

# Understanding and Responding to Recurrent Suicide Attempts

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PhD

2017



# Understanding and Responding to Recurrent Suicide Attempts

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Thesis submitted for the award of PhD

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October 2016

## **Declaration**

I hereby certify that this material, which I now submit for assessment on the programme of study leading to the award of PhD is entirely my own work, and that I have exercised reasonable care to ensure that the work is original, and does not to the best of my knowledge breach any law of copyright, and has not been taken from the work of others save and to the extent that such work has been cited and acknowledged within the text of my work.

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Date: November 20, 2016

## Acknowledgements

Without the participants in the SfSL/PISA groups, none of this work would have been possible. I feel truly blessed to have been given the opportunity to work with such a courageous group of people. It is you who motivate me to keep doing the work I love.

I am grateful to the vision, wisdom, insights and tenacity of my supervisory teams and the support, encouragement and contributions of my colleagues in the individual studies and publications: Professor Chris Stevenson, Dr. Evelyn Gordon, Dr. Rahel Eynan, Dr. Paul Links, Professor John Cutcliffe, Dr. John Langley, Dr. James Lavery, Keehan Koorn and Colleen Pacey. Thank you all for being my 'team'.

Thanks to my family and friends who offered and provided the implicit and explicit support necessary to complete this thesis by sifting through drafts, feeding me, and reminding me I need to laugh and sing.

Last and not least, my heartfelt gratitude to my parents who never gave up in pushing me to try to do my best regardless of what came in the way.

The young adults study was made possible through a grant from The Wellesley Institute.



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## **Abstract**

People who have had recurrent suicide attempts (RSA) are known to be at higher risk of future attempts and eventual death by suicide. They are also identified as having unique psychosocial needs, however few treatment interventions have been developed for this particular population. The Skills for Safer Living: A Psychosocial-Psychoeducational Intervention for People with Recurrent Suicide Attempts (SfSL/PISA) is a psychotherapeutic group intervention created for and with people with RSA; seeking to engage with the possibility of living, enhance skills for living more safely and addressing their needs.

This research project aimed to address these issues by examining whether participants who have engaged with this intervention transition away from RSA, and explores their experiences of this transition and of living with RSA. The project comprises four interlinked studies, two quantitative outcome studies and two qualitative studies, with different participant samples, all of whom had graduated from SfSL/PISA.

These studies highlight that risk factors and deficit areas for RSA can be attenuated over time for those who completed the SfSL/PISA intervention; that the process of transitioning away from RSA comprises three phases wherein the person moves from a death orientation to a life orientation; and that living with RSA is marked by states that are ambiguous, fragile, and arduous. The findings suggest that psychotherapeutic intervention for RSA needs to address the specific needs of this group and to be sensitive to the particular stage of living with RSA to navigate through this experience.

## **Glossary of terms used in the thesis**

The current literature has documented at least 15 definitions of suicidality (Menon, 2014). The lack of consensus on a single definition of what constitutes a suicide attempt contributes to much of the debate and confusion in research and clinical environments, thus making prediction, documentation and comparison between studies challenging. To assist in maintaining clarity, the following terms will be used throughout this thesis, recognizing that ambiguities continue to exist within each definition. As noted by Silverman, Berman, Sanddal et al (2007) and applicable to this thesis, terms are not meant to be a classification, nor a reflection of causal or behavioral pathways, rather, a clarification of what each term represents.

**Non-Suicidal Self-Injurious Behaviour (NSSI):** A self-injurious behavior engaged in entirely for reasons other than to end one's life that is self-inflicted and with deliberate harm to their body with no intent to die (Posner, Brodsky, Yershova, et al., 2014, p.15).

**Suicidality:** A broad term used to identify suicide ideation, behavior, attempts, and or suicide without any specificity in terms of intent or lethality. It is identified as commonly used in the literature (Silverman, Berman, Sanddal et al., 2007) and has little clinical value (Meyer, Salzman, Youngstrom et al., 2010). This term will be used throughout this thesis to indicate the broad spectrum of ideation i.e. thoughts of ending one's life, attempts, and death by suicide.

**Suicide Ideation (SI):** can be either/both “passive” -“a desire” (not a plan) and “active”- “desire to make an attempt”. Suicide ideation, also referred to as thoughts of suicide, are cognitive happenings that are separate from suicidal behavior although they may be predictive of suicidal behavior where the difference however, is in the intent i.e., an intent to die versus an intent to act (Posner et al., 2014).

**Deliberate Self Harm (DSH):** A large portion of the published research literature uses the broader definition of deliberate self-harm which includes nonfatal self-poisoning and self-injury irrespective of motivation or intent to die (Hawton, Zahl and Weatherall, 2003).

**Index Attempt:** a term used in epidemiology, and cited throughout the suicidology literature as being the event, or the attempt that brought someone to the hospital and from which point their participation in a study began. Although there is overlap, not all index attempts are the first suicide attempt a person has had.

**Suicide-related Behaviours:** The definition of this term throughout this thesis will be used to reflect- “ A self-inflicted, potentially injurious behavior for which there is evidence (either explicit or implicit) either that: (a) the person wished to use the appearance of intending to kill himself/herself in order to attain some other end; or (b) the person intended at some undetermined or some known degree to kill himself/herself.” (Silverman et al. 2007b, p.272).

**Suicide Attempt:** “...A self-inflicted, potentially injurious behavior with a nonfatal outcome for which there is evidence (either explicit or implicit) of intent to die

(Silverman et al., 2007b. p.273). There must be presence of a ‘nonzero’, meaning some intent, to die where the behavior and the intent are linked (Posner et al., 2014).

**Single Suicide Attempt (SA):** A single instance where it is identified that an individual has attempted to end their own life.

**Recurrent Suicide Attempts (RSA):** Two or more attempts to die by suicide as reported by the study participant.

**Death by Suicide (DBS):** a death resulting from a person taking their own life.

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### List of abbreviations

Abbreviation	Explanation
DBS	Death by suicide
IPA	Interpretive Phenomenological Analysis
RSA	Recurrent suicide attempts
SA	Single suicide attempt
SfSL/PISA	Skills for Safer Living: A Psychosocial / Psychoeducational Intervention for People with Recurrent Suicide Attempts





## **Chapter 1: Overview of the Project**

### ***Introduction to chapter 1***

This chapter will provide an overview of this research project which focused on gaining a better understanding of the experience of recurrent suicide attempts (RSA), responses to a psychosocial intervention designed to meet the needs of this group (SfSL/PISA) and illuminate the processes of transitioning away from RSA. The chapter will begin with a rationale for the study, followed by an introduction to the intervention created with and for people who have experienced recurrent suicide attempts. Finally, it will describe the project studies and thesis layout.

### ***1.0 Background and Rationale for the Project***

Internationally suicide is recognised as a major health concern, with the World Health Organisation (WHO) designating it as the 15<sup>th</sup> leading cause of death worldwide (WHO, 2014). Suicide is a complex and multifaceted phenomenon that is comprised of a dynamic interplay of neurological, biological, psychological, social, spiritual, and cultural factors (Sheehan & Giddens, 2015). The field of suicide is comprised of three broad and inter-related categories: suicide prevention, suicide intervention, and suicide postvention (Hirji, Wilson, Yacoub, & Bhuiya, 2014).

It is estimated that for every death by suicide (DBS), up to 20 other individuals will attempt to end their lives (WHO, 2014) (16,000,000 worldwide; 74,560 in Canada). The published literature identifies that re-attempts occur for many after surviving an index attempt (Cavanagh et al., 2003; Colman et al., 2004; Dieserud et al., 2010; DeJong,

Overholser & Stockmeier, 2010; Isometsä & Lönnqvist 1998; Owens, Horrocks & House, 2002; Ruengorn et al., 2011; Sjöström, Hetta & Waern, 2009). Previous attempts have been noted as an independent and powerful predictor of a future attempt (Wong et al., 2007) and are associated with eventual death by suicide (DBS) (Christiansen & Jenson, 2007; Haukka et al., 2008; Holmes & Almendrala, 2016; Jenkins, 2002). Those who experience RSA live with a chronic and relapsing burden of illness and/or distress (Kreitman & Casey, 1988) which includes quality of life issues, such as socio-economic losses due to disability incurred by the RSA, continuous emotional distress interacting with the consequences of RSA and may be related to living with a mental disorder. This population has also been identified as high health service/resource users impacting the individual, family and the social environment emotionally. For example, repeated visits to emergency departments (ED), recurrent crisis episodes, and the toll associated with the unpredictability of eventual death by suicide can leave clinicians, family and friends concerned and frustrated impacting how they respond to the individual. Financial burden is related to healthcare costs, and personal financial losses and job losses (Parachute, 2014; Sgobin, Traballi, Botego, & Coelho, 2015).

It would appear that intervention at the acute phase of crisis is doing little to prevent future RSA (Kreitman & Casey, 1988) with the quality of evidence for most interventions offered for deliberate self-harm and attempted suicide (non-RSA specific) being rated as moderate or poor (Hawton et al., 2016; Soomro & Kakhi, 2015). Despite those with RSA being considered a unique population that differ in many respects from those with single suicide attempts (SA), treatment intervention has not acknowledged this particular population.

The focus of this research project is threefold: a. to present a model of intervention designed specifically for this population; b. to examine changes in risk factors and deficit areas associated with RSA; and c. to better understand the lived experience of RSA and transitioning away from suicidal behaviour for the RSA population. All of the studies' participants in this research project had participated in SfSL/PISA, an intervention created specifically with and for this population.

### ***1.1 Skills for Safer Living: A Psychosocial/Psychoeducational Intervention for People with Recurrent Suicide Attempts (SfSL/PISA)***

The SfSL/PISA intervention began in 1999 in response to the number of presentations of people with RSA to a local general hospital emergency department (ED). A review of the literature indicated a number of theoretical frameworks for understanding and intervening with those who experience suicidality and conceptualizations of RSA that highlighted the complexity of possibilities and avenues for intervention. It was noted that there were no interventions found that pertained specifically to those who engage in RSA that did not focus on a particular psychiatric diagnosis. Drawing on the theoretical literature of suicidality of the time (Kern, Kuehnel, Teuber & Hayden, 1997; Levine Marziali & Hood, 1997; Linehan, 1993; Miller, 1994) and the distinguishing characteristics of this population (Hengeveld, 1994; Nehls, 1998; Ryan, Parle & Babadge, 1998), the group intervention- A Psychosocial/Psychoeducation Intervention for Recurrent Suicide Attempts (PISA) was developed for participants over the age of 18 years, who reported stated intent to die, and had experienced RSA defined as 2 or more suicide attempts (Blasco-Fontecilla et al., 2014; Hakansson, Bradvick, Schlyter, & Berglund, 2011;

Hengeveld, 1994). It is a 20-week group intervention comprising four interlinked modules and is described in detail in Chapter 3.

By narrowing the focus to people with RSA, it is hoped that this research project will provide a greater understanding of a highly complex and complicated behaviour that will inform future research and intervention, informing the field of suicidology and the treatment of this population.

*“Unfortunately, not all who survive a near-fatal attempt would change their life for the better. Those who regret not having died, or who keep going with their wish to die, and who even promise a more fool-proof attempt at the next occasion--- alas, they deserve our best attention. Their prognosis is not very good, and we are called to pay all possible efforts in trying to reverse their dangerous attitude toward death.” (De Leo, 2010, p. 190).*

## **1.2 The Research Project**

This research project is a compilation of four published works and one study in press. One paper provides an overview of the SfSL/PISA intervention for which I was the lead clinician in the development of the intervention, two quantitative studies examine if the intervention was targeting known risk factors and deficits for the population who have had RSA, and two qualitative studies that sought to gain a better understanding of the experience of living with RSA and the process of moving away from RSA. Overall, 111 participants took part in this project. I was the principal investigator in the studies reported in Chapters 4, 6 & 7 and lead author in the published reports. I was the co-principal investigator and lead author for the study reported in Chapter 5. All co-authors were made aware and agreed to these studies / papers being used as part of this thesis.

### **1.3 Thesis Layout**

This thesis is comprised of 3 sections. The first section contains 2 chapters; a review of the literature pertaining to RSA, highlighting gaps in the published literature (Chapter 2), and a published study describing the SfSL/PISA intervention (Chapter 3).

Section 2 contains four chapters which correspond to the four studies that comprise this research project. Chapters 4-6 contain three published studies and Chapter 7 contains one study that has been submitted for publication. The first study (Chapter 4) is the initial quantitative study which sought to examine whether measures of potential risk factors in the areas of cognition, affect and impulsivity, known to characterize RSA, were reduced among participants of the SfSL/PISA intervention. A second quantitative study reported in Chapter 5, was undertaken to determine if measures of potential risk factors and known areas of deficit that characterize RSA for people who participated in the SfSL/PISA intervention remained changed and stable over time. This study had a larger sample size and included a community sample. Chapter 6 reports on a qualitative study which sought to develop a theoretical understanding of how young adults between the ages of 18-25 years who have participated in the SfSL/PISA intervention transition away from RSA. The final chapter of this section (Chapter 7) reports on a qualitative study that explored the lived experience of adults over the age of 25 years living between life and death, who had participated in the SfSL/PISA intervention and engaged in RSA. These chapters, used with permission from the publishers, are presented in their original format, therefore there are some layout and referencing differences across papers.

Section 3 concludes the thesis with a discussion of the project implications and conclusions, SfSL/PISA intervention evaluation and strengths and limitations of the entire research project (Chapter 8).

#### ***1.4 Summary***

This research project focused on the high-risk population of people with RSA. The project incorporates a literature review and description of the SfSL/PISA intervention, two quantitative and two qualitative studies examining changes in risk factors and deficit areas, the relationship to suicide and the lived experience of people who have RSA who participated in SfSL/PISA. Implications for practice and future study for this group are reported upon.

## **Section 2: Introduction to Section 2**

This section contains two chapters. The first will describe the existing published literature regarding suicide and suicidality, RSA in particular, and provide an overview of treatment interventions. Chapter 3, a published article entitled “Creating An Intervention For People With Recurrent Suicide Attempts” will describe the SfSL/PISA intervention.

## **Chapter 2: Literature Review**

### ***2.0 Introduction to Chapter 2***

This literature review outlines: suicide rates and trends, RSA and the relationship between suicide, suicide attempt and RSA; psychological, social and economic burdens related to RSA; and risk factors associated with RSA to provide a context and rationale for the project. Theoretical frameworks for understanding suicidality are discussed, psychotherapeutic treatment interventions are reviewed and current knowledge identifying the components related to healing from suicidality are considered. Finally, the chapter identifies challenges and gaps in the published literature that this research project sets out to address.

