (pp. 148-171). Northvale, NJ: Jason Aronson.

Maltsberger, J. T. (2004). The descent into suicide. *International Journal of Psychoanalysis, 85*, 653-658.

Maltsberger, J. T. (2008). Self break-up and the descent into suicide. In S. Briggs, A. Lemma & W. Crouch (Eds.), *Relating to self-harm and suicide: Psychoanalytic perspectives on practice, theory and prevention* (pp. 38-44). London: Routledge.

Maltsberger, J. T., & Buie, D. H. (1974). Countertransference hate in the treatment of suicidal patients. *Archives of General Psychiatry, 30*, 625-633.

Maltsberger, J. T., & Buie, D. H. (1980). The devices of suicide: Revenge, riddance and rebirth. *International Review of Psychoanalysis, 7*, 61-72.

Maltsberger, J. T., & Goldblatt, M. J. (1996). Editorial comment. In J. T. Maltsberger & M. J. Goldblatt (Eds.), *Essential papers on suicide* (pp. 118-119). New York: New York University Press.

Maltsberger, J. T., Goldblatt, M. J., Ronningstam, E., Weinberg, I., & Schechter, M. (2011). Traumatic subjective experiences invite suicide. *Journal of the American Academy of Psychoanalysis and Dynamic Psychiatry, 39*(4), 671-694.

Maris, R. W. (1981). *Pathways to suicide: A survey of self-destructive behaviors.* Baltimore, MD: Johns Hopkins University Press.

McAuliffe, C., Corcoran, P., Keeley, H. S., Arensman, E., Bille-Brahe, U., De Leo, D., . . . Wasserman, D. (2006). Problem-solving ability and repetition of deliberate self-harm: A multicentre study. *Psychological Medicine, 36*, 45-55.

McGinley, E., & Rimmer, J. (1992). The trauma of attempted suicide. *Psychoanalytic Psychotherapy, 7*(1), 53-68.

McWilliams, N. (2002). Relationship, subjectivity and inference in diagnosis. In J. B. Barron (Ed.), *Making diagnosis meaningful: Enhancing evaluation and treatment of psychological disorders*. Washington, DC: American Psychological Association.

Mehta, K. (1990). *Giving up hope: A study of attempted suicide amongst Indian women*. Singapore: Times Books International.

Menninger, K. (1938). *Man against himself*. New York: Harcourt Brace.

Mental Health Council of Australia. (2011). *Consumer and carer experiences of stigma from mental health and other health professionals*. Canberra: MHCA.

Michel, K., Maltsberger, J. T., Jobes, D. A., Leenaars, A. A., Orbach, I., Stadler, K., . . . Valach, L. (2002). Discovering the truth in attempted suicide. *American Journal of Psychotherapy, 56*(3), 424-437.

Miles, M. B., & Huberman, A. M. (1994). *Qualitative data analysis: An expanded sourcebook* (2nd ed.). Newbury Park, CA: Sage.

Moscicki, E. K. (1995). Epidemiology of suicidal behavior. In M. M. Silverman & R. W. Maris (Eds.), *Suicide prevention: Toward the year 2000* (pp. 22-35). New York: Guilford.

Nock, M., K., Borges, G., Bromet, E. J., Alonso, J., Angermeyer, M., Beautrais, A. L., . . . Williams, D. (2008). Cross-national prevalence and risk factors for

suicidal ideation, plans and attempts. *British Journal of Psychiatry, 192*(2), 98-105.

O'Carroll, P. W., Berman, A. L., Maris, R. W., Moscicki, E., Tanney, B., & Silverman, M. (1996). Beyond the tower of babel: A nomenclature for suicidology. *Suicide and Life-Threatening Behavior, 26*, 237-152.

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

Page, A., Taylor, R., & Martin, G. (2010). Recent declines in Australian male suicide are real, not artifactual. *Australian and New Zealand Journal of Psychiatry, 44*, 258-363.

Pallikkathayil, L., & Morgan, S. A. (1988). Emergency Department nurses' encounters with suicide attempters: A qualitative investigation. *Scholarly Inquiry for Nursing Practice, 2*, 237-253.

Paris, J. (1990). Completed suicide in borderline personality disorder. *Psychiatric Annals, 20*, 19-21.

