Lived Experiences: Surviving and Thriving After A Suicide Attempt

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Improving the Care of those who Engage in Suicidal Behaviour

- Improving the care of those who make suicide attempts will involve clinicians, families/whānau and community agencies developing and evaluating more effective methods of treatment, management, aftercare and support.
- Little is known about the "lived experiences" of those who attempt suicide, how they view the interventions of others around the attempt and what expertise they have developed as recipients of the interventions of others.
- The perceptions, stories and lived experiences of people who have attempted suicide constitute valuable knowledge for researchers and practitioners within the context of suicide intervention initiatives and the promotion of wellbeing.

Updating Knowledge and Practice - Key Questions

- What do we know about the experience of being suicidal?
- What does it mean for a person to "survive" a suicide attempt?
- What do we know about how people who have engaged in non-fatal suicidal behaviour perceive the interventions they receive?
- What specific aspects of interventions are helpful and unhelpful and why are they perceived as helpful/unhelpful?
- What do we know about what is required for a person to stop engaging in suicidal behaviour? What do they need to survive?
- What do we know about is required for a person to recover from suicidal behaviour and what protects them from future suicidal behaviour?

Bigger Questions

- What counts as knowledge?
- Who's knowledge is valued?
- How is knowledge produced and reproduced?
- When should knowledge be challenged?

- **Social Constructionist Position**: knowledge does not come through the objective, scientific study of phenomena such as suicidal behaviour but through a democratic process whereby people discuss and debate knowledge, its meaning, importance and that knowledge is socially and culturally constructed.
- **Knowledge** is also used to position people and knowledge is also connected to power. Some forms of knowledge are seen as more valid and useful than others. Some people who hold knowledge (gatekeepers) so that they can retain positions of authority, expertise and power.
- It is through **interdisciplinary and integrative studies** that we can generate new research questions, expand and situate knowledge within a broader context and improve our response to pressing human problems.

The Scholarship of Integration

- Boyer (1990) identified four separate but overlapping functions of scholarly activity:
  - Scholarship of Discovery
  - Scholarship of Integration
  - Scholarship of Application
  - Scholarship of Teaching
  - Messages from the edge
- Scholarship means doing original research but also means stepping back from one investigation, looking for connections, building bridges between theory and practice, and communicating one's knowledge effectively (Boyer, 1990).
- **The scholarship of integration means interpreting, drawing together, and bringing new insight to bear on original research.** It involves fitting one's own research – or the research of others – into a larger context and perspective.

> Those engaged in the scholarship of discovery ask, "What is to be known, what is yet to be found?" whereas those who are engaged in integration ask, "What do the findings mean? It is it possible to interpret what's been discovered in ways that provide a larger, more comprehensive understanding?" (Boyer, 1990, p.19)

Integrating Standpoint Theory, Lived Experience and Suicide Research

- **Standpoint Theory** is extremely influential within the social sciences (particularly sociology) and is both insightful and controversial.
- A standpoint can be conceptualised as a perspective: a place in time and space from which an individual views the world around them. It provides a lens to see the world and influences how an individual and groups of individuals socially construct the world. A standpoint determines what we focus on as well as what is obscured from us.
- Suicide attempters have standpoints, so do practitioners and researchers (there are not often acknowledged or made explicit).
- Standpoint theorists (e.g., Harding, 1991; Wood, 1982) suggest that societal inequalities generate different accounts of nature, the world and social relationships.
- **The world looks different depending on where you view it** and those who engage in non-fatal suicidal behaviour will see and understand the world in ways that are different to family, friends, professionals and researchers.
- By gaining access to the knowledge and perspectives of suicide-attempters we will be in a better position to critique the knowledge around suicide, and what are effective forms of intervention and prevention.

- Standpoint theory suggests we should access these marginalised groups' perspectives and that we should value their knowledge and expertise because they are privileged to certain insights compared to other groups.

> "Because understanding an individual's perception of the world may shed light on why a suicidal decision is made, it is important in particular to explore the meaning that the suicidal individual gives to the suicidal act" (Ketelaar & Ohara, 1989, p.393).

Lived Experience

- **Lived experience is a filter** through which experiences and events are made sense of. Like a standpoint it is influenced by gender, age, developmental stage, class, culture, prior learning, knowledge and experience etc. It involves conscious, subconscious and unconscious processes (Brown, 2000).
- It is the result of living through the experience, **it is constructed** and is not just a perception of that experience (Gadamer, 1975).
- A person's way of being in the world (or not wanting to be in the world in the case of the suicidal person) is reflected in his or her everyday lived experiences.
- The perceptions, stories and lived experience of people who have engaged in suicidal behaviour constitute a valuable source of knowledge for researchers and practitioners. Provides "experts" with a potentially powerful means of developing knowledge about the suicidal process and what makes a difference to people in their recovery and growth.
- Why don't we ask them? – brings us back to the big questions: what counts as knowledge? Who's knowledge counts? Suicidal people are often seen as irrational.