### ***2.1 Rates and Trends of Suicide and Recurrent Suicide Attempts***

In 2012, suicide was the 15<sup>th</sup> leading cause of death worldwide with estimates of one person dying by suicide every 40 seconds, accounting for over 800,000 deaths annually (WHO, 2014). While particular populations have been identified as being at higher risk, for example, suicide is the second leading cause of death for young people aged 15-29 years, death by suicide (DBS) occurs across the life span (WHO, 2014). In Canada, 3,926 people

died by suicide in 2012 (Statistics Canada, 2015), with the age-standardized rate (i.e. a weighted average or age adjustment where the weights are the proportions of those corresponding to a particular age group to compare populations when age profiles are different) per 100,000 being 9.8 (WHO, 2014), ranking suicide as the 9<sup>th</sup> in leading causes of death in the country. The suicide rate for Ireland and the UK in 2014 was 10.8 and 10.9 per 100,000 respectively, with 21% of ED visits being repeat presentations for self-harm (National Office for Suicide Prevention, 2014; Office for National Statistics, 2016; Hawton, Kapur, Waters, Ness, Thacker, & Townsend, 2015). A recent report for Northern Ireland identified that for the year 2013/2014, 43.2% of presentations to hospital for self harm were repeat visits (Knowledge Exchange Seminar, 2015-2016). Viewed from a global perspective, the UK (39<sup>th</sup>), Canada (40<sup>th</sup>) and Ireland (48<sup>th</sup>) rank within the midrange of countries reporting suicide rates (WHO, 2012). It is hypothesized that statistical data for suicide attempts are an under estimation of the actual number of deaths by suicide due to variances in data collection systems and the stigma associated with suicide (WHO, 2014), suggesting that the issue is greater than reported.

It is estimated that for every DBS, up to 20 people will attempt to end their lives (WHO, 2014) (~16,000,000 worldwide; 74,560 in Canada) and between 19% and 42% of people who die by suicide are reported to have made a previous suicide attempt (Cavanagh, Carson, Sharpe & Lawrie, 2003; DeJong, Overholser & Stockmeier, 2010; Isometsä & Lönngqvist 1998). Of those who attempt to end their lives and survived their attempt, it is estimated that within one year of the index suicide attempt, between 8.2% and 16% will reattempt (Dieserud, Gerhardsen, Van den Weghe & Crobett, 2010; Owens, Horrocks, House, 2002; Colman et al., 2004; Sjöström, Hetta & Waern, 2009). Two



previous suicide attempts have been found to substantially increase the rate of re-attempt within a year (Ruengorn et al., 2011) and previous suicide attempts have been noted as being an independent and powerful predictor of a future attempt (Wong et al, 2007). Hence, the RSA population is thought to be at higher risk of DBS and of re-attempting, living with a chronic and relapsing burden of illness and/or distress (Kreitman & Casey, 1988).

## ***2.2 Risk Factors Associated with Recurrent Suicide Attempts***

There are numerous identified biospsychosocial risk factors associated with suicidality in general and RSA in particular. The discussion that follows will report on the evidence relating to the major risk factors including psychiatric, psychological, emotional and socio-economic factors.

### **Psychiatric Illness and Diagnoses**

Psychiatric illness has been identified as a risk factor for suicidality with psychiatric comorbidity being identified as one feature of RSA (Sinclair, Hawton and Gray 2010; Monnin, Thiemard, Vandel et al., 2012). RSA crosses diagnostic categories with risks related to a particular disorder and RSA ranging from 25%-72%. Conferred risks for RSA amongst single diagnoses include 38% of individuals with Bipolar disorder (Fiedorowicz et al., 2009) and between 38% - 46% of those with depressive disorders (Brådvik & Berglund, 2011; Lee, Lin & Yeh, 2012). About 25% of those diagnosed with schizophrenia (Shrivastava et al., 2010), up to 30% of people with substance misuse disorders (Monnin et al., 2012), and up to 73% of those with Borderline Personality Disorder (Soloff, Lis, Kelly, Cornelius & Ulrich, 1994) have been identified with RSA.

Among those with eating disorders, 42% report RSA (Soukas et al., 2014). Some studies found no evidence of psychiatric disorder present for 4%-27.8% of participants (Monnin et al., 2012; Sinclair, Hawton & Grey 2010) suggesting that the role of diagnosis for RSA is complex. More recently, Klonsky and May (2016) suggest that risk factors for suicide and most psychiatric illnesses are better predictors of suicidal ideation than behaviour. Furthermore, risk factors including mental illness fail to differentiate those who have made a suicide attempt from those who experience suicidal ideation and have never made an attempt (Klonsky, May & Saffer, p. 317). A previous attempt has been noted as conferring a greater risk for a re-attempt regardless of other risk factors, including psychiatric illness (Beghi & Rosenbaum, 2010; Monnin et. al., 2012).

### **Economic Disparity**

Given the lack of correlational evidence between suicide rates and psychiatric diagnoses, social, environmental, and cultural factors have been suggested as explaining the globally diverse suicide rates (De Leo, 2010). Evidence remains inconclusive with respect to the role of economic disparity, poverty and unemployment as risk factors contributing to RSA (Beautrais, 2004; Beghi & Rosenbaum, 2010; Da Silva Cais, Stefanello, Mauro, de Freitas & Botega, 2009; Pagura et al., 2008; Sinclair et al., 2010) as these have not borne out across studies (Vijayakumar, Ali, & Umamaheswari, 2008).

### **Childhood Maltreatment**

Differing methodologies, comparison groups, outcome variables, or inclusion criteria such as age, duration or type of trauma may account for discrepancies found in the roles of childhood maltreatment and family history of suicide as a significant risk factors

in the broad range of suicidality from ideation to attempts (Cankaya, Talbot, Ward, 2012; Forman, Berk, Henriques & Beck, 2004; Hakansson, Bradvik, Schlyter, & Berglund, 2011; Kim et al., 2005; Krynska, 2003; Links, Kolla, Guimond & McMain, 2013; Pagura, Cox, Sareen & Enns, 2008; Rhodes, Boyle, Bethell et al., 2013; Wedig et al., 2012; Yip et al., 2011; Yoder, Whitbeck & Hoyt, 2010).

## **Gender**

It has been suggested that there may be distinct pathways, specific characteristics and risk factors for men and women experiencing RSA (Rudd, Joiner & Rumzek, 2004; Monnin et al., 2011) yet such pathways require further exploration particularly since in clinical studies fewer men participate, which may reflect the lower number of men seeking care when compared with women (Farrimond, 2012; Strike, Rhodes, Bergmans & Links, 2006).

## **Regret, Intent and Lethality**

Regret about survival, the wish to be dead (Beautrais, 2004; Bhaskaran et al., 2014; Miranda et al., 2008), perceived intent (Bilen et al., 2011; Chandraskan & Gnanaselane, 2008; Gibb, Andover & Miller, 2009), higher lethality of means (Kaslow, Jacobs, Young & Cook, 2006) and greater ideation (Yoder et al., 2010; Merchant, Kramer, Joe, Venkataraman & King, 2009; Witte, Fitzpatrick, Warren Schatschneider, & Schmidt, 2006) are thought to contribute to the prediction of a future suicide attempt (Brådvik & Berglund, 2011; Dieserud et al. 2003; Gibb et al, 2009; Spokas, Wenzel, Brown & Beck., 2011; Suominen, Isometsä, Ostamo & Lönnqvist, 2004). Self-prediction of the likelihood

of making a future suicide attempt is noted as the best predictor of a future suicide attempt (Nock et al., 2010).

### **Hopelessness**

Widely discussed in the context of RSA is hopelessness, a feeling that there are no solutions to problems and that the current situation will never improve (Caruso, n.d.a; Vijayakumar et al., 2008). Identified within multiple constellations of psychosocial (Beautrais, 2004; Forman et al., 2004; Merchant et al., 2009) and psychiatric challenges associated with suicidality (Fiedorowicz et al., 2009; Horesch, Orbach, Gothelf, Efrati & Apter, 2003; Yoder et al., 2010), it was not found to be a significant predictor of RSA amongst all diagnoses (Gibb et al, 2009; Esposito, Spirito, Boeregers & Donaldson, 2003; Stringer et al., 2013). For example, the degree of hopelessness was found to be the distinguishing characteristic of RSA from a single suicide attempt (SA) independent of depression (Menon, Kattimani, Sarker & Mathan, 2016). If RSA is viewed as a means of coping with emotion dysregulation, Witte and colleagues (2006) suggest that the variability in subjective experiences of hopelessness may be what needs to be targeted in interventions.

### **Difficult Interpersonal Relationships**

Some studies identify poor family relationships as a risk factor contributing to RSA (Dieserud et al., 2010; Wong et al., 2007; Yoder et al., 2010), and Wong and colleagues (2007) propose that the impact of living with someone with RSA could create or add to poor family relationships. Shame, stigma, secrecy, feeling unwell or hopeless about their own RSA behavior or situation could account for reports of difficulties with

family and friends (Vijayakumar et al., 2008; Oh, Park, Jeong, Kim & Lee, 2011). Individuals living in a dysfunctional family with a history of current or past trauma may contribute to them leaving the family situation and feeling misunderstood (Goldstein et al., 2005; Mynatt, 2000; Wedig et al., 2012).

### ***2.3 Estimated costs and burdens associated with RSA***

The economic and emotional burdens of suicidality for society, family, friends and healthcare systems are far-reaching. These burdens can add to a complex set of assumptions and interactions for the person engaging in RSA. Regarding the direct (i.e. health care costs) and indirect costs (i.e. cost arising from reduced productivity as a result of hospitalization, disability and premature death) to society, current Canadian data, although not distinguishing between NSSI, ideation, attempts, or DBS, estimated the cost of suicide/self-injury at \$2,956M (CDN) in 2010, reflecting a significant impact on the Canadian economy (Parachute, 2015, p.22). Suicide/self-injury accounted for 1% of injury related presentations to ED's, 7% of hospitalizations, and 24.9% of deaths by injury (Parachute, 2015).

The emotional burden to family members and friends of those who have survived a suicide attempt can create disengagement from the individual who has attempted suicide. Family and friends are reported to experience multiple emotions including guilt, anger, anxiety, insecurity, shame, betrayal, burdensomeness, powerlessness, helplessness, or hostility. Resulting responses might include, intensified contact, hypervigilance, critical comments, hostility, or emotional over-involvement (Bryan, 2006; Buus, Caspersen, Hansen et al., 2013; SIEC, 2009; Buus et al. 2013; Santos, 2014; Wong, et al., 2007).

Disengagement may result in an effort to emotionally self-protect oneself, or may arise out of a social, cultural, personal belief that a suicide attempt is a bad or a selfish act indicating disrespect for the family (Santos, 2014; Wong et al., 2007). Such feelings and responses are not unique to an individual's personal network and have also been identified among healthcare workers.

Clinician attitudes, feelings, beliefs and responses toward individuals who have engaged in RSA have been described as less empathic or compassionate due to the belief that time could be better spent on a more legitimate or "real problem" (Bergmans, Spence, Strike et al., 2009). Clinicians are reported to perceive themselves as unable to "cure", and/or are unable to understand why someone would want to end their life (Cutcliffe & Barker 2002; McElroy & Sheppard, 1995; Spence et al., 2008; Wallin & Runeson, 2003). Beliefs that the suicide attempt was manipulative, a communication of hostility, or an attempt to influence others (Schnyder, Valach, Bischel & Michel, 1999) or a "call for help" (Gratton, 2004) can serve to perpetuate stereotypes and stigmatization through the use of such derogatory terms as "frequent flyers" or "attention seekers". Clinicians have been noted to potentially feel as helpless and distressed as the person who has repeatedly attempted to end their life (Cureton & Clemens, 2015; Bohan & Doyle, 2008). Repeated presentations or crises are antithetical to those who enter into the caregiving professions with the intention of being helpful, and repeated presentations are perceived to be an indication that no matter what is being offered, clinicians have not been successful at their jobs (Bergmans et al., 2009). Such feelings, perceptions and attitudes toward individuals with RSA can contribute to behaviours that include less documentation regarding medical lethality, fewer psychosocial assessments, little inquiry into the person's attitude to suicide

or recent planning of the attempt, or a lack of referral to mental health services (Da Cruz et al., 2011; Jo et al., 2011; Kapur et al., 2004; Miret, et al., 2010).

The emotional impact, attitudes and beliefs that are manifested in responses to the individual with RSA can significantly contribute to already existing shame and/or demoralization, serving to negatively impact the course of current or future engagement in healthcare and treatment interventions (Verway et al., 2010; Wiklander, Samuelsson & Åsberg, 2003; Samuelsson, Wilklander, Åsberg & Saveman, 2000). The stigmas of mental illness and attempted suicide can “leave people on their own” (Alexander, Haughland, Ashenden, Knight & Brown, 2009) increasing the suicide risk factors of isolation and perception of burdensomeness (Joiner, 2005) for individuals with RSA.

#### ***2.4 Treatment Interventions for Suicidality***

To date interventions for suicidality have been developed across the spectrum of ideation to attempts, some differentiating self-injury from suicide attempts, others based on specific diagnoses, and each focusing on different targeted outcomes such as reducing symptoms, risk factors, or self-harming behaviours (Brent et al., 2009; Cuijpers et al., 2013; Harned et al., 2009; Lakeman & Fitzgerald, 2008; Lakeman, 2010; Leitner, Barr & Hobby, 2008; Sledge et al., 2014; Ward-Ciesielski & Linehan, 2014). Interventions for suicidality have included outpatient, Emergency Department (ED) and inpatient hospitalization. ED interventions holding promise include referral to specialized aftercare by ED staff (Kapur, et al. 2004) and Safety Planning targeting engagement and suicide attempts (Stanley & Brown, 2012). At face value, intervention comprised of hospitalization has been seen to be ineffective (Ward-Ciesielski & Linehan, 2014) yet the

alternatives to ameliorating risk for RSA in acute or crisis situations through least restrictive care (SPRC, 2015) such as the respite centre Maytree in the UK (Briggs, Webb, Buhaglar & Braun, 2007) seem limited in most jurisdictions. Stepped care for the suicidal person moving from the least intrusive such as crisis line support to inpatient hospitalization (Suicide Prevention Resource Centre, 2015) has been suggested. Hospitalization has been identified as having both advantages and disadvantages. It can be seen as a “critical incident” whereby coming into hospital and receiving care can be life-saving (Samuelsson et al. 2000; p. 640) as a step toward living or conversely, it can generate shame and embarrassment. Being cared for by the same team may exacerbate perceived burdensomeness (Joiner, 2005) with the patient wishing to leave care arising from the belief that clinicians will be disappointed in them. This may escalate the potential for another attempt (Carlén & Bengtsson, 2007; Samuelsson et al., 2000).