Patton, M. Q. (1990). *Qualitative evaluation and research methods* (2nd ed.). Newbury Park, CA: Sage.

Paulson, B. L., & Everall, R. D. (2003). Suicidal adolescents: Helpful aspects of psychotherapy. *Archives of Suicide Research, 7*(4), 309-321. doi: 10.1080/713848939

Perseius, K.-I., Öjehagen, A., Ekdahl, S., Åsberg, M., & Samuelsson, M. (2003). Treatment of suicidal and deliberate self-harming patients with borderline personality disorder using Dialectical Behavioral Therapy: The patients' and the therapists' perceptions. *Archives of Psychiatric Nursing, 17*(5), 218-227.

Pirkis, J., Burgess, P., & Dunt, D. (2000). Suicidal ideation and suicide attempts among Australian adults. *Crisis, 21*(1), 16-25.

Ralph, R. O., & Corrigan, P. W. (Eds.). (2005). *Recovery in mental illness: Broadening our understanding of wellness*. Washington, DC: American Psychological Association.

Richman, J., & Rosenbaum, M. (1996). A clinical study of the role of hostility and death wishes by the family and society in suicidal attempts. In J. T. Maltsberger & M. J. Goldblatt (Eds.), *Essential papers on suicide* (pp. 221-242). New York: New York University Press. (Reprinted from Israel Annals of Psychiatry and Related Disciplines, 8, 213-231, 1970).

Robertson, J. (1970). *Young children in hospital* (2nd ed.). London: Tavistock.

Robinson, J., Cotton, S., Conus, P., Schimmelmann, B. G., McGorry, P., & Lambert, M. (2009). Prevalence and predictors of suicide attempt in an incidence cohort of 661 young people with first-episode psychosis. *Australian and New Zealand Journal of Psychiatry, 43*, 149-157.

Robinson, J., Pirkis, J., Krysinska, K., Niner, S., Jorm, A. F., Dudley, M., . . . Harrigan, S. (2008). Research priorities in suicide prevention in Australia: A comparison of current research efforts and stakeholder-identified priorities. *Crisis, 29*(4), 180-190.

Rudd, M. D., Joiner, T., & Rajab, M. H. (1996). Relationships among suicide ideators, attempters and multiple attempters in a young-adult sample. *Journal of Abnormal Psychology, 105*(4), 541-550.

Samuelsson, M., Wiklander, M., Åsberg, M., & Saveman, B.-I. (2000). Psychiatric care as seen by the attempted suicide patient. *Journal of Advanced Nursing, 32*(3), 635-643.

Sarfati, Y., Bouchard, B., & Hardy-Baylé, M.-C. (2003). Carthartic effect of suicide attempts not limited to depression. *Crisis, 24*, 73-78.

Schafer, R. (1992). *Retelling a life: Narration and dialogue in psychoanalysis*. New York: Basic Books.

Scoliers, G., Portzky, G., van Heeringen, K., & Audenaert, K. (2009). Sociodemographic and psychopathological risk factors for repetition of attempted suicide: A 5-Year follow-up study. *Archives of Suicide Research, 13*, 201-213.

Seager, M. (2008). Psychological safety: A missing concept in suicide risk prevention. In S. Briggs, A. Lemma & W. Crouch (Eds.), *Relating to self-harm and suicide: Psychoanalytic perspectives on practice, theory and prevention* (pp. 210-223). London: Routledge.

Séguin, M., Lynch, J., Labelle, R., & Gagnon, A. (2004). Personal and family risk factors for adolescent suicidal ideation and attempts. *Archives of Suicide Research, 8*(3), 227-238. doi: 10.1080/13811110490444379

Shneidman, E. S. (1984). Aphorisms of suicide and some implications for psychotherapy. *American Journal of Psychotherapy, 38*, 319-328.

Shneidman, E. S. (1992). A conspectus of the suicidal scenario. In R. W. Maris, A. L. Berman, J. T. Maltsberger & R. I. Yufit (Eds.), *Assessment and prediction of suicide* (pp. 50-64). New York: Guilford.

Shneidman, E. S. (1993a). Suicide as psychache. *Journal of Nervous and Mental Disease, 181*, 145-147.