Suicide Research

- While some research reviews (e.g., Gould, Greenberg, Velting and Shaffer, 2003) have identified approaches and interventions that may reduce risk of suicidal behaviour and suicide Beautrais (2006) states that:

> "…despite our vastly increased knowledge about the causes of suicidal behaviour we know relatively little about what is most effective in preventing suicide" (p.2).

- Understanding the lived experiences near-fatal suicide attempters and the factors that contributed to their attempt and survival may help prevent not only suicidal behaviour but suicide (O'Carroll et al., 2001).
- Cutliffe (2003) argues for more **phenomenological studies** of suicide attempts and that there is an urgent need to better understand the particular life experiences and the meanings of the individual's experiences in order to design interventions to help reduce the suicide rate.
- Studying the lived experience of suicidal behaviour may contribute to our knowledge of what causes suicide and protects people from suicide but it may contribute to the development of more responsive and effective practice by shedding light on what works and why.

Quantitative vs. Qualitative

- Identifying the number of suicide attempters who experience decreases in suicidal thinking and behaviour as a result of intervention, treatment and care through a survey or measuring the reduction of levels of suicidality, depression, and associated states by means of a questionnaire will not bring us in direct contact with the living in order to capture the experiential quality of the lives of those who have engaged in suicide attempts.
- In decontextualizing an individual's experiences of suicide, treatment and recovery, we lose sight of the fullness of life and what it means to survive, and therefore, risk losing the meaning we hope to capture.
- **The complexities of human experience preclude the use of such reductionist approaches in answering questions of meaning.** A question of meaning calls for a method that truly explores the lives of the suicidal as they are cared for, comforted and helped to recover.
- By listening to suicide attempter's voices and their stories, it becomes possible to come closer to life as suicide attempters live it "rather than as we conceptualize, categorize or theorize about it"; and in this way the possibility of **uncovering and capturing a deeper understanding of the nature or meaning of what it means to survive a suicide attempt and thrive** (van Manen, l984).

Some Selected Studies

- Coggan and Bennett (2002) young Pakeha suicide attempters (NZ), experience of recovery.
- Chesley and Loring-McNulty (2003) experiences of attempts, what helped them stop and what helped recover.
- Crockwell and Burfod (1995) young female suicide attempters, experiences of intervention.
- Curtis (2003) female suicide attempters (NZ), cessation & recovery.
- Gair and Cammilleri (2003) young suicide attempters and help seeking behaviours.
- Heckler (1994) adult suicide attempters, focuses on suicidal process and recovery.
- Hill (1995) young suicide attempters and suicides, focuses on risk factors and experiences of treatment and support.
- Söderberg (2004) adult suicide attempters with and without BPD, focuses on treatment experiences, stabilisation & recovery.
- Tzeng (2001) Taiwanese suicide attempters, suicidal experience and needs.

Tend to be smaller sample populations, qualitative, issues of retrospection but trade off is rich descriptions, explanations and data.

What Contributed to Suicidal Behaviour?

Themes from the Research

- **Series of events** (relational, instrumental and health problems) but some were impulsive acts (Gair & Cammilleri, 2003).
- **Childhood abuse** including sexual abuse (Curtis, 2003; Söderberg, 2004).
- **Overwhelming and multiple losses**: traumatic, dysfunctional, alienation (Heckler, 1994).
- Early unaddressed pain (Heckler, 1994).
- **Mental health problems** (Hill, 1995).
- An event that cements the conviction that there is no hope or recourse other than suicide (Heckler, 1994).
- **Unrecognised depression and view of limited agency** (Bennett, Coggan & Adams, 2003).
- **Feeling trapped** (Tzeng, 2001), unbearable thoughts and/or unbearable situation, loneliness (Söderberg, 2004).

> "Well the main reason I tried to kill myself was because my girlfriend left me and took my kid away from me…so I got really depressed. I didn't think I could take it…so I just didn't want to live…I just took…a cocktail of tablets (Brad, 22 years old) (Gair & Cammilleri, 2003, p.87).