RCT’s investigating promising treatments suggesting a reduced rate in repetition of suicidal behaviours include interventions with a problem solving focus, Dialectical Behavior Therapy (DBT), Cognitive Behavioral Therapy (CBT), home visits attempting to actively address issues of non-compliance, maintaining non-demanding contact with high risk individuals, and pharmacotherapy (Comtois, 2002; Stanley et al., 2009; Ward-Ciesielski & Linehan 2014). Further studies reporting changes in RSA include: General Psychiatric Management (McMain et al., 2009; McMain, Guimond, Streiner & Links, 2012); psychoeducation (Kudo et al., 2010) combined with brief counselling (Pan et al. 2013); mindfulness (Luoma & Villatte, 2012); telephone contact (Vaiva et al., 2006); post-hospital follow-up contact (Bertolote et al., 2010; Comtois, 2013; Fleischmann, et al., 2008; Luxton, June, Inagaki, Kawashima & Kawanishi, 2015); psychosocial intervention



(Erlangsen et al., 2015); or, a combination of interventions (Hatcher et al., 2015; van der Sande et al., 1997).

The discussion that follows, reviews the dominant treatment interventions where suicidality was identified as a focus, targeting a broad range of suicidality presentations, which include ideation, single attempts and RSA. Interventions can take the form of individual or group therapies, with some models incorporating both. With the exception of SfSL/PISA (Bergmans & Links, 2002), no other intervention, in the published literature, specifically targets the higher risk group of people with RSA.

### ***2.5 Theoretical Orientations of Suicidality in Psychotherapy Interventions***

There are a range of theoretical perspectives on suicidality spanning different theoretical orientations, each of which proposes particular intervention approaches and strategies. Interventions, some more dominant than others, address suicidality in the context of a specific diagnosis and others will target identified deficit areas such as problem solving or interpersonal relationships.

Discussing suicidality in the context of Borderline Personality Disorder (BPD), and transferability across the biopsychosocial understandings, Sledge and colleagues (2014) state that interventions for suicidality have a theoretical ideology based on behavioural or psychoanalytic theory. Behavioural therapies focus intervention on ‘rectifying deficits in skills or capacities needed to tolerate intense affects and distortions in thinking’ (p.2) and include Dialectical Behaviour Therapy (DBT) and Schema Therapy (ST). DBT focuses on the role of emotional dysregulation and impulsivity in suicide by taking a dialectical stance of validating the experience of the individual and skill training

in the areas of distress tolerance, emotion regulation, interpersonal effectiveness and mindfulness. Within this framework, non-lethal, self-destructive and suicidal behavior with intent is seen to be on a continuum thus the intervention does not differentiate NSSI from SA or RSA. The focus in ST is on decreasing risk through challenging negative thoughts and beliefs a person has about themselves through behavioural experiments and cognitive techniques while using the therapeutic relationship to improve the person's capacity to attach to others. Psychodynamic Therapies, Mentalization Based Therapy (MBT) and Transference Focused Psychotherapy (TFP) theorize suicide as being substantially related to unconscious mental processes driving intense and unbearable affects. Underpinning MBT is an attachment perspective, with the goal of intervention to improve the person's ability to 'mentalize', focusing on what someone believes about a relationship (Sledge et al. p.2) through the provision of different perspectives to the client. TFP uses a psychodynamic object-relations perspective, with a focus on the internal representations of self and other, and the affects that link them as a way of understanding the person's' subjective and interpersonal experience. Suicide attempts are theorized to be related to distorted images of oneself and others. TFP explores these representations and affect states as they relate to suicide; the focus is to gain awareness of the experience of self in relation to other that could motivate suicidal urges. General Psychiatric Management (GPM), more recently renamed "Good Psychiatric Management" (Links, Ross & Gunderson, 2015), an integrated psychotherapy that includes both psychodynamic and behavioural concepts stems from the understanding that suicidality for persons with BPD is based on interpersonal hypersensitivity. The intervention goals are to learn to control suicidality and/or emotions with a focus on lethal versus non-lethal intent. Sledge

and colleagues (2014) suggest that, “there is a clear agnostic sense that theory is relatively unimportant compared to pragmatic engagement of the issues” (P. 3), suggesting a transtheoretical framework in the GPM intervention for BPD. RSA is not differentiated in the above interventions and it is unknown if the underlying assumption is that anyone with RSA has BPD, given its centrality to the diagnosis (Koehne & Sands, 2008). If so, it could potentially limit access and availability to intervention based on the stigma associated with the disorder (Aviram, Brodsky & Stanley 2006; Hersh, 2008; Horn, Johnstone & Brooke, 2007; Koehne & Sands, 2008; Lenzenweger & Cicchetti 2005; Lequesne & Hersh, 2004; Rusch et al., 2008).

Without diagnostic specificity, cognitive behavioural approaches and cognitive restructuring have been suggested as most suitable interventions to ameliorate the cognitive distortions associated with perceived burdensomeness, disconnection and isolation from others (Anestis, 2009; Joiner, 2005). Seen as a promising intervention for suicidality, the goal of Cognitive Behavior Therapy for Suicide Prevention (CT-SP) is to develop cognitive, behavioral and interactional skills to enable the individual to refrain from suicidal behavior (Ghahramanlou-Holloway, Neely & Tucker, 2014). This intervention however, excludes those with RSA as they are seen as a different subset by virtue of a multitude of psychiatric and environmental problems (Stanley et al., 2009).

Person-Centered Psychotherapy (Leenaars, 2004) and the Collaborative Assessment and Management of Suicidality (CAMS) (Jobes, 2009) advocate for a person-centered approach versus a mental disorder focused therapy directly addressing suicidality regardless of theoretical orientation (Jobes, 2009; Leenaars, 2004). Within this framework, Leenaars

(2009) advocates for multi-modal interventions that are long-term being “critical” (p.223) whereas CAMS is problem-focused and short term (Jobes, 2012).

A systematic review of 22 randomized controlled trial (RCT) interventions reported that intervention effectiveness for suicidality is unknown for the majority of interventions targeting suicidality (Soomro & Kakhi, 2015). More recently, Hawton and colleagues (2016) studied the effects of specific psychosocial treatments versus treatment as usual, enhanced usual care or other forms of psychological therapy, in adults following DSH. In this Cochrane review, the authors reviewed 55 RCT trials with a total of 17, 699 participants and concluded that the quality of research evidence for psychosocial interventions ranged between moderate and low or results were inconclusive. Further reviews of pharmacotherapy (Kumpula & De Leo, 2012), psychodynamically informed interventions for people with RSA (Links, Bergmans & Cook, 2003), interventions focused on suicide and specific diagnoses (Cuijpers et al., 2013; Harned et al., 2009; Hirji, Wilson, Yacoub & Bhuija, 2014) report that a reduction in RSA through the noted interventions cannot be firmly established. Challenges in the intervention research for suicidal behaviour are identified as having a plethora of methodological weaknesses that “cast doubt in nearly every trial” (Ward-Ciesielski & Linehan, 2014, p. 381) congruent with the observation that, “there are more promises than accomplishments” (Bertolote, 2014). Consideration of the outcomes or goal of intervention such as seeking to eliminate suicidality versus being able to manage suicidality need to be taken into account if intervention studies are to be compared. As a research strategy, using intermediate proxy outcome measures such as depression or hopelessness that are broader than suicide attempts or DBS has been suggested (Pitman, 2007).

The study and implementation of effective interventions for suicidality seem equally as complex as the behavior itself and the lasting long-term effects of current intervention on RSA remains unknown (Inagaki et al., 2015). The components of therapy that are of particular value, or rationales for combining therapies have not been well articulated nor are they well understood (Spirito, Esposito-Smythers, Wolff & Uhl, 2011) making it difficult to ascertain if effects are due to single or multiple components of any intervention (Daigle, Pouliot, Chagnon, Greefield & Mishara, 2011; Leitner et al., 2008). The foci of the above interventions are on relationships (Sledge et al., 2014), cognitions and behavior (Brown et al., 2005), pharmacotherapy (Comtois, 2002; Stanley et al., 2009) or a particular deficit focus such as problem-solving and tolerating intense affects, often in relationship to a particular diagnoses (e.g. BPD-Linehan; Armstrong, Suarez, Allmann & Heard, 1991; Linehan, 1993; Depression – Stanley et al., 2009). None spoke directly to what is identified as common across all theoretical understandings of suicidality, the core of emotional pain (Sledge et al., 2014), or “psychache” (Shneidman, 1993) the unbearable and unresolved psychological pain a person experiences that is theorized to emerge from unmet psychological needs and, when unresolved results in suicidal behavior (Sperber and Sperber, 2011).

Joiner’s Interpersonal Theory of Suicide (2005) suggests that a suicide attempt will result from the intersection of a perceived sense of burdensomeness whereby the individual feels they are a burden on others; low sense of belongingness and isolation where the individual feels alienated or that they do not belong; and an acquired capacity where the individual develops a decreased fear of death through increased experiences with painful and provocative events. O’Connor and Nock (2014) report that within the

psychologically based Integrated Motivational-Volitional Theory of Suicide (IMV), suicide is viewed as a behaviour rather than a byproduct of a mental disorder. The behaviour is hypothesized to arise out of two phases: motivational and volitional. The premise of IMV is that defeat and entrapment are the motivations to suicidal ideation and intent. Factors that determine if a person will attempt suicide or not are housed within the volitional phase. Furthering Joiner's concept of acquired capability, IMV hypothesizes that there exists a wider array of factors that increase the likelihood of an attempt, including access to means, impulsivity and exposure to the suicidal behaviour of others (O'Connor, 2011). Combining both of these theoretical frameworks, Klonsky and May (2015) developed the three-step theory (3ST) utilizing the ideation-to-action framework (Klonsky and May, 2014) to assist in improving understanding and prediction of suicidal behaviour. The key constructs of this theory include pain and hopelessness, connectedness, and suicide capacity. Ideation is believed to emanate from pain regardless of its source, physical, emotional or psychological, thus incorporating previous theories to better understand suicidality. The authors propose that pain needs to be accompanied by hopelessness, the perception that the pain will never improve, in order for ideation to emerge. The second step in the evolution toward a suicide attempt is when pain supersedes a sense of connectedness whether that connection is with people, interests, purpose or any sense of meaning that connects a person to living. Operating differently from Joiner's conceptualization of perceived burdensomeness and belongingness, which are thought to directly cause suicidal ideation, connectedness in 3ST is said to protect against a rise in suicidal ideation for those who experience pain and hopelessness. The third step leading to an attempt in this theory broadens Joiner's factor of acquired capability to include three

variables that contribute to acquired capability: disposition, acquired and practical. Disposition includes variables that an individual may be born with such as pain tolerance. Acquired, similar to Joiner, refers to habituation through experiences associated with pain, such as death, which can lead to a higher capacity for a suicide attempt. Practical variables are those that make it possible for an attempt to occur including access to and knowledge of lethal means.

Advances in theory development beyond risk factors are exciting in terms of broadening understanding of suicidality and potentially developing effective interventions. The identification of future suicide attempts continue to be seen as highly complex and recent theory development has not yet identified factors that can be associated with RSA outside of an acknowledgement that there may be important differences in clinical presentations and motivations amongst other characteristics that differentiate DBS and non-fatal attempts. Therefore, we continue to work with “imperfect knowledge” (White, 2005) when working with RSA.

Despite the methodological challenges, Soomro & Kakhi (2015) offer that some interventions might work for some people, yet it is undetermined what will work for whom due to the heterogeneity of those who attempt suicide. A focus on the identification of different types of suicidal behavior guiding treatments that are more aligned with underlying biology, causal pathways or unique clinical profiles (Forman et al., 2004; Horesch et al., 2003); making intervention more personalized (Monnin et al., 2012); focusing on suicide coping (Ellis, Allen, Green et al., 2012); incorporating broad-based and multidisciplinary intervention (Mechri et al., 2005) have all been suggested.

## ***2.6 Elements of effective treatment for suicidality***

Primarily from a cognitive behavioral perspective, the common elements found in “...a handful” of effective treatments for suicidality (Rudd, 2014, p. 334) include: (a) a well-articulated and defined, understandable theoretical model that arises out of empirical evidence that is easily understood by participants and explains suicidal behavior and hopelessness; (b) a focus on treatment compliance in a structured and consistent manner; (c) targeting identifiable skills in the areas of emotion regulation, anger management, problem solving, cognitive thinking errors and interpersonal relationships; (d) clients taking personal responsibility for growing awareness and control for their treatment and safety; (e) guaranteeing easy access to crisis and emergency services with an understanding of what constitutes a crisis for an individual and an action plan for dealing with such instances; (f) consistent documentation of what happens in treatment with the recognition that when distressed, cognitive processes may be impaired. Models included the common elements of identifying cognitions, emotional processing and behavioural responses in relation to understanding the motivation to die and the associated distress symptoms therein.

Similarly, Sledge and colleagues (2014) report 5 consistent factors considered necessary for working with the population with BPD: (a) negotiating a treatment frame; (b) recognizing and insisting on the participant’s responsibility in the therapy; (c) providing the therapist with a conceptual framework for understanding and intervening; (d) using the therapeutic relationship to engage and address suicide actively and explicitly; (e) prioritizing suicide as a topic to be addressed when it emerges and (f) provision of support for the therapist.