Shneidman, E. S. (1993b). *Suicide as psychache: A clinical approach to self-destructive behavior*. Northvale, NJ: Jason Aronson.

Shneidman, E. S. (1994). Clues to suicide, reconsidered. *Suicide and Life-Threatening Behavior, 24*, 395-397.

Sibthorpe, B., Drinkwater, J., Gardner, K., & Bammer, G. (1995). Drug use, binge drinking and attempted suicide among homeless and potentially homeless youth. *Australian & New Zealand Journal of Psychiatry, 29*, 248-256.

Silverman, M. M., Berman, A. L., Sanddal, N. D., O'Carroll, P. W., & Joiner Jr., T. E. (2007a). Rebuilding the Tower of Babel: A revised nomenclature for the study of suicide and suicidal behaviors. Part I: Background, rationale, and methodology. *Suicide and Life-Threatening Behavior, 37*(3), 248-263.

Silverman, M. M., Berman, A. L., Sanddal, N. D., O'Carroll, P. W., & Joiner Jr., T. E. (2007b). Rebuilding the Tower of Babel: A revised nomenclature for the study of suicide and suicide-related behaviors. Part II: Suicide-related ideations, communications and behaviors. *Suicide and Life-Threatening Behavior, 37*(3), 264-277.

Sinclair, J., & Green, J. (2005). Understanding resolution of deliberate self harm: Qualitative interview study of patients' experiences. *British Medical Journal*. doi: 10.1136/bmj.38441.503333.8F

Sinclair, J., Horton, K., & Gray, A. (2010). Six-year follow-up of a clinical sample of self-harm patients. *Journal of Affective Disorders, 121*, 247-252.

Smith, J. A. (1996). Beyond the divide between cognition and discourse: Using interpretative phenomenological analysis in health psychology. *Psychology and Health, 11*(2), 261-271.

Smith, J. A. (2003). Validity and qualitative psychology. In J. A. Smith (Ed.), *Qualitative psychology: A practical guide to research methods* (pp. 232-235). London: Sage.

Spence, D. P. (1982). *Narrative truth and historical truth: Meaning and interpretation in psychoanalysis*. New York: Norton.

Stengel, E. (1970). *Suicide and attempted suicide* (Rev. ed.). Harmondsworth, U.K.: Penguin.

Strike, C., Rhodes, A. E., Bergmans, Y., & Links, P. (2006). Fragmented pathways to care: The experiences of suicidal men. *Crisis, 27*(1), 31-38.

Sudak, H., Maxim, K., & Carpenter, M. (2008). Suicide and stigma: A review of the literature and personal reflections. *Academic Psychiatry, 32*(2), 136-142.

Sullivan, G., Han, X., Moore, S., & Kotrla, K. (2006). Disparities in hospitalization for diabetes among persons with and without co-occurring mental disorders. *Psychiatric Services, 57*(8), 1126-1131.

Sullivan, H. S. (1954). *The psychiatric interview*. New York: Norton.

Sun, F.-K., & Long, A. (2008). A theory to guide families and carers of people who are at risk of sucide. *Journal of Clinical Nursing, 17*, 1939-1948.

Sun, F.-K., Long, A., Huang, X.-Y., & Huang, H.-M. (2008). Family care of Taiwanese patients who had attempted suicide: A grounded theory study. *Journal of Advanced Nursing, 62*(1), 53-61.

Taylor, T. L., Hawton, K., Fortune, S., & Kapur, N. (2009). Attitudes towards clinical services among people who self-harm: Systematic review. *British Journal of Psychiatry, 194*, 104-110.

Tzeng, W.-C. (2001). Being trapped in a circle: Life after a suicide attempt in Taiwan. *Journal of Transcultural Nursing, 12*(4), 302-309.

Waldo, C. R., Hesson-McInnis, M. S., & D'Augelli, A. R. (1998). Antecedents and consequences of victimization of lesbian, gay and bisexual young people: A structural model comparing rural university and urban samples. *American Journal of Community Psychology, 26*, 307-334.

Weishaar, M. E., & Beck, A. T. (1992). Clinical and cognitive predictors of suicide. In R. W. Maris, A. L. Berman, J. T. Maltsberger & R. I. Yufit (Eds.), *Assessment and prediction of suicide* (pp. 467-483). New York: Guilford.