Intent and Motive

Themes from the Research

- Gair and Camilleri (2003) found **intent was unique to individuals but reflects those reported in the research.**
- Some of the participants described some attempts that were 'more serious' and when they 'just didn't want to live' while other attempts were described as 'just more about getting out' and 'just didn't want to be in the world for a while'.

Gina) To die or to get help.

(Wendy) I thought I really wanted to die but I wanted help.

(Darlene) Every time I wanted to die.

(Darlene) I wanted someone to know how frustrated I was. (Crockwell & Burford, 1995, p.6)

Clear Motives & Ambivalence

Themes from the Research

- To **escape inescapable pain.**
- **Communicate distress** and about intolerable situation (Heckler, 1994).
- Suicide was seen as a **solution**, a comforting and attractive solution when they were experiencing despair, low self-esteem and powerlessness.
- **To manage pain** (Heckler, 1994).
- Some change their minds after an attempt but at the time of the attempt they were serious about ending their life (Curtis, 2003).
- Hill (1995) found that for some young suicide attempters actions intended to be lethal do not always have that outcomes, and some not intended to be lethal still convey suicidal intent:

"Up until that point, I just had this hopelessness, this powerlessness and the only power I had was knowing that I was going to take my own life. That was the only thing I could see and the only strength I had. (Ian)" (Heckler, 1994, p.112).

"I tried to commit suicide four times. I slashed my hands, wrists and arms. I just felt so much mental pain inside. When the blood came out it felt like all the pain coming out. I felt calm. I still don't know whether I was trying to kill myself or just hurt myself." (Maxine) (Hill, 1995, pp.126).

The Suicidal Process

"It's a terrible thing when you wake up in the morning and you don't want to be alive. I genuinely wanted to die. It's just something you can't get away from. Life seems so pointless. You cannot think about the pain you might cause anybody else. That's not even a consideration, because you feel so unimportant in yourself you don't think it will affect anyone else. I didn't want to be here. I was sure I'd die." (Hill, 1995, p.129).

"I decided right then: I already felt dead. Everything I did, I felt more dead. Nothing felt alive and nothing would help. I just felt it would be more congruent to be dead. Just not to have this body to keep being in" (Karen) (Heckler, 1994, p.67).

Why Did They Survive?

Themes from the Research

- Impromptu or sought rescue or intervention.
- **Unsolicited and unexpected intervention** (Heckler, 1994).
- Lethality of means chosen.
- Giving up when they became alarmed by **unexpected physical distress** – increased heart rates, uncontrollable muscle spasms, shortness of breath and calling help.
  - **Intervention of another person** (49%, n=33).
  - **Changed their minds** after initiating a suicide attempt and then sought help (22%, n=15).
  - **Not taken enough medication or non-lethal means** (18%, n=12) Chesley & Loring-McNulty, 2003).

"I told him I was fine, but I'm sure he could hear something in my voice. He was over here in minutes, dressed in a tux! I didn't want to open the door, but it seemed like providence had stepped in. I thought "Who am I to fuck with the universe?" (Deborah) (Heckler, 1994, p.124)

How Did They Feel About Surviving?

- Chesley and Loring-McNulty (2003) found that suicide attempters expressed a range of feelings in the time immediately after their suicide attempt.
  - Sad, depressed, disappointed, empty (31%, n=25)
  - Angry (17%, n=14)
  - Embarrassed, ashamed (14%, n=11)
  - Happiness, relief (12%, n=10)
  - Scared (11%, n=9)
  - Sense of failure (9%, n=8)
  - Other (ambivalent, unable to remember) (5%, n=4)
  - **55% (n=30) currently reported feeling 'glad or grateful' about having survived their suicide attempt.**
- Highly stressful and emotional time for attempter and family (Coggan & Bennett, 2002).
- Physical symptoms and feeling of emptiness Tzeng (2001).
- Coming to terms with the physical damage caused to the body; a loss of privacy;
- acknowledging one's vulnerability; anger, reproach and condescension from one's family, physicians, nurses and other health professionals (Heckler, 1994).

The Suicidal Trance is Broken

- As Heckler (1994) describes, for some the attempt fails and yet the trance and desire to end their lives remains.
- Others experience the beginnings of a change, either during or just after the harrowing episode.
- When the devotion for the suicidal quest wanes, it leaves a vacuum.
- Heckler (1994) claims that how that vacuum is filled strongly influences the trajectory of the individual's recovery or whether as Curtis (2003) points out there is often only a brief moment of cessation.
- **The quality and nature of support and intervention received affects whether or not an individual will stop making suicide attempts and go on to recover.**

Cessation vs. Recovery

- Curtis (2003) makes an important distinction between cessation and recovery.
- She argues that **cessation** relates more to a decrease in suicidal behaviour (but the possibility of still experiencing suicidality), whereas **recovery** entails an individual developing coping strategies, problem-solving skills that lead to a reduction in the suicidality.