Recent studies using qualitative methods, without a focus on RSA, have begun to shed light on the components of moving away from suicidality from the perspective of those with lived experience. Transition indicates a movement or change away from suicidality and has been reported as “healing” (Paproski, 1997; Hoover & Paulson, 1999; Talseth, Lindseth, Jacobsson et al., 1999; Bostik & Everall, 2007; Sun & Long, 2013), “recovery” (Han, Chou, Liu, Rong, & Shiau, 2014) and “resiliency” (Fergusson, Beautrais & Horwood, 2003). Key elements identified as influencing the move away from suicidality speak to a necessity for intervention to take into account the individual’s understanding of their attempts (Leitner et al., 2008), the person’s perceptions of themselves in the world, their future and their relationships to others (Paproski, 1997; Bennett, Coggan, & Adams, 2002; Taylor, 2002; Everall et al. 2006; Bostik & Everall 2007; Han et al., 2014), access to people who are available, supportive and nonjudgmental (Bennet et al., 2002; Leitner et al., 2008) and providing skill development in the areas of understanding emotions and problem solving (Bennet et al., 2002; Han et al., 2014). These themes suggest the essence of intervention goes beyond attenuating risk factors, pharmacotherapy and instrumental care to include collaboration, respect, individualized approaches, and an inherent belief in the value of the person who is suicidal (Cutcliffe, Stevenson, Jackson et al., 2006; Gordon, Stevenson & Cutcliffe, 2014) where the pain has been acknowledged and validated (Gordon et al., 2014; Samuelsson et al., 2000; Sun, Long & Tsao, 2014; Talseth, 1999). Chapter 8 will comment on the components SfSL/PISA as they relate to the above intervention criteria.

## **2.7 Summary**

Despite those with RSA being hypothesized as a distinct subset within the continuum of suicidality, research has provided little guidance for treatment intervention for this high risk group. A review of the published literature suggests that interventions for suicidality are fragmented emphasizing different foci across the known biopsychosocial spectrum of risk factors, divergent in their theoretical underpinnings and goals with an emphasis on cognitive and behavioural frameworks. Little specific attention is given to those with RSA, subsuming this group of high service users into interventions for those with or without intent to die, and with SA. This research project addresses some of these gaps by a) evaluating the efficacy of SfSL/PISA, an intervention specific to and for those with RSA outlined in the following chapter b) elucidating the process of transitioning away from RSA for young adults who have completed SfSL/PISA; and c) illuminating the lived experience of living between life and death in the context of RSA for adults over the age of 25 years.

## **Chapter 3: Skills for Safer Living: A Psychosocial/Psychoeducational Intervention for People with Recurrent Suicide Attempts: Background and Development**

### ***Introduction to Chapter 3***

This chapter describes the SfSI/PISA intervention, its roots and the key components published as: Bergmans, Y., Koorn, K., Eynan, R. & Pacey C. (2014) Creating and Intervention for People with Recurrent Suicide Attempts. In, Cutcliffe, J. R. Santos, J., Links, P.S. Zaheer, J., Harder, H., Campbell, F., McCormick, R., Harder, K., Bergmans, Y., and Eynan, R. (Eds.) (2014). *International Handbook of Clinical Suicide Research*. London and New York. Routledge:Taylor & Francis Group. Chapter 18.

Reference to part two of this chapter, Chapter 19, in the first paragraph of the published work, is presented as chapter 5 of this thesis.

## **CREATING AN INTERVENTION FOR PEOPLE WITH RECURRENT SUICIDE ATTEMPTS**

Yvonne Bergmans, Keehan Koorn, Rahel Eynan and Colleen Pacey

### **Introduction**

What follows is a two section submission; the first is the background story to the development of the Psychosocial/Psychoeducational Intervention for People with Recurrent Suicide Attempts (P.I.S.A) [Also known in some locations as Skills for Safer Living (SFSL)] and part two (Chapter 19) focuses on the results of the group intervention to date. Accordingly, this chapter will provide the reader with an introduction to the development of the SFSL/PISA. It begins with the identified need, followed by attitudes

and assumptions of the person working with this group. Finally, the last section articulates the basics of structure, inclusion and assessment. To date the intervention has been delivered at 4 sites in Ireland, 3 community sites in Southern Ontario, and at 2 outpatient hospital sites in Toronto, Canada.

### **The need for the intervention**

Suicide and self-injury create significant health care costs in Canada and the US. It is estimated that for every suicide in the United States, there are 22 emergency department (ED) visits and 5 hospitalizations for suicide-related behaviors (<http://mentalhealth.samhsa.gov/publications/allpubs/SMA01-3517/ch7.asp>, Aug. 20, 2009). In Canada, in 2004, suicide and self-harm were the leading cause of injury death overall (28%) and the leading cause (88%) of intentional injury deaths (3,616), hospitalizations (69%), and permanent partial disability (83%). Suicide and self-harm accounted for 9% of all injuries resulting in hospitalization. There were 18,210 hospitalizations and 41,930 non-hospitalization treatments. Intentional self-injuries accounted for 4% of all ED visits due to injuries. For nearly four-thousand (3,879) individuals their self-harm resulted in permanent partial disability and 199 suffered total permanent disability. An analysis of injury costs by intent shows that suicide and self-harm accounted for 12% of total injury costs, 7% of direct injury costs, and 19% of indirect injury costs in Canada in 2004. The direct and indirect costs of suicide and self-harm added to \$2,442 billion. In 2004, suicide and self-harm were among the leading causes of death by injury in Ontario per capita (8.2 per 100,000 population), accounting for 22% of all injury deaths. Ten percent of all hospitalizations were due to injuries as a result of suicide and self-harm: 7,052 individuals required hospital treatment and 16,045 received non-hospital treatment. For over one

thousand individuals (1409) the self-harm behaviour resulted in permanent partial disability and 76 suffered total permanent disability (<http://www.smartrisk.ca/downloads/research/publications/burden/EBI-Em-Final.pdf>, p. 84, Accessed September, 2012). Approximately 16% of those who attempt to end their lives will reattempt suicide within the first year following their first event (Owens, Horrocks, House, 2002; Colman, Yiannakoulis, Schopflocher et al., 2004).

Attempted suicide and death by suicide are also expensive in terms of emotional, physical and psychological costs for everyone involved. A conservative estimate of six individuals being personally affected by each suicide, would translate to close to 2.5 million Canadians being affected annually by suicide and suicide-related behaviours (<http://www.casp-acps.ca/Publications/blueprint%20final%20september.pdf>). In Japan, the direct production loss of bereaved family members who lost a loved one to suicide was estimated at approximately 197 million US Dollars in 2006 alone (Chen, Lee, Chang, & Liaoh, 2009). It remains unknown how many classmates, coworkers, colleagues, immediate and extended family members have been affected by suicide and self-injury, including lost work time, reaching out to social supports, and financial support to their loved one whether before or after a death by suicide.

### **Suicide Intervention Research**

Hjelemand and Knizek (2010) point out that suicidology research tends to fall into three categories: epidemiological, (neuro)biological, and intervention studies, with a primary emphasis on explanations and cause-effect relationships. According to White (2005) we continue to work with “imperfect knowledge”, using current measurement tools that are potentially inadequate for observing and understanding meaningful changes for suicidal

people. We require an understanding that goes beyond our current knowledge of cause-effect explanations so often found in the suicidology literature with its focus on risk factors and warning signs (Hjelemand & Knizek, 2010). Linehan (2008) suggests that treatments targeting suicidal behaviour are more efficacious than those targeting a “presumed underlying disorder” (p.484). Similarly, Leenaars (2004) suggests that psychotherapy for those who have attempted suicide needs to be person-centered therapy not mental disorder centered therapy (p.221), further suggesting that the need for multi-modal, long-term interventions is “critical” (p.223). The research, by and large, shows a large gap in the experience of those who have attempted to end their lives, and/or have repeatedly tried to end their lives. This could then seriously impact how intervention is created, delivered, and/or facilitated.

### **Why focus on people with recurrent suicide attempts?**

Several studies have found that people who made repeated attempts have been identified as:

- having a greater number of DSM-IV axis I diagnoses with an earlier onset of psychiatric disorders,
- elevated levels of suicidal ideation, depression, hopelessness, perceived stress;
- poorer social problem-solving skills;
- a history of childhood maltreatment;
- family histories of suicide attempts and psychiatric illness;
- alcohol and substance abuse issues (Rudd, Joiner, and Rajab, 1996; Forman, Berk, Henriques et al., 2004; Rosenberg, Jankowski, Sengupta et al., 2005).

It is suggested that not only are those who engage in repeated suicide attempts at higher risk for dying, they are also identified as a potentially “unique population” (Gibb, Andover & Miller, 2009) across the illness spectrums as suggested by some of the factors listed above.

### **The background story**

The PISA/SFSL intervention arose from the concerns of mental health department management and staff. The need was to develop a group intervention to try to stem the tides of people with recurrent attempts repeatedly coming to the emergency department (ED). This was evident from the sheer numbers of people who had repeatedly attempted suicide presenting to the ED and the general frustration and helplessness the ED staff felt in trying to deal with repetitive suicide- related behaviours and self-injury (McElroy and Sheppard, 1999; Spence al., 2008; Bergmans, Spence et al., 2009). The aim of the intervention was to address domains the literature identified as challenging: affect, (Linehan, Armstrong, Suarez et al., 1991; Levine, Marziali & Hood, 1997; Dieter et al., 2000), behaviour (Bender, Gordon, Bresin et al., 2011), and cognition (Marzuk, Hartman, Leon et al., 2005; Pitman, 2007). Affective challenges included managing emotional dysregulation, and addressing observed deficits in emotional literacy including naming and describing emotions. Behavioural challenges included impulsivity preventing individuals from keeping themselves safer while experiencing crises. Finally, cognitive challenges were in the area of problem solving, particularly while experiencing emotional crises. The aim of the intervention was to enhance awareness and skills levels in the areas of affect, behaviour and cognition so individuals could keep themselves safer.

### **The goal**

The goal of this intervention is not to cure people, or to have them expect to never have a suicidal thought or attempt again. We cannot make suicidal thinking go away, however, we can identify skills and strategies to help steer the behaviour away from acting unsafely and towards acting more safely. The goal is ultimately to reduce the duration, intensity and frequency of suicide attempts and for the person to recognize their own moments of control and choice to live life as safely as they are able. This goal is grounded in the beliefs that:

- a. by voluntarily coming to group, the person is either curious or un/consciously wants to change;
- b. people want to and have the capacity to make changes;
- c. people don't 'like' being suicidal. Rather, they may not have the skills and/or awareness to know how to live differently.

People want their pain to end, even if just for a moment (Dieter, Nicholls, Pearlman, 2000) and in moments of no or less distress, they are capable of learning new skills that will help them to tolerate and/or ease their pain in moments of increased vulnerability and fragility.

**Stepping stones to creating an intervention: attitudes and assumptions on the part of the professional.**

Multiple attitudes and lessons have been taken into consideration when moving toward creating an intervention and these have been characterized as:

- Keeping it real
- The three Cs.

***The cloak of professionalism: keeping it real***



Paying attention to one's own strengths and challenges as a therapist is an ongoing process that requires vigilance and continuous reflection in order to be effective in the work. Ultimately, we want to work from our surplus and not our core (see the reply to article, Aksunai, n.d.). At the end of the day, or week, our work needs to be invigorating and energizing to our souls. This is not to deny that there will be times when we feel exhausted and spent, yet, can we still say, "even in my tired state, I like what I'm doing and want to get up in the morning and go to work?" It is our responsibility to identify when we are no longer able to inherently identify that we like the work we do. The assumption here is that without passion, interest, flexibility, curiosity, and openness, we may be merely delivering rather than participating and engaging in the intervention. If as professionals we are not participating and enjoying what we're doing, there is a high potential for not being genuinely engaged with the "self", the participants or the intervention. It is not a crime, and more likely a credit, to identify that a particular intervention or population is not within the realm of one's interest or skill set. While skills can be learned, an inherent interest and genuine engagement or, as Minkoff (2012) suggests, attachment to the intervention one is doing requires more than learning the cookbook of intervention skills.

We are socialized into our professions and the question arises, "Who am I as a professional and as a person? What does it mean to act or be a professional?" When I find myself donning the "professional cloak", it usually represents a feeling of the need to protect myself from a perceived feeling of vulnerability or fragility. If I observe and reflect on myself in this position, I realize that I am removed from the people I am working with and for. There is an invisible barrier whereby I am not engaged as myself, rather, I have chosen to engage with people from a completely rational, cognitive place. I

am protecting my emotional vulnerability. I am only partially present. By remaining curious, empathic, respectful, ethical, and working with integrity, I can be myself and work in a professional setting. It is not an either/or, rather, it is an “and”. I can say “I don’t know.” I can feel unsure or overwhelmed and ask colleagues for support. In remaining in and practicing this stance, you don’t have to be the “hero” struggling alone in the dark alone with a person whom you are really worried about or feel helpless around. It is therapeutically helpful to say “I’m sorry” if you have said or done something wrong in the therapeutic setting. Furthermore, using the words of Barbara Coloroso (1994): “Mean what you say, say what you mean and do what you say you’re going to do” have been instrumental in providing clear, consistent and caring language both with colleagues and participants.

Ultimately, for some people, it is the relationship with the clinician and/or group that keeps them alive (Linehan, 1993, p.6). Yalom and Leszcz (2005) remind us that, “The basic posture of the therapist to a participant must be one of concern, acceptance, genuineness, empathy. *Nothing, no technical consideration, takes precedence over this attitude*” (p.117, original emphasis).

### **The three Cs**

In working with people who have had recurrent suicide attempts, it needs to be recognized that as clinicians, we are working with imperfect knowledge (White, 2005), and as such, there needs to be an acknowledgement that some people may die by suicide. We do not have the power to “make” them want to live nor to stop their attempt(s) to end their lives. Our assumption that participants have the capacity to engage in the 3 C’s: competency, control and choice, can be challenged by a loss to suicide. Alternatively, clinicians may

feel like the only hope that exists is what they themselves are holding on behalf of the person. Oftentimes the capacity within the person is hidden. As such, the skills need to be taught with the recognition that in times of crises, as one person stated, “ya gotta know that when the emotions go up there, the brain got left behind a long time ago!” (participant in Group 5, see Chapter 20). The greatest professional challenge I have experienced has been to titrate my hope. To be too hopeful for a person who is in the pit of despair runs the risk of the person feeling invalidated or not understood. It is dissonant to their internal experience. Sometimes when a person identifies that they have lost or are losing hope, our response will be “We (I) will carry the hope until such time as you are able to carry it for yourself.”

### *Learning from the experts*

Our greatest teachers are our participants, colleagues, and mentors. We are the professionals and participants are the experts in their experience; when we come together, we are both learners and teachers of, and to one another. I cannot assume to know what is right for a particular person or what will or won't work. It is my role to walk with them on their journey, not to “make” them live or “make” them better. As a learner, I take what the person has to teach me seriously. I am an accompanier who sometimes has to take the lead and at other times has to follow or walk alongside. It is my responsibility to ask questions in order to find the balance of what is called for, when, with a particular person with respect to the level of involvement and direction the person would like to take, to remain as safe as possible. It has become a rare occurrence when I think and actively take any control away from the person in order to fulfill my professional and ethical duties

regarding the risk of imminent harm that someone could inflict upon themselves. The interaction and intervention are interdependent where we come together as ‘we’.