Wertz, F. J., Charmaz, K., McMullen, L. M., Josselson, R., Anderson, R., & McSpadden, E. (2011). *Five ways of doing qualitative analysis: Phenomenological psychology, grounded theory, discourse analysis, narrative research and intuitive inquiry*. New York: Guilford.

Wiklander, M., Samuelsson, M., & Åsberg, M. (2003). Shame reactions after a suicide attempt. *Scandinavian Journal of Caring Sciences, 17*, 293-300.

Williams, J. M. G. (1997). *The cry of pain: Understanding suicide and self-harm*. London: Penguin.

Willig, C. (2001). *Introducing qualitative research in psychology: Adventures in theory and method*. Maidenhead, U.K.: Open University Press.

Wirbel, R. J., Olingar, A., Karst, M., & Mutschler, W. E. (1998). Treatment of severe injuries caused by attempted suicide: Pattern of injury and influence of the psychiatric disorder on the postoperative course. *European Journal of Surgery, 164*, 109-113.

Worden, J. W. (2002). *Grief counseling and grief therapy: A handbook for the mental health practitioner* (3rd ed.). New York: Springer.

Yardley, L. (2000). Dilemmas in qualitative health research. *Psychology and Health*, 15, 215-228.

Zayas, L., Gulbas, L. E., Fedoravicius, N., & Cabassa, L. J. (2010). Patterns of distress, precipitating events, and reflections on sucide attempts by young Latinas. *Social Science and Medicine, 70*, 1773-1779.

Zilboorg, G. (1996). Some aspects of suicide. In J. T. Maltsberger & M. J. Goldblatt (Eds.), *Essential papers on suicide* (pp. 83-92). New York: New York University Press (Originally presented as a talk in 1938; Reprinted from Suicide and Life Threatening Behavior, 5, 131-139, 1975).

Appendix A

Invitation to participate in a research study

Project title: Experiences following a suicide attempt
My name is Anne Graham. I am a Senior Lecturer in Psychology at Victoria University where I teach in the postgraduate clinical psychology training program. I am doing a PhD studying experiences after a suicide attempt. My supervisor is Associate Professor Ross Williams, Department of Psychology, Victoria University.

The aim of this study is to find out more about change and recovery after a suicide attempt, both immediately after and during the year or so following the attempt. I hope the study will provide information to help health professionals and others plan responses and programs which are most likely to reduce pain and suffering as well as lessen the risk of further self-harm.

What participants will be asked to do: Participation in the study involves an interview of approximately one to one and a half hours. You will be asked to outline the circumstances of your suicide attempt and to talk about your experiences afterwards and in the year or so following. You will be asked about how you felt in yourself after the attempt, how other people responded, what steps you took to deal with your situation, and what you found helpful or unhelpful. In addition you will be asked to give some (brief) background information about yourself. You can withdraw from the interview at any time or decline to answer specific questions. With your permission the interview will be audio-taped.

Confidentiality: All information given in the interviews will be kept confidential. (The only exception to this would be if the researcher became seriously concerned about your safety and, after discussing the concerns with you, felt it necessary to contact someone to arrange extra support for you.) Tapes and transcripts will be labelled by number not by name and will be securely stored at Victoria University. No names will be used in the transcript and there is no need for names on the tape.

Reporting the findings: Any reports or publication of the research will focus on common themes and issues emerging from a group of interviews. There will be no identifying information about individuals. However because it is important to hear the voices of people describing their own experience, I hope research reports can include direct quotes from participants. You will be asked whether you give permission for your words to be quoted anonymously.

Possible risks of participation: Talking about painful feelings and events can be very upsetting even if these feelings and events are in the past. You may find that the interview brings back distressing feelings and thoughts that you thought you were finished with. It is important that you take time to think over whether you feel ready at this time to talk about your experiences.

If you would like to participate in this study, or would like further information, please fill in the attached Expression of Interest and return it in the reply-paid envelope provided. Alternatively you can phone me on 9365 2159. (If I am not there please leave a message and I will return your call as soon as possible.)