Reasons for Stopping

Themes from the Research

Chesley and Loring-McNulty (2003) found:

- **Treatment with a professional** (14%, n=13) (contact with primary health provider, hospital staff, or a mental health professional)
- **Sense of self-empowerment** (10%, n=10) (developing a stronger sense of self, improving self-esteem, or increasing personal power)
- **New outlook on life** (10%, n=10)
- Personal/professional success (10%, n=10)
- Concern for children (9%, n=9)
- Medication (8%, n=8)
- Spirituality (7%, n=7)
- Relationship with significant other (6%, n=6)
- Relationship with family/friends (5%, n=5)
- Improved mood (4%, n=4)
- Maintaining sobriety (3%, n=3)
- Sharing feelings with others(2%, n=2)
- Emotional maturity (2%, n=2)
- Other (7%, n=7)

Narratives of Discontent: What Didn't Help?

Themes from the Research

- Male roles and help-seeking seen as weakness, stigma of having a mental illness, **not having enough time with mental health professionals** (Gair & Camilleri, 2003).
- Having someone else do all the talking, people **not listening** (Hill, 1995).
- **Unhelpful statements** – You've got heaps to look forward to (Hill, 1995).
- Inflexible crisis support (Hill, 1995).
- **Silencing** – Family and friends pretending nothing has happened (Hill, 1995).
- **Recrimination and Ridicule** – look what you are doing to us (Hill, 1995).
- **Minimising and Chastising** – you silly pathetic girl' 'it's just cry for help' (Hill, 1995)

"When I got out of hospital it was like nothing happened. Nothing was ever said about it again. It was like I'd just come home from school for the day. Nobody asked if I was all right. I was in bed for a few days and they treated me like I'd got a sore throat or something. Just nothing was said. Which makes it quite hard when you're 12" (Debbie) (Hill, 1995, p.176).

Narratives of Discontent

Themes from the Research

- **Maintaining professional distance** and not respecting the individual's rights (Crockwell & Burford, 1995; Söderberg, 2004).
- **Interventions that reinforce feelings of lack of control** (Curtis, 2003).
- **Difficulties with medication** (Curtis, 2003).
- **Parents and family not knowing how to support cessation or recovery** (Curtis, 2003).
- **A lack of mutual understanding** (Söderberg, 2004).

"I felt uncomfortable – she said nothing, only listened. I had need of some guidance, not just hearing myself talk"

"(The therapist) was cold and distant, seemed like she felt burdened by another depressed middle-aged man. I felt abandoned" (Söderberg, 2004, p.68).

Negative Experiences as Motivation for Change

Themes from the Research

"I did it myself – got a grip on my life, created a new life situation. I had let myself be sick before, had waited for others to do it all for me – but nothing changed, in spite of all the resources that were mobilised." (woman, BPD, abused). (Söderberg, 2004, p.60).

"The second suicide attempt was a turning point, a shock – I felt I don't want to go through this again. There was no change until I took a decision of my own to take a hold of the situation. I think things could have gotten much worse if I had waited for a therapist to fix it." (man, BPD) (Söderberg, 2004, p.60).

Narrative of Contentment: What Helped Them Stop?

Themes from the Research

- **Family members providing access to information on depression** and making contracts around help-seeking 'saying goodbyes' (Gair & Camilleri, 2003).
- **Feeling loved and valued** (friends and family); **feeling guilty for making parents angry or worried; or an absence of reaction from significant others** (non-successful manipulation or communication) (Curtis, 2003).
- **Being hospitalised or being stigmatised helped stop** (Curtis, 2003; Hill, 1995).
- **Reaching a turning point and having to make a decision** (Söderberg, 2004).

"Before, I thought I couldn't manage life – so I didn't try, because I didn't dare. Then I found things so destructive, I had reached rock bottom. Then I sat down and thought about what I really needed, and decided things like that should never happen again." (woman, BPD, not abused). (Söderberg, 2004, p.60).

"I decided to work things through – top open up, talk to my friends. I had kept it all locked up before. Nowadays I treat situations quite differently when I come to a conflict or a crisis - I go straight at it." (man, NoBPD). (Söderberg, 2004, p.60).

Narrative of Contentment: What Helped Them Stop?