***How we view the person: stigma or strength?***

Too often the people whom we work with are put in the position of “other.” Some are more stigmatized than others by virtue of their diagnoses, behaviours, or in some cases our transference/countertransference to the situation, person or issues. Often working under the medical model lens, the deficit is the focus while paying minimal or no attention to the competency inherent in survival to this point in people’s lives. Working with people who have attempted to end their lives can arouse our greatest fears and, for others, personal stories and experiences may engender questions about choices to live or die, seeing the act of suicide as a right or wrong. As facilitators paying attention to the language we use when speaking about the person with colleagues may provide us with clues...is the person referred to as “just a (name diagnosis/cutter etc.)”?; is hearing their name met with “Ughhh! Not her/him again!” These attitudes and responses place the person or population in the position of “less than” or “less able than”. Consider a night of no sleep, multiple personal issues piling up in a single month, improper eating or lack of exercise and an under-resourced workplace. As professionals, our human needs and pressures can slowly tap at the shield of ‘professional’, perhaps leaving us feeling less tolerant, de-skilled, exhausted, vulnerable and not as fully engaged as we would like to be. Hence, it is safer, easier or even a survival strategy to widen the gap between us and them. It does not mean we are less capable, it means we are run down, exhausted, frustrated etc. Some professionals may become depressed and need “professional help.” This is a reminder that we are square in the middle of being human and “not less than.” Our participants are

human and experience times of despair in a way that some of us might never experience. They have endured, survived and are able to tell their stories, and agree to work as hard as they can to try and help themselves. The motivation to try to live life more safely is a testament to their inner courage, strength and capacity. In remaining accountable to each other, facilitators and participants are challenged and invited to hold no judgments of right or wrong regarding the choices that have been made to survive. The bottom lines of the intervention are to connect the participant to having the choices to make the decision to live and, create a space and place where they will be accepted as human with full regard and respect for who they are as a human being.

***The intervention: deliver vs. participate and facilitate***

As facilitators, we do not ‘deliver’ an intervention. We participate in and facilitate a group intervention. It is a process in which we are working out, together, what will be most relevant and related to the experiences of participants. At the initial start of providing this group intervention, I was encouraged to use an already existing protocol. I found was not my language, not me being authentic. It was the delivery of “a program.” Our first participants took their roles as learners and teachers seriously. They let us know “This isn’t working for us!” Together we began to co-create an intervention that they could relate to with skills they found they needed, that the literature supported, and that we could manage. After 14 years of providing the program to 60+ groups, we continue to co-create each group with the people in the room. Their experiences, skills, insights, and previous learning are all added to the foundational content to make it “their group.” Over the years, materials have been re-written to have more meaning for the population as a whole,

handouts have been tweaked, new material has been brought in by participants and added to the guide, and some materials have been discarded.

It is a blend of process and content with the latter being quite fluid in the placement of its delivery based on the needs and issues raised by participants at their check in where we discuss “skills used, challenges, and ‘aha’ moments” since we last met. Content from our guide’s first module is generally covered as a base in the first month and from then on, content is delivered as it arises. Homework is offered as an invitation to consider, reflect upon, try, discuss. This reflects our conscious choice not to participate in the potential power struggle, the residual shame, guilt of ‘feeling like a bad student’ or adding to the unwritten rules or expectations of shoulds of authority figures. We are dealing with adults, and hence, expect that people will do what has meaning for them and what is reflective of their own process. To decline the invitation is a choice which must be accepted without judgment.

### **The Team**

The interprofessional team is the “juice” that keeps facilitators fuelled and accountable. Working with people from different professional backgrounds, training, skills, gender, cultural backgrounds is an enormous benefit to doing this work. I can’t expect myself to know everything, nor to have the most up-to-date training in the most recent efficacious treatment protocols. However, usually someone else on the team does, and it’s often the students from varying professions who are an integral part of the team.

To do this group, two facilitators are the minimum. To do it by yourself is extremely challenging and nerve-wracking, and if one member is particularly fragile on a

given day, it is sometimes frightening. It can be done; however, don't expect to be able to do a lot of intensive work for the rest of the day.

We meet prior to group for 15 minutes to go over anything that has come up for participants during the week, and to check in with one another in terms of energy. The time is also used to strategize who might be best able to respond to a particular person due to an alliance or skill that others on the team might feel they don't have. Finally, the pre-group meeting is used to discuss topics to address from the previous week or content we would like to introduce.

Integral to the team, at this stage in our development is the volunteer peer facilitator. The peer facilitator is an individual who has participated in two groups, taken a year away from the group to integrate what was learned in their daily lives, and is still participating in their own therapy. We have found that on some occasions, it is the peer facilitator who carries more credibility than the professionals, as it is they who can oftentimes say things to a participant that are more easily received than if said by a 'professional'. We have recently added four groups per year in a community outside of the large metropolitan city and renamed the intervention to "Skills for Safer Living" to provide a more accurate description for community members what the intervention is about. The facilitation team consists of a mental health professional working for a community mental health organization, a hired person with lived experience regarding suicide attempts, and a hired peer who is 'learning' the intervention; the latter two work for a peer support-run organization for people with lived experience of mental illness. It has been noted that peer facilitators who did not disclose previous suicide attempts to the

group have, to date, tended to focus more on the content pieces/modules rather than the process.

After each group session the team meets to debrief, discuss potential content for the following week and air any concerns they may have about particular group member(s). It is decided at this time who will contact group members who were absent from the session without notice or follow up if there were any concerns regarding a particular individual. All of the facilitators meet with a co-supervisor on a weekly basis for one hour of supervision. To date, this has been a psychiatric consultant who is not a facilitator in order to: (1) provide an 'outsider' perspective; (2) assist in the discussions of transference/counter-transference; (3) provide a psychiatric perspective regarding clinical issues that may be interfering or contributing to a person's progress or challenges; and (4) pay attention to content 'drift'. The out-of-town groups meet weekly with YB, sometimes accompanied by a psychiatrist via video conference initially made possible by a community granting agency. Groups overseas meet via teleconference with YB every 4-6 weeks.

Overall the team members can expect to devote a minimum of 3 hours per week to the intervention. At the very basic, 15 minutes pre and post group, 1.5 hours in group and 1 hour team supervision on a weekly basis. In some jurisdictions, prior to meeting with the larger supervision group, small teams will meet independently for an hour per week. Being the person responsible for the intervention includes additional time for minutes to be taken, photocopying to be done, checking in with participants who were absent or who were perceived by the team as being at higher risk than usual. Peer facilitators can be



enormously helpful in many of these areas, as well as task sharing amongst team members, providing they have been given the time in their workday.

### **Inclusion criteria**

People who report two or more lifetime attempts are eligible for the intervention. The key is that the person identifies having had attempts. It is not unusual for a professional to comment, “Well, it really wasn’t serious.” The frame of reference is not the externalized, observable ‘seriousness’ of the attempt such as medical/physical results as concurred by a hospitalization or serious medical event rather, it is the person’s unique and experienced emotional/ psychological intent that resulted in a behavioural expression of their wish to die.

People who are experiencing active psychoses; have recently assaulted another person for which charges have been laid; do not have stable housing; are unhoused, are unable to attend group sober; and/or have a high degree of narcissism with paranoia are participants for whom the intervention has not been found to be helpful. Once housing is procured, some level of sobriety is attained, and/or the person with the psychotic episodes are stabilized, people are welcome to re-apply if suicide-related behaviours remain an issue for them.

### **Assessment**

A full assessment is done prior participating in the groups. Basic socio-demographic questions are asked; persons on their networks of support; strengths, hobbies and goals are also included in the assessment. There is a focus on suicide-related behaviour with attention paid to self- injury to determine how the individual understands the similarities and/or differences between the two, if they engage in both. Participants are asked what

dying or ending their lives would do for them; how it might be helpful. This provides an inroad to understanding what meaning suicide has for the person, with example answers being: “to end the pain”; “to end this miserable life”; “to get out of my horrible situation”; “so I won’t have to worry any more”; “it’s the only control I have”; “to give other people some peace because I’m just too much to handle”. With respect to self-injury, the range of responses has included: “to let the bad out”; “to release the pain”; “to get other people to see how bad I feel inside because I have no words”; “to prevent myself from killing myself”; “to punish myself for what’s happened”. It is key to understand the suicide-related behaviors and self-injury from the perspective of the individual. Although participants are asked their diagnoses, the focus of the intervention is on the behaviour. The belief is that the behaviour is a form of communication for which the person has no words available.

Intent to die, beliefs about dying by suicide in the future, worst attempt, hospitalizations, reasons for living, and how a person has managed to remain alive up to this point are all discussed in the assessment. A previous peer facilitator suggested that for those engaging in suicide-related behaviours, intent could be better measured through the awareness or belief that the person thinks (1) they could die; (2) wants to die or (3) will die. This allows for a better understanding of where death lies on the spectrum between life and death. While the majority of individuals identify with “could or want to die”, a minority of individuals identify that they do not wish to die. The person’s present level of commitment to die or live at this time does not impact whether or not they participate in the group.

Socialization in the mental health field may have engendered a medical model lens, or a focus on deficits that need to be fixed. A participant remarked, “Why is it when you guys get us in to treatment you never ask what are the parts about myself that I like. Why does it feel like I’m such a “(bad word)” that everything about me needs to change?” This was a reminder that the assessment needs to include strengths, likes and dislikes, hobbies and friends. If they can’t remember strengths, friends etc. or answer “none” the person will be asked to look backwards, “What were they when you were well?” “What did you used to like to do that you find you don’t do any more?” Strengths are the foundation to re-aquainting the person with their competencies and are articulated and reinforced from the initial meeting through to graduation from the intervention.

#### **Intervention content and process:**

The weekly struggle in many groups has been to find the balance between process and content. The content/skills that are discussed arise out of the check in of skills, challenges and “aha moments” experienced by group members in the past week. The first four sessions rely fairly heavily on introducing the language and basics to keeping oneself as safe as possible and the remaining 16 weeks build from there. There have been some groups which are more concrete and want a “lesson” to be formally introduced each week and others prefer the new skill/concept to arise out of the discussions. To prepare an agenda is helpful for some people. However, sticking to what the facilitators want irrespective of what arises during check in negates the underlying assumption that this is the participants’ group, so changes in focus need to be negotiated with participants. The key we found is that facilitators need to be flexible and know the content so it can be presented when the issue arises. This usually will take two cycles of co-facilitation for it to

feel more natural. Nonetheless, after 60+ groups, even the person who wrote the guide gets “stuck” in not knowing which direction to go next. Interprofessional and peer co-facilitators are key in those moments.

### **Manualization and guides**

There has been a strong push for manualization of interventions over the past decade. This has resulted out of research foci and is an attempt to maintain fidelity and transferability of a particular intervention across locations and sites. Contrary to trends, the PISA/SFSL guide is a guide, not a manual. Each group has its own personality. Each group will bring its own needs, strengths and skills. In this vein, the guide provides the content and skills with the understanding that it remains a living document. The foundational concepts remain consistent, yet the delivery, metaphors, and strategies utilized to explain and ‘teach’ them are permeable and to be used as they pertain to the needs of the group. As noted earlier, metaphors, articles, and stories might change based on the training, experiences, and creative ideas of participants and co-facilitators. A recent example is the use of the words “emotional hangover” the experience of feeling fragile, exhausted and raw after a group session or after an intense emotional experience. A colleague who is an addictions specialist proposed to the supervision team that this might not be the best term to use for those who have experienced substance abuse issues. A week later another member of the supervision team proposed “emotionally sore”, like one would feel in their muscles after a work-out. It’s not a bad thing, it means you’ve had a good workout and now you have to be gentle with the sore areas. It is open discussions like these that keep the intervention living/changing and relevant to the people who are using it and working with it.

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### ***Additional Information on the SfSL/PISA Intervention***

Format: 20 weeks, 1.5 hours weekly, group format

Facilitation Team: Trained interprofessional team members including peer facilitation by peers with lived experience.

Theoretical Foundations:

1. Protective Behaviors – a personal safety program (Flandrau-West, 1989), three key elements that form the basis of the SfSL/PISA Intervention:
  - a. We all have a right to feel safe all the time and a responsibility to ensure others feel safe around us;
  - b. Behaviour is a choice with an effect (consequence). Neither a feeling nor a thought can kill you however, what you choose to do with either could;
  - c. “ A feeling is a feeling, is a feeling. Not good. Not bad. It just is. It’s about being human.”
2. Emotion-Focused Therapy (EFT) (Greenberg, 2000). Emotion is considered to be a primary signaling system communicating intention and regulating interaction, (Greenberg, 1993). The primary purpose of EFT is to enable participants to better identify, experience, explore, story, make sense of, transform and flexibly manage their emotions for the achievement of more satisfying intrapersonal and interpersonal outcome (Angus and Greenberg, 2011). By being better able to access emotions, the meanings of emotions and the information they provide about the person and their environment, participants can become more skillful in using that information to live more safely.
3. Narrative Therapy (Angus and Greenberg, 2011). Narrative work in conjunction with EFT assists the person to construct stories that give a different meaning to their sense of self and the meaning of their emotions.

4. Solution Focused Therapy (SFT) (Fiske, 1998; 2005). Concepts in SFT relevant to the SfSL/PISA intervention include looking for solutions, finding exceptions, having a present and future orientation, and validation of the strengths and challenges a participant experiences. The concept of scaling has been modified for use in conjunction with other concepts in SfSL/PISA including emotions felt, early warning signs, networks and distraction, self-soothing and grounding strategies.

Content of SfSL/PISA Intervention (presented modularly while enacted fluidly)

1. Safety and Personal Rights. Weeks 1-4. This module facilitates the groundwork for the intervention. It includes crisis de-escalation strategies, developing an understanding of social networks, understanding the difference between safe and ‘predictable’ behavior, creating an awareness of early warning signs; and developing a scale of intensity.
2. Emotional Literacy. Weeks 5-10. This module emphasizes the creation, expansion and use of a language for feelings. Premised on emotions being human, participants are encouraged to remove judgments of “good” and “bad” in their experience of emotions. Module content includes learning about unwritten rules and expectations, physical, emotional and psychological self-care, and where appropriate, diagnostic education.
3. Problem-Solving. Weeks 11-15. This module juxtaposes the relationship between emotions, needs and goals alongside developing different strategies for viewing and working toward problem-solving.
4. Interpersonal Relationship. Weeks 16-20. This module emphasizes the need for clear communication, understanding the impact versus the intent of communication,



and managing relationships from a position of emotional, physical, sexual, psychological and spiritual safety.