Anne Graham

Appendix B

Victoria University

Permission Form for Participants Involved in Research

Please read carefully, cross out any sections which you do not agree to, and sign

CERTIFICATION BY PARTICIPANT

I, ...

of

....

certify that I am at least 18 years old, and

that I am voluntarily giving my permission for participation in the research entitled: Experiences following a suicide attempt, being conducted by Anne Graham and Ross Williams, of the Department of Psychology, Victoria University

I have read the statement 'Invitation to participate in a research project', and I have had the opportunity to have my questions answered by Anne Graham

I understand that I can withdraw from this study at any time and that this withdrawal will not jeopardise me in any way.

I give permission for my participation in an audio-taped interview

I give my permission for my words to be quoted in reports of the research provided any identifying information is removed.

Signed: ....   **Date:** ....

One copy of this form will be kept by the participant and one copy kept by the researcher

Any queries about your participation in this project may be directed to the researchers (Name: Anne Graham ph. 9919 2159 or Ross Williams ph 9919 4590). If you have any queries or complaints about the way you have been treated, you may contact the Secretary, University Human Research Ethics Committee, Victoria University, PO Box 14428 MC, Melbourne, 8001 (telephone no: 03-9919 4710).

Appendix C

Project: Experiences following a suicide attempt

Interview: Preliminary information

A. Background

Age

Education   Occupation

Marital status   Children

Place of birth   1st language   Arrived in Australia

B. Brief health history:

General health problems?

Mental health problems?

    How long for?

    Formal diagnosis?

    Current treatment:

    Name of doctor/psychiatrist/psychologist

Appendix D

Project: Experiences following a suicide attempt

Interview Guide

Introductory statement: I'm interested in people's experiences after making a suicide attempt, how this impacts on their life and how they might begin to recover. But to talk about that I need to start by asking you about your suicide attempt.

A. The attempt

Have you made one suicide attempt or more than one?
(If more than one) : Well I think if we can focus on one particular attempt to begin with and then towards the end I can ask you whether there is something you would like to say about the other experiences.

Can you tell me about the suicide attempt? (What did you do? What were the circumstances? What happened then? Did someone find you or did you contact someone?)

B. Immediately after

Did you have medical treatment? What sort of treatment? Were you in hospital? What was that like?

How did you feel in yourself just after the attempt?

Who among your family and friends knew about the attempt? How did they respond?

Did you feel like talking to people about it or not?

When you went for medical treatment: Did someone ask you about your circumstances, and your feelings? Were you referred for ongoing help?

Who or what was most helpful to you in the time just after the attempt?

Did anything happen which was particularly unhelpful?

C. In the months after or the year after

Did anything change after the attempt? Did you feel different or the same? Did people treat you differently or the same?

How were you in yourself in the months after the attempt? What was happening in your life? What were the main issues you were facing or dealing with?

How were things with your family and friends?

Interview Guide continued

What was happening in terms of seeing someone about mental health issues (clinic, psychiatrist, psychologist)? What was that like?

Who or what was most helpful to you in the months after the attempt?

Did anything happen which was particularly unhelpful?

D. Present & support

How are things for you at present? Where do you see yourself today?

Household: Who are you living with?

Sources of support: Who would you turn to for assistance now if you needed it?

How are you feeling at this stage about the interview?

Discuss plan in case of distress developing after the interview

Appendix E

HUMAN RESEARCH ETHICS COMMITTEE

MEMORANDUM

TO: A/P Ross Williams
Principal Investigators
Psychology

FROM: Dr John McDougall
Director, Office for Research and Development

DATE   27 September 2004

SUBJECT: **Approval of application involving human subjects**

Dear Ross,

Thank you for your submission detailing amendments to the research protocol for the project titled, ***Experiences following a suicide attempt*** (HRETH.029/04).

The proposed amendments have been accepted by the Human Research Ethics Committee and approval for application HRETH.029/04 has been granted from 18/10/04 to 18/10/06.

Please note that, the Human Research Ethics Committee must be informed of the following: any changes to the approved research protocol, project timelines, any serious or unexpected adverse effects on participants, and unforeseen events that may effect continued ethical acceptability of the project. In these unlikely events, researchers must immediately cease all data collection until the Committee has approved the changes.

If you have any queries, please do not hesitate to contact me on 9688 4708.

The Committee wishes you all the best for the conduct of the project.

Dr John McDougall
Director, Officer for Research and Development