Themes from the Research

- **Thinking positively**, and focusing on positive aspects of the future.
- Not losing sight of the **balance** between positive and negative experiences in life.
- Realising that **problems are frequently a temporary experience** (Coggan & Bennett, 2002).
- **Talking about feelings which led to being able to identify problems** (Hill, 1995).
- Exploring suicidal feelings and assessing danger (Hill, 1995)
- Recognising when they were experiencing a problem and seeking help (Hill, 1995).

"It's not worth it [attempting suicide] because it just does get better. You're not going to stay like that through your whole life. And even if it is bad like kind of a lot, there's always good times and things you can miss with your friends" (Emma) (Coggan & Bennett, 2002, p.20)

Mixed Perceptions of Interventions

Themes from the Research

- **Hospitalisation** kept them from harming themselves (and contributed to cessation) but did not contribute to recovery (Curtis, 2003).
- **Some staff** from CAT Teams, counsellors, therapists, psychologists, and psychiatrists to be helpful. Community based organisations and counselling were reported more beneficial than other organisations (Curtis, 2003).
- **Some treatment approaches** as helpful particularly those that encouraged learning coping strategies and problem-solving skills that would be useful in the long-term. These included Cognitive Behavioural Therapy, Dialectical Behaviour Therapy and Narrative Therapy (Curtis, 2003).
- **Medication c**an be helpful but when mixed with counselling (Curtis, 2003).
- **Wanting advice and guidance but also greater self-control** (Corckwell & Burford, 1995).

"[They should tell me] what I should do when I get suicidal tendencies, what I should do when I get the flashbacks, how I'm supposed to get over the abuse" (Darlene) (Crockwell & Burford, 1995, p.7)

Negative Perceptions of Interventions

Themes from the Research

- **Not fitting the model** (Söderberg, 2004).
- Not matching the therapeutic method to the personal qualities, expectations and values of patients (Söderberg, 2004).
- **Reliance on therapeutic method instead of therapeutic alliance** (Söderberg, 2004).
- **Expert language that has labelled them** – symptoms and experiences that have the power to control them (Söderberg, 2004).

"I fit the model, but the model didn't fit me" (Söderberg, 2004, p.69)

"They start practicing their ideas about what help I need – and only after they've come to a dead end they start asking me what we should do" (Söderberg, 2004, pp.69-70).

Key Features of Counselling/Therapy That Helped

Themes from the Research

- An empathic counsellor.
- A sense of control or partnership in the counselling process.
- Feeling listened to.
- Not feeling blamed/invited to feel guilty for their actions.
- Not feeling judged.
- Not feeling like a burden, as compared to trying to talk to family and friends and having to censor what was said for fear of worrying or hurting them
- Feeling the counsellor could relate to what they were saying – similar age and/or background and/or experience.
- Feeling the counsellor genuinely cared.
- Feeling the counsellor could be trusted – this was particularly important issue for women who felt betrayed by a number of people in their lives including parents and previous counsellors (Curtis, 2003, p.261)
- Acceptance and listening (Hill, 1995).

"He met me like an equal human being. I felt like I was being seen and heard"

"She saw I needed to make changes in my life, and she supported me in the process. I felt her support and I felt I was safe with her" (Söderberg, 2004, p.66).

Other Important Aspects

Themes from the Research

- **Getting to know the person and acknowledging what the individual has been through** (Crockwell & Burford, 1995).
- Social workers **listening** to young people's unique stories (Gair & Camilleri, 2003)
- Social workers **filling a 'mate' role** (Gair & Camilleri, 2003)
- **Regular contact** (Gair & Camilleri, 2003).
- **Honest and forthright answers so that false promises** (e.g., everything will be OK) **are not made** Crockwell & Burford, 1995).

The guy just wanted the facts but she was like I could howl and she would say 'don't worry about being upset, just cry if you want to. You have every right to cry, you've been through hell' and just validation of your feelings and she got more into 'where did I come from' 'what kind of things have led up to it?' but so that was really nice but then I went to [social worker]" (Darlene) (Crockwell & Burford, 1995, pp.9-10).

Narratives of Contentment: What Helped Recovery?

Themes from the Research

Coggan and Bennett (2002) report that for the young people they interviewed reported a number of factors that contributed to them not engaging in further suicidal behaviour. These included:

- **A change in self-image**, the ability to perceive themselves in a more positive light.
- Having responsibilities and commitments.
- **Making a connection with the future.**
- Decreasing a sense of social isolation and reconnecting with friends.
- Personal counselling that enabled them to **develop interpersonal skills** to reconnect with others who could provide them with good things in times of crisis.
- **A sense of self-responsibility in seeking effective help.**
- **A change of circumstances** and living environment that provides greater personal safety and autonomy.