#### Group Structure

- a. check in – micro check in – name, feeling they are experiencing and ice-breaker; formal check in - focus on skills, challenges or “aha” moments experienced by utilizing the format of feelings, thoughts/choices and behaviours.
- b. New content/concepts delivered through group discussion and/or didactic teaching based on formal check-in which identifies relevant content/concepts and issues for group members.
- c. Closing the session which might include a review of discussion, concepts/content identified in the session or exploring the focus for the upcoming week..

For further information regarding the intervention and training opportunities contact:

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### **Section 3: Research Studies**

#### ***Introduction to section 3***

Section 3 includes 3 published studies and a fourth study, which at the time of submission of this thesis, had been submitted for publication. Chapters 4 and 5 report findings from two quantitative studies examining changes in risk factors in the areas of affect, cognition and impulsivity, which are known areas of deficit for those with RSA. Both studies employed the same pre and post intervention measures. The study outlined in Chapter 5 was conducted several years later and included participants from a community based SfSL/PISA intervention group. An asterisk (\*) next to the BHS scores in table 19.3 indicates a misprint in the calculations at the time of publication.

Chapter 6 presents a qualitative Grounded Theory study with young adults between the ages of 18-25 years, exploring their transition away from RSA. This study was conducted following the quantitative study reported in Chapter 4. Chapter 7 is an Interpretive Phenomenological Analysis (IPA) study exploring the experience of living between life and death in the context of RSA for adults over the age of 25 years, which builds on the findings from the previous qualitative study.

## **Chapter 4: The Pilot Quantitative Study**

### ***Introduction to Chapter 4***

The study reported in this chapter examined whether measures of potential risk factors and areas of deficit associated with RSA showed any pre-post changes among participants of the SfSL/PISA intervention. The chapter was published as follows: Bergmans Y. and Links P.S. (2009). Reducing Potential Risk Factors for Suicide-Related Behavior with a Group Intervention for Clients with Recurrent Suicide-Related Behavior. *The Annals of Clinical Psychiatry*. 21(1), February 2009: 11-19. doi 10.1027/0227-5910.30.3.120

### **Reducing Potential Risk Factors for Suicide-Related Behavior with a Group Intervention for Clients with Recurrent Suicide-Related Behavior.**

**BACKGROUND:** This paper reports the results of a pilot study of a 20-week outpatient Psychosocial/Psychoeducational Intervention for Persons with Recurrent Suicide Attempts (PISA) targeting potential risk factors and areas of deficit, including cognitive, affective, and impulsivity known to characterize persons with recurrent suicide-related behavior.

**METHODS:** One hundred sixty-three persons completed the 20-week intervention. Self-report questionnaires related to psychological deficits and risk factors associated with suicide-related behavior were given to participants before and after the intervention. Descriptive and paired t tests were performed using SPSS 15.

**RESULTS:** This pilot study demonstrated that a 20-week group intervention led to significant pregroup and postgroup reductions in the risk factors associated with suicide-related behavior. Risk factors included cognitive factors: Beck Hopelessness Scale ( $P =$

.006), Satisfaction With Life Scale ( $P = .001$ ), Problem Solving Inventory ( $P = .008$ ); affective factors: Beck Depression Inventory ( $P = .018$ ), Toronto Alexithymia Scale ( $P = .001$ ); and impulsivity factors: Barratt Impulsivity Scale ( $P = .034$ ).

**CONCLUSIONS:** Findings in this pilot study suggest that participants in this short-term intervention report changes in identified risk factors and psychological deficits. These modest changes may be an important first step that facilitates persons at high-risk for suicide to access additional mental health services.

**KEYWORDS:** recurrent suicide-related behavior, intervention, deficits, risk factors

## **INTRODUCTION**

In the United Kingdom, persons who have a history of suicide attempts are approximately 66 times more likely to die by suicide than those without previous attempts.<sup>1</sup> In the United States, the estimated ratio of suicide to attempted suicide is 1:8 to 1:25, with a higher ratio for women and youth.<sup>2</sup> Based on the World Health Organization (WHO) statistics for 2000, if 815,000 persons died by suicide, this could potentially mean 6 million suicide attempts worldwide.<sup>3</sup> In the United States, for every suicide there are an estimated 5 hospitalizations and 22 emergency department visits for suicide-related behaviors.<sup>4</sup> This suggests a large financial burden on the health care system, alongside the financial and emotional ramifications to individuals, families, and friends.

Difficulties understanding individuals with recurrent suicide attempts arise from the varying research approaches used to study this population. Studies have varied in their inclusion of patients who are acutely suicidal or who have substance abuse and other comorbidities.<sup>5-7</sup> Personality traits may or may not be investigated, and some studies will focus on particular diagnoses, whereas others will investigate symptoms, with little or no

focus on diagnoses.<sup>8-13</sup> Finally, the definition of repeat suicide attempts or attempts with intent to die vs. self-injury without intent to die is not always delineated.<sup>6,8,14</sup> To date, effective treatments shown to reduce rates of recurrent suicide-related behavior include problem-solving interventions, dialectical behavior therapy, cognitive behavior therapy, home visits to actively address issues of noncompliance, and maintaining non-demanding contact with high-risk individuals.<sup>5,6</sup> Although evidence supports the efficaciousness of some interventions in preventing recurrent suicide-related behavior, there is a lack of evidence for the effectiveness of psycho-social interventions following suicide-related behavior to prevent actual suicides.<sup>5,16-19</sup> A recent review indicated that evidence is “emerging,” based on a limited number of high-quality studies, that restricting access to means, maintaining ongoing contact with suicidal persons, and providing specialist services hold promise for reducing rates of death by suicide. Cognitive behavior therapy for persons with a history of suicidal behavior and dialectical behavior therapy with persons with borderline personality disorder (BPD) were identified as promising for reducing future suicide-related behavior.

For the past 10 years, there has been a call for practical but comprehensive interventions that would target persons with recurrent suicide-related behavior.<sup>20-24</sup> However, as suicidal behavior and suicide are still rare clinical outcome events, even among persons with recurrent suicide-related behavior, establishing treatment efficacy is challenging. Pitman<sup>20</sup> suggested that research utilizing outcome measures that go beyond the outcome of suicide or suicide-related behavior might have more utility. She recommended that intermediate measures that reduce potential risk factors for suicide-

related behavior, such as depression and hopelessness, could be used as feasible yet important proxy outcome measures.

This article reports on the results of a 20-week out-patient intervention, the Psychosocial/Psychoeducational Intervention for Persons with Recurrent Suicide Attempts (PISA), on risk factors and areas of deficit known to characterize persons with recurrent suicide-related behavior.<sup>25</sup> For the purposes of this article, the nomenclature of Silverman et al<sup>15</sup> will be used, with particular focus on suicide-related behavior, defined as “a self-inflicted, potentially injurious behavior for which there is evidence (either explicit or implicit) either that (a) the person wished to use the appearance of intending to kill himself/herself in order to attain some other end; or (b) the person intended at some undetermined or some known degree to kill himself/herself. Suicide-related behaviors can result in no injuries, injuries or death.”<sup>15</sup> They further explain that suicide attempts are defined as “self-inflicted, potentially injurious behavior with a nonfatal outcome for which there is evidence (either explicit or implicit) of intent to die. A suicide attempt may result in no injuries, injuries or death.”<sup>15</sup>

### **Recurrent suicide-related behavior**

Various comorbidities, psychological deficits, and potential risk factors have been identified as characteristic of persons with recurrent suicide-related behavior. Diagnostically, persons with recurrent suicide-related behavior are reported as having a variety of comorbidities that include combinations of depressive illness, substance abuse, BPD, and/or bipolar disorder.<sup>26-28</sup> Women with bulimia nervosa and recurrent suicide-related behavior, when compared with those without suicide-related behavior, had greater lifetime comorbidity, including anxiety disorders, depression, and higher rates of alcohol

dependence.<sup>27</sup> Rudd et al<sup>30</sup> reported that a childhood history of anxiety disorder or major depressive disorder predisposed a person to both later multiple suicide attempts and personality psycho- pathology; further, they noted that for women, exhibiting recurrent suicide attempts was a function of having childhood anxiety disorders, not mood disorders. Forman et al<sup>31</sup> found that multiple suicide attempters vs. single attempters had more severe psychopathology, suicidality, and interpersonal difficulties when assessed following presentation to the emergency department after an attempt. Taken together, these findings indicate that persons with recurrent suicide-related behavior are not characterized by one diagnosis, but moreso by the magnitude and breadth of their psychopathology.

Alongside a complex combination of comorbidities, a variety of psychological deficits and potential risk factors have been identified in persons with recurrent suicide attempts. These include problem-solving deficits, cognitive rigidity, hopelessness, alexithymia, negative self-evaluation, and negative affectivity.<sup>8,32,33</sup> Evidence has indicated that those who experience recurrent suicide-related behaviors and BPD suffer with instability and/or the following: deficits in emotion regulation, decreased levels of emotional awareness, difficulty in problem solving, or difficulties in managing interpersonal relationships.<sup>20,34-37</sup> Current research suggests that neurobiological factors may also contribute to some of the identified deficits and/or psychological factors.<sup>38-40</sup> Given these factors, we specifically chose variables that reflect potential personal risk factors or psychological deficits associated with recurrent suicide-related behavior that purportedly could be changeable as targets for our PISA intervention. The potential risk factors chosen were: affective (alexithymia because of its relationship to emotional

awareness, depression), cognitive (hopelessness, life satisfaction, problem-solving), and impulsivity.

### **A psychosocial/psychoeducational intervention for persons with recurrent suicide attempts**

PISA is a 20-week psychosocial/psychoeducational group intervention program developed for clients with a history of recurrent suicide attempts.<sup>25</sup> (This article provides an outline of the intervention; for a more in-depth discussion, the reader is invited to refer to “A Description of a Psychosocial/Psychoeducational Intervention for Persons with Recurrent Suicide Attempts.”<sup>25</sup>)

The group intervention targets skills or coping strategies to lessen the potential risk factors or psychological deficits associated with recurrent suicide-related behavior. Clients have a lifetime history of 2 or more suicide attempts and are self-referred or referred after a suicide crisis from a variety of in-hospital or community resources. Participation in the group is based on the presence of recurrent suicide attempts as identified by the client and is not based on the presence of a particular psychiatric diagnosis. Clients with active psychotic disorders or a recent history of interpersonal violence are excluded from the program. Clients are expected to have an individual therapist in the community while participating in the group. There are no restrictions regarding whether or not clients participate in other treatment; e.g., entering specific programs for eating disorders or substance abuse.

Clients meet in small groups of 8 to 10 at the hospital, once a week for 1.5 hours for 20 weeks. After attending the 20-week program, clients are presented with a certificate of completion and are offered the option of returning for a second 20-week cycle to help



cement their newly acquired skills. The program has been manualized to guide the work of the group facilitators.

The group is cofacilitated by an interprofessional team and undergraduate, graduate, and postgraduate students from a range of disciplines, including social work, nursing, psychology, and psychiatry. Training for therapists is in situ experiential, with weekly peer supervision of all facilitators by the originator of the intervention and a senior clinician to maintain adherence to the intervention protocol.

When possible, there is also a peer facilitator on the team. The peer facilitator is someone who has completed 2 cycles of the group, is a year away from their last participation, and continues to be in individual therapy. The person must express an interest in peer facilitation and/or facilitators must identify the individual as a potentially strong peer facilitator. Every effort is made to have at least 2 different professions represented on the facilitation team as a way of in situ modeling different approaches to a similar issue.

The intervention program consists of 4 modules of skill development in the areas of identified deficits: emotional literacy, problem solving, crisis management, and interpersonal relationships. Each of the modules contains a number of sub-skills. All modules are based on the belief that clients have the capacity to keep themselves safer when they have the understanding and skills to do so. The responsibility to keep themselves as safe as possible emerges from becoming aware of feelings, having a name for them, and having choices in means and methods to keep themselves safer. For example, the module on emotional literacy includes education regarding the role and function of emotion; developing a language for emotion that is not behavior based; recognizing physical, behavioral, and cognitive early warning signs; developing a scale of intensity; recognizing

the “umbrella of anger”; unwritten rules; and negative self-talk. The skills and concepts emerged over time through literature review, facilitator observation, therapist and client feedback, and client contributions to content. Resources included the Internet, client contributions, popular media, concept or skill handouts developed within a group, and self-help references in related areas, including posttraumatic stress disorder, substance abuse, BPD, and depression. The topics are interchangeable, and the order is meant to vary so that facilitators can address clients’ current needs. Marziali et al<sup>41</sup> found that for any intervention to be successful, therapists need to be flexible, creative, and skillful, as the content of intervention alone may not be sufficient to ensure the success of the treatment.

The PISA intervention embodies the following principles:

1. keeping oneself as safe as possible
2. developing a language to communicate distress in a nonbehavioral manner
3. recognizing that every behavior is a choice and every choice has an effect
4. learning that “a feeling is a feeling, it just is,” removing the judgments of good or bad, expanding one’s emotional vocabulary, and developing choices on how one experiences feelings in a safer manner.

This pilot study specifically addressed whether measures of the cognitive, affective, and impulsivity risk factors for suicide-related behavior were significantly reduced after the PISA intervention in clients with recurrent suicide-related behavior, regardless of diagnosis.

## **METHODS**

### **Participants**

A total of 239 clients participated in the groups (64 men and 175 women). Clients were either self-referred or referred by health care or community caregivers. All participants

were assessed by Y.B. prior to participation in the group. The assessment interview includes social, employment, and education history; family, social, and professional supports; child welfare, forensic, and substance use or treatment histories; suicide and self-injury histories, including the intent and meanings of each; reasons cited for living; previous hospitalizations; previous and current diagnoses; and the client's goals for participation.

The mean age at study entry was 36.2 years ( $SD = 10.83$ ), with the average age between men and women (38.3 vs. 35.3 years) being significantly different ( $F = 4.91$ ;  $P \leq .028$ ). The mean age of onset of suicide-related ideation for the total group was 15.8 years ( $SD = 9.04$ ; range, 2 to 50 years), and the mean age of first recalled suicide-related behavior was 20.35 years ( $SD = 9.93$ ; range, 4 to 52 years). Two hundred (83.7%) participants were single, and 52 (21.8%) were employed either full- or part-time. Seventy-nine participants (33%) had less than a high school education, and 74 (30.9%) had completed university. Ninety-eight (41.0%) lived on their own with no support, and 75 (31.3 %) reported living with family or friends. The others lived in shelters, boarding homes, the street, group homes, or supportive housing units.