What Helped Recovery?

Themes from the Research

- **A change in perspective or standpoint on life.**
- **Mental stability through psychiatric care** (particularly for those with serious mental illness) (Söderberg, 2004).
- A change in situation (e.g., leaving a destructive relationship) (Söderberg, 2004, p.56).
- **Regaining control and learning new skills.**
- Taking control of self-harming behaviour, emotions (e.g., feelings of hopelessness and helplessness) and one's body seemed to contribute to **cessation** and also learning positive coping strategies and interpersonal problem-solving skills resulted in enhanced self-esteem, coping skills and increased sense of control which seems to have contributed to **(recovery)** a reduction in the likelihood of repeated suicide attempts (Curtis, 2003).

"The last few years have been quite OK. What I went through gave me a new perspective on my life, and my priorities changed. I'm truly grateful I'm alive" (man NoBPD) (Söderberg, 2004, p.55).

What Helped Recovery?

Themes from the Research

Chesley and Loring-McNulty (2003) asked their participants how they learned to cope with suicidal feelings and this question generated a wide range of responses:

- **Medical treatment** (12%, n=18) (with health professional or health care provider)
- **Sharing feelings with others** (10%, n=14)
- **Involvement in activities/hobbies** (10%, n=14)
- **Relationships with friends** (7%, n=10)
- Improved self-esteem (7%, n=10)
- Spirituality (5%, n=8)
- Recognising that suicidal thoughts are transient (5%, n=8)
- Involvement in support groups (5%, n=7)
- Sense of control over their life (4%, n=6)
- Medication (3%, n=5)
- Journaling (3%, n=5)
- Professional success (3%, n=5)

Heckler (1994) Five Stages of Recovery

1. **Dissolving the Suicidal Trance** - person discovers that it is the suicidal context, not the individual, that has to die. This involves the person suspending doubt, grieving, and learning to trust & letting go of dying.
2. **Rebuilding the self** - focuses on healing the past, taking responsibility for one's actions, and discovering new answers to the question "Who am I?" exploring oneself through creative work, and cultivating an openness to life.
3. **Building a new relationship with oneself.** Person reaches out (the opposite to the isolation of the suicidal trance) learns to ask for help, being willing to be seen,
4. **Allowing others in** and inviting the intimacy of others.
5. **Giving back**. The individual having learned to receive from others in new and healthy ways, now must learn to offer what they have learned back to their community.

Heckler (1994) Four Attitudinal Shifts Essential For Recovery

These shifts include a movement from:

- **Powerlessness to authorship.**
- **Loss of faith to a working relationship with the spiritual.**
- **Being or feeling "stuck" to becoming "unstuck",** and
- **A lack of belonging to a sense of place.**

"Just look at how my life has changed so far, and this is just the first year of my promise. I know terrible things could happen in the future, but in a way, I want to see it. I want to see all of it now. I'm truly looking forward to what happens next" (Ruth) (Heckler, 1994, p.291).

Experiences Required for People to Recover?

- **Mirroring**
- **Seeing a bigger picture**
- **Experiencing the humanness of others,**
- **Extending to family** (Heckler, 1994).

Heckler (1994) writes:

> Some of these experiences will be serendipitous and unexpected, while others will be consciously sought and hard-won. Nevertheless, they constitute major turning points in the process of rebirth. And while not everyone passes through various stages in the same linear progression, people who recover do experience most of them at some point during the road back" (p.168).

"I needed to hear that there are other options besides killing myself. (Deborah)" (Heckler, 1994, p.252).

What Is the Difference That Makes A Difference?

Challenging Dominant Ideas & Practice

Therapeutic Alliance

- Therapeutic contact and a therapeutic alliance **that allows the person to take a new perspective or standpoint** (Söderberg, 2004).
- Finding a different perspective in life that has modulated their identity self-concept (Söderberg, 2004, p.71).

Therapeutic Alliance

Challenging Dominant Ideas & Practice

- The therapeutic alliance is important for **alleviating a suicidal individual's sense of powerlessness** to change himself or herself or the environment, and facilitate the experience of success and mastery in dealing with his/her situation.
- **The aim of this alliance should be to help the individual find a different perspective on the situation** (Söderberg, 2004).

"I don't know what happened that night, but something clicked. I think I just got things into perspective. It scared me that I'd got so depressed. I thought I've got to get on and sort myself out. If I fail finals, I fail. I can always take them again" (Karen) (Hill, 1995, p.161).

Personal Commitment to Change

Challenging Dominant Ideas & Practice

- **Change is always dependent upon the perception of the individual**, and cannot be implemented from without.
- It follows, that helping an individual identify his or her standpoint and perspective, as well as showing him/her that there are other standpoints and perspectives might be a promising starting point for change.
- **Making an active decision**.
- **Acknowledging that relief and change need to be achieved and not merely received** (Söderberg, 2004).

"The change came when I realized I could change things, I wasn't helpless." (Söderberg, 2004, p.73).

Empowerment

Challenging Dominant Ideas & Practice

- **Freedom through empowerment** so the individual can make self-directed changes in their own life.
- The therapeutic relationship, whether it exists within the context of therapy, treatment, care or support calls for a perspective of **collaboration** that enables the individual to define their own needs, use a language that makes sense to them and their significant other and empowers them to take control of their life.

"I started to see that every problem in the relationship wasn't my fault. She gave me the strength […] to make a stand" (Söderberg, 2004, p.67).

"You start the process, you get someone's help – and finally it changes, although it always takes time" (Söderberg, 2004, p.71)

Relationships

Challenging Dominant Ideas & Practice

- **Long-term stable personal relationships with someone they can trust, who understands them.**
- **The support to take a different standpoint and maintain the change.**
- Achieving a change in perspective or standpoint requires the presence of persons that can become **'significant others"** who have an instrumental role in helping the person develop a new identity and reinforce their new approach to the world.
- These relationships carry the potential for a development of **self-esteem and self-worth** and build on an active decision and personal commitment for change (Söderberg, 2004).

"It's basically a question of attachment – relationship is the basis for change" (Söderberg, 2004, p.71).

"No matter if the parasuicide was related to severe mental problems leading to extensive psychiatric treatment or an act of despair due to a crisis situation in life, the core feature for subsequent stabilisation was described to be reliable relationships that could further enhance self-esteem and self-worth, or getting rid of relationships that withheld such a development. The process has resulted in the integration of a different understanding of the possibilities and limitations in life" (Söderberg, 2004, p.75).

The Need to Meet the Expert Within

Challenging Dominant Ideas & Practice

- Suicidal people **are valuable sources of expertise and knowledge** and that if practitioners have well developed communication skills, and are **willing to see past the suicidal behaviour to meet the "expert" within** the individual they are more likely to find the answers to what the person needs to stop their suicidal behaviour and recover and thrive (Crockwell & Burford, 1995).
- There is a need for professionals to **build more trusting relationships** with people.
- There is a need to **move away from aloof professionalism to developing therapeutic alliances** with troubled people defined by a bond, where friendship is offered but negotiated in relation to providing relevant resources.
- The importance of establishing a therapeutic alliance with the suicidal person is also something recognised within New Zealand guidelines (NZGG, 2003) as something that can facilitate the disclosure of information and a sense of hopefulness and connectedness.

The Need for More Research and Translation of Findings into Models

- It is only through this **mutual understanding** can the individual and practitioner understand and work towards resolving the issues that have led the person to suicide (Crockwell & Burford, 1995).
- There is also a need to **translate findings from research into workable models and methods of measuring recovery that take into account the perspectives and meanings of individuals.** For example, the Stages Of Recovery Instrument (STORI) (Andreson, Caputi & Oades, 2006) while acknowledging the complex and non-linear nature of recovery from metal illness and psychological trauma identifies four key processes of recovery and five stages or phases of recovery.
- This model has implications for promoting recovery and resilience and training of mental health professionals. It may be that a similar model could be proposed for those who experience cessation and recovery following a suicide attempt.

STORI – Stages of Recovery Instrument

The four component processes of recovery identified from the thematic analyses of personal accounts of recovery are:

1. **finding and maintaining hope;**
2. **the reestablishment of a positive identity;**
3. **finding meaning in life; and**
4. **taking responsibility for one's life**.

The five stages of recovery that were proposed in the model are:

1. **Moratorium:** A time of withdrawal characterised by a sense of loss or hopelessness.
2. **Awareness:** Realisation that all is not lost, and that a fulfilling life is possible.
3. **Preparation:** Taking stock of personal strengths and limitations regarding recovery, and starting to work on learning and developing recovery skills.
4. **Rebuilding:** Actively working towards a positive identity, setting meaningful goals and taking control of one's life.
5. **Growth:** Living a full and meaningful life, characterised by self-management of the illness, resilience and a positive sense of self (Andresen et al., 2006, p.973).