Diagnoses were recorded solely based on the clients' self-report at study entry. Clients most often reported multiple psychiatric diagnoses (see Table 1). Depression (66.5%) and BPD (50.6%) were the most frequently self-reported diagnoses.

The study received ethics approval from St. Michael's Hospital Research Ethics Board, and all participants provided signed informed consent. Participants were not financially compensated for participation in the program.

## **Measures**

Since PISA is an evolving pilot project, measures were introduced over a 3-year period, beginning in 2000. As such, the number of subjects differed for each measure. Analysis involved pretesting and posttesting in the areas identified as deficits or risk factors for clients with recurrent suicide-related behavior: cognition, affect, and impulsivity. Participants were given the pregroup measures at the first session, and postgroup measures were given at the second-to-last session. All measures were completed by participants at home and returned the following week. Within the affective, cognitive, and impulsivity domains, the following measures were given.

***Affective.*** The 20-item Toronto Alexithymia Scale (TAS-20) is a self-report questionnaire containing items that are rated on a 5-point Likert-type rating scale from 1 (strongly disagree) to 5 (strongly agree). Total possible scores range from 20 to 100. Of a possible score of 100, a score  $\leq 51$  is considered nonalexithymic; a score of 52 to 60 is considered moderately alexithymic; and a score  $\geq 61$  is considered highly alexithymic. This scale was chosen because the 3 subscales captured concepts relevant to identified deficits in emotional awareness: (1) difficulties identifying feelings, (2) difficulties describing feelings, and (3) externalization of emotion. The TAS-20 has been used in a variety of populations, including psychiatric outpatients, and previous evidence supports the convergent, discriminant, and concurrent validity of the TAS-20.<sup>42,43</sup>

The Beck Depression Inventory (BDI) is a 21-item self-report questionnaire that assesses different aspects of depressive symptomatology.<sup>44</sup> The BDI has demonstrated excellent psychometric characteristics, with a split-half reliability of 0.93, and excellent convergent and predictive validity, e.g., significantly predicting suicide ideation and eventual suicide.<sup>44,45</sup>

**Cognitive.** The Beck Hopelessness Scale (BHS) is a 20-item scale measuring negative attitudes about the future. The scale has been shown to have high internal consistency (Kuder-Richardson-20 coefficient alpha = 0.93) and a relatively high correlation with clinical ratings of hopelessness ( $r = 0.74$ ) in a population of 294 hospitalized patients with recent suicide attempts.<sup>46</sup>

The self-administered 5-item Satisfaction With Life Scale (SWLS) refers to the self-identified cognitive judgmental aspects of general life satisfaction. The SWLS has demonstrated acceptable reliability, with high internal consistency, and test-retest reliability over periods of 2 months ( $r = 0.82$ ) and 4 years ( $r = 0.54$ )<sup>40</sup> respectively. The SWLS has demonstrated convergent and discriminant validity, relating positively with other measures of well-being, relating negatively with measures of distress, and yielding no significant relationship with emotional intensity.<sup>47</sup>

The Problem Solving Inventory (PSI) is a 32-item self-report scale that captures the person's perception of his or her own problem-solving behaviors and attitudes.<sup>48</sup> Joiner et al<sup>49,50</sup> reported test-retest reliabilities from their previous research; coefficient alphas for the total scale were 0.93, and for 3 factor subscales they ranged from 0.76 to 0.87.

**Impulsivity.** The Barratt Impulsivity Scale (BIS) has been classically used in the investigation of impulsive behavior and, in its present format (BIS-11), consists of 30 items divided into 3 subscales. It is useful to identify impulsivity and evaluate the influence of this dimension on client performance without the influence of confounding factors such as anxiety traits.<sup>51</sup>

**Table 1****Participants' self-reported diagnoses at intake**

	<b>Participants N=239</b>
<b>AXIS I</b>	<b>No. (%)*</b>
Depression	159 (66.5)
Bipolar disorder	70 (29.3)
Anxiety/panic	62 (25.9)
Posttraumatic stress disorder	47 (19.6)
Eating disorder	33 (13.8)
Obsessive compulsive disorder	18 (7.5)
Alcohol and/or drug dependence and/or abuse	14 (5.8)
Schizophrenia	13 (5.4)
<b>AXIS II</b>	
Borderline personality disorder	121 (50.6)
Antisocial personality disorder	4 (1.6)
PD-NOS/other PD	23(10.1)
Other	96 (38.4)

PD-NOS: Personality Disorder Not Otherwise Specified. \*Numbers do not total 239 because of multiple responses.

**DATA ANALYSIS**

Data were analyzed using SPSS 15.0 for Windows. The data are presented using descriptive statistics and paired sample t tests. Response rates for completion of pregroup and postgroup measures were as follows: TAS-20, 68.3%; BDI, 62%; BHS, 66.24%; BIS-11, 59.7%; SWLS, 62.4%; and PSI, 73.6%. Missing data were accounted for through individual mean imputation if <10% of the values for a single respondent were missing.<sup>52</sup>

As noted, pregroup and postgroup measures were completed as a portion of the full sample as follows: TAS-20, 77 of 144 (53.4%); SWLS, 69 of 136 (50.7%); BIS, 55 of 110 (50.0%); BDI, 48 of 95 (50.5%); BHS, 55 of 95 (57.8%); and PSI, 42 of 81(51.8%).

## **RESULTS**

Nearly two-thirds (163 [68.2%]) of the participants “graduated” from the 20-week group intervention. Those who graduated had a mean attendance of 76.3% of the scheduled sessions (median, 80; mode, 90; range, 20 to 100). Of those who were early terminators, i.e., those who did not complete the group to graduate, 10 re-enrolled in another group and completed the intervention at a later date. As such, their data were incorporated into the present analysis of completers. Reasons for early termination included: potential problems with readiness for the group (22.8%), extraneous health, treatment, and life issues (53.9%); and no reason given or lost to follow-up (23.7%). Pregroup and postgroup measures and paired t test scores are presented in Tables 2 to 4.

### **Cognitive.**

The overall total and all subscales of the PSI changed significantly from the beginning to the end of the group intervention. This indicates that after 20 weeks, participants subjectively reported that their ability to solve problems became better in terms of problem-solving confidence, approach avoidance, and personal control.

Results of the BHS indicated significant reductions in hopelessness from pregroup to postgroup; however, hopelessness scores remained moderate (range, 9 to 14) from pregroup (M = 12.6; range, 1 to 19) for the total group.

Mean scores on the SLS changed significantly, from pregroup (10.02; range, 5 to 26) to postgroup (12.3; range, 5 to 35).

**Table 2**  
**Preintervention and postintervention scores on cognitive measures**

<b>Measure</b>	<b>Preintervention Score (SD)</b>	<b>Postintervention Score (SD)</b>	<b>P value</b>
Problem Solving Inventory (N = 42)			
Global mean score	134.09 (24.71)	120.99 (27.48)	.008
Problem-Solving Confidence subscale	45.47(10.51)	39.45 (11.54)	.001
Approach-Avoidance subscale	64.54 (12.14)	58.72 (13.80)	.023
Personal Control subscale	25.88 (3.50)	22.45 (5.48)	.006
Beck Hopelessness Scale (N = 55)	14.58 (3.90)	12.55 (5.07)	.006
Satisfaction With Life Scale (N = 69)	10.02 (5.07)	12.30 (7.26)	.001

**Impulsivity.**

A significant difference ( $P = .034$ ) was found in the BIS mean score, which dropped from 77.6 pre-group to 75.0 pos-group ( $SD = 9.01$ ). All subscales in the BIS-11, except the nonplanning subscale, were significantly reduced by the intervention.

**Table 3**  
**Preintervention and postintervention scores on behavioral measures**

<b>Measure</b>	<b>Preintervention Score (SD)</b>	<b>Postintervention Score (SD)</b>	<b>P value</b>
Barratt Impulsivity Scale (N=58)			
Global Mean Score	77.6 (13.38)	75.03 (10.96)	.034



Nonplanning Subscale	30.00 (5.85)	29.83 (4.29)	.769
Motor Impulsivity Subscale	26.77 (5.75)	25.44 (4.87)	.023
Attentional Impulsivity Subscale	17.57 (3.74)	16.6 93.61)	.017

### **Affective.**

The total and all subscales on the TAS-20 showed significant changes by the end of the intervention. The means scores significantly decreased from the pregroup mean of 63.8 (range, 24 to 90) to the postgroup mean of 58.3 (range, 24 to 83). Overall, this indicated a shift from high alexithymia (>60) to moderate alexithymia (range, 52 to 60).

The change in BDI mean scores pregroup (37.3; range, 13 to 40) to postgroup (32.83; range, 1 to 56) indicates a significant reduction in self-reported depression; however, the overall depression scores remained severe (range, 30 to 63).

**Table 4**

<b>Preintervention and postintervention scores on affective measures Measure</b>	<b>Preintervention Score (SD)</b>	<b>Postintervention Score (SD)</b>	<b>P value</b>
Toronto Alexithymia Scale (N = 48)			
Global mean score	63.84 (13.46)	58.38 (13.81)	.01
Difficulties Describing Feelings subscale	24.81 (6.51)	23.27 (6.9)	.024
Difficulties Identifying Feelings subscale	18.17 (4.67)	16.77 (5.03)	.006
Externally Oriented Thinking subscale	20.97 (5.45)	18.67 (4.97)	.001
Beck Depression Inventory (N = 48)	37.30 (10.96)	32.83 (15.17)	.018

## **DISCUSSION**

The results from this pilot study suggested that, overall, for those who completed the 20-week PISA intervention, significant changes in the potential risk factors or deficit areas

characteristic of persons with recurrent suicide-related behavior were demonstrated. Specifically, from pregroup to postgroup, the participants had significantly less depression and hopelessness, reported more general life satisfaction, perceived themselves as better problem solvers, and scored themselves lower on alexithymia. Despite these significant changes, the overall BDI and BHS scores remained in the severe and moderate range, which likely reflected the magnitude of psychopathology that persons with recurrent suicide-related behavior are observed to manifest.<sup>53</sup> Given that the changes were observed within a 20-week period, it is difficult to know if clients continued to make further gains in the longer term. Huband et al,<sup>54</sup> working with individuals with personality disorders, suggested that perhaps it is unrealistic for a 20-week intervention to produce significant and enduring changes for persons with longstanding conditions such as personality disorders. Therefore, the modest changes found in this pilot study were to be anticipated. The PISA intervention might be one of several possible steps toward further reduced risk of suicide in persons with recurrent suicide-related behavior.

The results of this pilot study indicate that persons who participated in the PISA intervention were successful in reducing specific deficits associated with recurrent suicide-related behavior. An earlier qualitative study of men age 18 and older with substance abuse, a history of suicide-related behavior, and severe personality disorders provided some evidence to suggest that participating in the PISA intervention was helpful. These men reported difficulties in accessing mental health services, often reporting negative experiences with mental health providers that resulted in their avoiding health care settings until a crisis arose.<sup>55</sup> They identified a cyclical pattern of fragmented pathways into care, utilizing emergency services for mental health care, and often accessing the service

under strained and involuntary circumstances. They reported that positive interactions—many mentioning the PISA intervention—created a sense of hope for the future and engendered a greater openness to other formal mental health or addiction treatment.<sup>55</sup> The modest effects of this study suggest that PISA might be a first step in engaging persons with recurrent suicide-related behavior to seek ongoing treatment, such as dialectical behavior therapy or rehabilitation for substance disorders.

Another new finding from this pilot study suggests that the TAS-20 is a useful measure of the difficulties with emotional processing that are characteristic of individuals with recurrent suicide-related behavior, and that this measure is able to capture change following a time-limited intervention. The PISA intervention targets emotion-processing difficulties and focuses on teaching emotional literacy, identifying and describing how one is feeling, and learning alternatives to suicide-related behavior in response to emotional distress. Alongside subjective reports that problem solving was better, group participants also changed significantly in terms of their alexithymia scores. Our results showed that with a focus on teaching the language of emotion, alexithymia scores changed significantly. Of the group participants who completed the pregroup and postgroup questionnaires (N = 69), 42 (60.9%) scored in the highly alexithymic range, and 27 (39.1%) scored in the moderate or nonalexithymic range at the start of the intervention. Postgroup, 30 (43.5%) scored in the high range, and 39 (56.5%) scored in the moderate or nonalexithymic range (chi square = 12.28; df = 1; P = .0005). Alexithymia has been associated with several pathologies that are linked to suicidal behavior, e.g., BPD, disordered eating, childhood sexual abuse, panic disorder, and depression.<sup>56-58</sup> It could be suggested that a person who is neither able to identify or describe his or her emotions might be more prone to acting out

distress. Without a language, feelings overwhelm or flood cognitive functions. Izard<sup>59</sup> suggested that in times of emotional flooding, emotion will be the driver taking a “low road,” or noncognitive move to action—a process that occurs within milliseconds. These results suggest that the TAS-20 is a useful measure to capture the emotional-processing deficits found in persons with recurrent suicide-related behavior and, more importantly, the measure may be sensitive to change that results from psychosocial interventions.

As a pilot study, several important limitations of this work need to be acknowledged. First, given limited resources, we were not able to systematically diagnose group participants, and this will be necessary in future research. Second, the sample size is limited and varies from one measure to another. Sample loss was affected by noncompletion of both pregroup and postgroup measures and the staggered introduction of the questionnaires. Failure of participants to respond to items within the measures was also a challenge, consistent with the use of self-report scales.<sup>52</sup> Resource limitations hindered our ability to aggressively pursue data collection of those who did not return measures at the last session of their group. A future controlled trial would assist in addressing the issues of missing data, limited measures, lack of a control group, and lack of outcome data on suicide-related behavior. Finally, if the PISA intervention is to go beyond demonstrating change in the potential risk factors for suicide-related behavior, further research will need to focus on demonstrating the efficacy of PISA in reducing the rate of future suicide-related behavior and indicating that PISA can enhance compliance with longer-term treatment.