Recovery & Resilience

Table 1. Two Discourses on Resilience

	Ecological Model	**Constructionist Interpretation**
Definition	• Resilience is health despite adversity	• Resilience is an outcome from negotiation with environment for resources to define one's self as healthy amidst adversity.
Theory	• Informed by Systems Theory • Predictable relationships between risk and protective factors • Circular causality • Transactional processes	• Nonsystemic, nonhierachical relationship between risk and relationships between risk and protective factors are chaotic, complex, relative, contextual
Research Methods	• Investigations can be qualitative or quantitative but knowledge is empirical, generalisable	• Investigations can be quantitative but tend to be qualitative or employ mixed designs; interpretation is dialogical, relativistic, constructed.
Risk Factors	• Risk factors are contextually sensitive • Risk impact is cumulative, factors combine exponentially; • Attributions and belief systems are preconditions of risk • Effect of risk factors may also be neutral or protective	• Risk factors are contextually specific, constructed, and indefinite across populations
Resilience Factors	• Resilience factors are: I. compensatory (individual or environmental characteristics that neutralise risk), II. challenging (stressors that inoculate individuals against future risk), III. protective (multidimensional factors and processes that reduce potential for negative outcomes and predispose child towards normative developmental paths)	• Resilience factors are: multidimensional, unique to each context, and predict health outcomes as defined by individuals and their social reference group; I. Characteristics identified by individuals as compensating for self-defined risks I. Challenges that building capacity for survival relative to lived experience of individuals II. Protection against threats to well-being through the exploitation of available health resources
Definition of Health	Health outcomes are predetermined	Health is constructed with a plurality of behaviours and signifiers

Adapted from Ungar (2004) p.344

The Experience of Resilience

- Ungar (2004) claims the **ecological approach to understanding resilience,** (one that is informed by Systems Theory that emphasises predictable relationships between risk and protective factors, circular causality and transactions between the individual and the environment)

  …is inadequate for explaining the diversity of people's experiences of resilience.

- The relationships between risk and protective factors are often chaotic, complex, relative to the individual or group and contextual.

A Constructionist Discourse

- Ungar (2004) suggests we take a constructionist approach where we look at the experience and meaning of resilience for the individual.

- According to the postmodern view of resilience, what is important is:
  - The **language** that people use to describe their resilience after suicide
  - Resilience is the outcome of **negotiations** between people and their environments for the resources to define themselves as healthy, achieving etc despite conditions that are defined by others as 'adverse'.

- Resilience research should look at the **multiple ways that wellbeing and resilience can be defined.**
- A constructionist interpretation of resilience explicitly **tolerates diversity in the way resilience is nurtured and maintained.** It also asks us to consider the effects of age, class, race, gender and so forth on the ability of youth to maintain healthy functioning.

Availability of Resources

- The difference that makes the difference between those who are considered resilient (healthy) and those who are labelled vulnerable is **the availability of resources to sustain their own wellbeing and their resulting self-constructions as healthy** (Ungar, 2004).

- In order to make suicide intervention more effective we need to consider the **needs of suicide attempters and the resources and power they require** to reposition themselves and maintain their own sense of wellbeing.

- A constructionist approach to resilience also fits well with growing interest in strength-based perspectives to treatment, youth work etc (Ungar, 2004).
- Suicide attempters require a **therapeutic alliance, mutual understanding and empowerment** to be able to find their own strengths and develop their own resources that can lead to recovery and resilience.

Conclusions: Interventions should…

Strive to be **multi-systemic**, addressing individual, family, whanau and community issues,

- **Enhance competencies and protective factors,**
- **Reduce risk factors**, and treat disorders.
- Take into account **diversity of experience** and differences in access to resources.
- Attempting to provide a quick fix, and fix one thing at a time won't work – **protective and risk factors are interactive and often interdependent.**

- **Focus on identifying the difference that makes a difference for that individual.**
- **Provide access to and acknowledge the standpoints of the suicidal.**
- **Take into account the meaning for the individual and his/her perspective.**

Conclusions

- **The standpoints and perspectives of suicide attempters should be acknowledged and studied.**
- They provide important information about intention, the unique aspects of suicide attempts, what impedes help-seeking, what aspects of treatment and care are effective and why, and they reveal that workers listening to the person's unique story is important for that person and for his/her recovery.
- **We need to stop treating suicide attempters as a homogenous group** with similar backgrounds and experiences and start treating them as individuals with unique experiences and insights into their own behaviour and needs.

Identifying the processes that helps the person find "the difference that makes the difference" should be in focus of future psychiatric research and at the heart of psychiatric support and treatment after parasuicide, to enable the patients to find their own strengths and resources and in this way be able to leave it all behind" (Söderberg, 2004, p.viii)

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