## **CONCLUSION**

This pilot study demonstrated that a 20-week group intervention led to significant reductions in the cognitive, affective, and impulsivity deficits and potential risk factors associated with suicide-related behavior. The findings suggest that this short-term intervention may be an important first step in engaging the client to seek longer-term help for problems associated with a high risk for suicide. From the current study, the TAS- 20 appears to be a promising outcome measure of emotional-processing difficulties and is sensitive to change. Future research will include systematic evaluation of the intervention, including formal diagnostic evaluation, longer-term follow-up, and measuring suicide-related behavior as an outcome.

**DISCLOSURES:** The authors report no financial relationship with any company whose products are mentioned in this article or with manufacturers of competing products.

**ACKNOWLEDGEMENTS:** The authors thank Dr. Anne Rhodes for her insightful comments in the preparation of this manuscript.

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© 2009 Hogrefe Publishing DOI 10.1027/0227-5910.30.3.120

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#### ***Overview of Chapter 4***

Results of this study indicated that many participants, while showing significant improvement in the areas measured, remained within the moderate to high end ‘symptom’ score ranges on the cognitive, behavioural and affective scales used. This was incongruent with subjective anecdotal reports from participants and from care-providers, who reported that group attendees were showing improvements in terms of their ability to articulate and manage their distress and in keeping themselves safe. Therefore, in order to gain a more comprehensive understanding of these subtle changes and the factors that prompted or impeded transition, the next study (Chapter 6) aimed to explore this process through qualitative interviews using a Grounded Theory methodological approach.

## **Chapter 5: The Large Scale Quantitative Study**

### ***Introduction to Chapter 5***

This chapter reports on findings from the second quantitative study examining risk factors and areas of deficit for RSA with a larger sample including a community based (non-hospital) sample who had participated in the SfSL/PISA intervention. The aim of the study was to examine if the improvements made in the affective, behavioural and cognitive domains remained consistent 4 years after the pilot study (Chapter 4). The reference for this chapter is as follows: Bergmans, Y. and Eynan, R. (2014). What Changes? What Does it Mean? A Clinical Intervention for People with Recurrent Suicide Attempts in Cutcliffe, J. R. Santos, J., Links, P.S. Zaheer, J., Harder, H., Campbell, F., McCormick, R., Harder, K., Bergmans, Y., and Eynan, R. (Eds.). *International Handbook of Clinical Suicide Research*. London and New York. Routledge: Taylor & Francis Group. Chapter 19.

### **What Changes? What Does it Mean?**

#### **A Clinical Intervention for People with Recurrent Suicide Attempts**

*Yvonne Bergmans and Rahel Eynan*

### **Introduction**

There has been a call for practical and comprehensive interventions that would target persons with recurrent suicide-related behavior (Hawton and Kirk, 1998; Links, 1998; Livesly, 2000; Pitman, 2007): however, as suicidal behavior and suicide are still rare clinical outcome events, establishing treatment efficacy is challenging (Leitner, Barr, & Hobby, 2008). Research utilizing outcome measures that go beyond the outcome of suicide or suicide-related behavior might have more utility, according to Pitman (2007).

She recommended that intermediate measures that reduce potential risk factors for suicide-related behavior, such as depression and hopelessness, could be used as feasible yet important proxy outcome measures.

This chapter reports on the results of a 20-week outpatient intervention, the Psychosocial/Psychoeducational Intervention for Persons with Recurrent Suicide Attempts (PISA), and known in one community as, Skills for Safer Living, on risk factors and areas of deficit known to characterize persons with recurrent suicide-related behavior (Bergmans and Links, 2002; 2009). The nomenclature of Silverman, Berman, Sanddal et al., (2007a; 2007b) will be used throughout this paper, with particular focus on suicide-related behavior, defined as:

*a self-inflicted, potentially injurious behavior for which there is evidence (either explicit or implicit) either that (a) the person wished to use the appearance of intending to kill himself/herself in order to attain some other end; or (b) the person intended at some undetermined or some known degree to kill himself/herself. Suicide-related behaviors can result in no injuries, injuries or death (Silverman et al., 2007a, p. 272).*

The authors further explain that suicide attempts are defined as a “self-inflicted, potentially injurious behavior with a nonfatal outcome for which there is evidence (either explicit or implicit) of intent to die. A suicide attempt may result in no injuries, injuries or death” (Silverman et al., 2007a, p. 273).

### **Recurrent suicide-related behavior**

People with recurrent suicide-related behavior have been reported as having a variety of diagnostic comorbidities that include combinations of depressive illness, substance abuse, bulimia nervosa, anxiety disorders, depression, and higher rates of alcohol dependence, BPD, and/or bipolar disorder (Anderson, Barter, McIntosh et al., 2002; Horesh, Orbach,

Gothel et al., 2003; Michaelis, Goldberg, Singer et al., 2003; Ystgaard, Hestetun, Loeb et al., 2004). Rudd Joiner and Rumzek, (2004) reported that a childhood history of anxiety disorder or major depressive disorder predisposed a person to both later multiple suicide attempts and personality psychopathology; further, they noted that for women, exhibiting recurrent suicide attempts was a function of having childhood anxiety disorders, not mood disorders. Forman, Berk, Henriques et al. (2004) found that multiple suicide attempters vs. single attempters had more severe psychopathology, suicidality and interpersonal difficulties when assessed following presentation to the emergency department after an attempt. Taken together, these findings indicate that persons with recurrent suicide-related behaviour are not characterized by one diagnosis, but more so by the magnitude and breadth of their psychopathology.

A variety of psychological deficits and potential risk factors alongside the complex combinations of comorbidities have been identified in this population. These include problem-solving deficits, cognitive rigidity, hopelessness, alexithymia, negative self-evaluation, and negative affectivity (Marzuk, Hartwell, Leon et al., 2005; Pruessner, Baldwin, Dedovic et al, 2005; Williams, Barnhofer, Crane et al., 2005). For those identified with BPD and recurrent suicide-related behaviours, instability and/or the following: deficits in emotion regulation, decreased levels of emotional awareness, difficulty in problem solving, or difficulties in managing interpersonal relationships have been evidenced (Linehan, Armstrong, Suarez et al., 1991; Levine, Marziali, Hood, 1997; Kern, Kuehnel, Teuber et al., 1997; Deiter, Nicholls, Pearlman, 2000; Pitman, 2007). Neurobiological factors may also contribute to some of the identified deficits and/or psychological factors (van Heeringen, 2003; Bostwick, 2005; LeGris, van Reekum, 2006).

Given these factors, we specifically chose to study variables that reflect potential personal risk factors or psychological deficits associated with recurrent suicide-related behavior that purportedly could be changeable as targets for our intervention. The potential risk factors chosen were: *affective* (alexithymia) because of its relationship to emotional awareness, depression (Taiminen, Saarijarvi, Helenius et al., 1996), self-injurious behaviour and suicide attempts (Polk and Liss, 2007; Horesh, Levi, Apter, 2012); *cognitive* (hopelessness, life satisfaction, problem solving), and *impulsivity*.

### **A Psychosocial/Psychoeducational Intervention for People with Recurrent Suicide Attempts (PISA)/Skills For Safer Living (SFSL)**

PISA/SFSL is a 20-week psychosocial /psychoeducational group intervention program developed for clients with a history of recurrent suicide attempts. (This chapter will provide an outline of the intervention however, for a more in-depth discussion, the reader is invited to refer to “A Description Of A Psychosocial/Psychoeducational Intervention For Persons With Recurrent Suicide Attempts” (Bergmans and Links, 2002) or (Chapter 4) in this volume.

The group intervention targets skills or coping strategies to lessen the potential risk factors or psychological deficits associated with recurrent suicide-related behaviour. People with a lifetime history of two or more suicide attempts, self-referred or were referred after a suicide crisis from a variety of in-hospital or community resources. Participation in the group is based on the presence of recurrent suicide attempts as identified by the person and is not based on the presence of a particular psychiatric diagnosis. People with an active psychotic disorder or a recent history of interpersonal violence are excluded from the program. Participants are expected to have an individual therapist in the community while participating in the group. There are no restrictions

regarding whether or not people participate in other treatments; for example, entering specific programs for eating disorders, substance abuse.

### **Methods**

To date, 62 groups have been completed across five Canadian sites. Two of the sites were outpatient hospital locations and 3 were community-based joint projects with the Canadian Mental Health Association and the Self Help Alliance. Six groups (66 registered participants) were held at the community locations with one underway at the time of this writing; 55 group interventions were held in an inner city hospital located in downtown Toronto. Of the 349 participants (238 women and 111 men), who began the 62 group intervention, 249 (71.1%) completed all 20 weeks and 12 (3.4%) are currently participating.

As indicated in Table 19.1, participants' age ranged from 16-71 years of age with the mean age being 36 years ( $SD = 11.4$ ). The age of onset of suicide-related ideation was 16.8 years ( $SD = 9.8$ ; range, 2 to 61 years). The mean age of first recalled suicide-related behaviour was 21.02 years ( $SD = 10.7$ ; range, 4 to 62 years). The majority of participants (66.9%) were single, nearly a quarter (23.7%; 83/349) had less than a high school education, and 28.9 % (101/349) had completed university. Nearly a quarter (24.2%; 85/349) were employed either full- or part-time and 28.9% (101/349) lived on their own with no support, while 22.9% (79/349) reported living with family or friends. Nearly half of the group participants (48.4%; 169/349) lived in shelters, boarding homes, the street, group homes, supportive housing units or the information was not obtained.

Participants reported various psychiatric diagnoses (see Table 19.2). The most frequent reported diagnoses were unipolar depression (63.5%) and Borderline Personality

Disorder (BPD) (43.2%) followed by Bipolar Disorder (25.8%) and Post Traumatic Stress Disorder (PTSD) (20%).

The study received ethics approval from St. Michael's Hospital Research Ethics Board, and all participants provided signed informed consent. Participants were not financially compensated for participation in the program.

### Design and Procedures

From the start, the group intervention has continued to be an ever-changing and evolving pilot project. Thus, beginning in 2000, over a 3-year period, various measures have been added. Consequently, the number of respondents differs for each measure. To measure the change resulting from the group intervention in areas identified as deficits or risk factors for clients with recurrent suicide-related behavior: cognition, affect, and impulsivity, a pre-post study analysis was conducted.

Participants were given the pre-group measures at the first session, and the post-group measures were given at the second-to-last session. All measures were completed by participants at home and returned the following week. Within the affective, cognitive, and impulsivity domains, the following measures were given.

*Table 19.1 Sample Characteristics*

<i>Number of respondents</i>		<i>Number of respondents</i>	
<b>Gender</b>	249 (100%)	<b>Children</b>	236 (95.9%)
M	81 (32.5%)	No	165 (66.3%)
F	168 (67.5%)		
<b>Marital Status</b>	222 (89.2%)	<b>Thinking will die</b>	175 (70.3%)
Single	176 (70.7%)	<b>by suicide with plan</b>	
Partnered	41 (16.5%)	yes	
		no	102 (40.9%)
		not sure	59 (23.7%)
			14 (5.6%)
<b>Employed</b>	238 (95.6%)		
Yes	68 (27.3%)	<b>Current medical</b>	243 (97.6%)
No	143 (57.4%)	<b>follow up</b>	



Long Term Disability	26 (10.4%)	No	44 (17.7%)	
<b>Currently in School</b>	220(88.3%)	<b>Current Allied health</b>	233 (93.5%)	
Yes	26 (10.4%)	<b>Follow up</b>		
No	194 (77.9%)	No	94 (37.8%)	
		Yes	107 (42.9%)	
<b>Grade Completed</b>	226(90.8%)	<b>Forensic history</b>	217 (87.1%)	
< high school	54(21.9%)	No	168 (67.5%)	
completed	74 (37.8%)			
High school	69 (27.7%)			
Post-secondary	9 (3.6%)			
Graduate program				
<b>Reported substance use</b>	235 (94.4%)	<b>Housing</b>	206 (83.7%)	
Current use	100 (40.1%)	On own	75 (30.1%)	
Previous hx, no current use reported	60 (24.1%)	With family member(s)	56 (22.5%)	
No	72 (28.9%)	Subsidized		
		Supportive/boardings/	22 (8.8%)	
		Group homes etc.	50 (20.0%)	
<b>Previous treatment for Substance use</b>	222 (89.1)	<b>Child Welfare involvement as a child</b>	218 (87.5%)	
Yes	58 (23.3%)	Adopted	14 (5.6%)	
No	147 (59%)	Yes	31 (12.4%)	
		No	173 (69.5%)	
		<i>Mean, Median</i>	<i>Range</i>	<i>Standard deviation</i>
Age	249 (100%)	37.1; 36	16-71	11.64
Age of recalled onset of feelings	218 (87.5%)	16.9yrs.; 14.0yrs	2-61yrs	10.11
Age of recalled first attempt	228 (91.5%)	21.0yrs.; 18.0yrs	4-61 yrs	10.6

*Table 19.2: Participants' self-reported diagnoses at intake*

<i>Axis I</i>	No. (%)*
Depression	159 (66.5)
Bipolar disorder	70 (29.3)
Anxiety/panic	62 (25.9)
Posttraumatic stress disorder	47 (19.6)
Eating disorder	33 (13.8)
Obsessive compulsive disorder	18 (7.5)
Alcohol and/or drug dependence and or abuse	14 (5.8)
Schizophrenia	13 (5.4)

## *Axis II*

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Borderline personality disorder	121 (50.6)
Antisocial personality disorder	4 (1.6)
PD-NOS/other PD	23 (10.1)
Other	96 (38.4)

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*Notes:* PD-NOS: Personality Disorder Not Otherwise Specified. Participants (N = 239).

\*Numbers do not total 239 because of multiple responses.

### ***Affective.***

The 20-item Toronto Alexithymia Scale (TAS-20) is a self-report questionnaire containing items that are rated on a 5-point Likert-type rating scale from 1 (strongly disagree) to 5 (strongly agree) with five items inversely scored. It is hand scored with a maximum score of 100. It uses cutoff scoring:  $\leq 51$  = non-alexithymic, scores of 52 to 60 = moderately alexithymic, and scores  $\geq 61$  = highly alexithymic. The TAS-20 was chosen because it has 3 subscales, a three-factors structure that is theoretically consistent with the alexithymia construct and captures concepts relevant to identified deficits in emotional awareness: (1) difficulties identifying feelings; (2) difficulties describing feelings; and (3) externalization of emotion. The TAS-20 has been used in a variety of populations, including psychiatric outpatients, and previous evidence supports the convergent, discriminant, and concurrent validity of the TAS-20 (Taylor, Bagby, Ryan et al., 1990; Bagby, Parker, Taylor, 1994). The Beck Depression Inventory (BDI) is a self-report questionnaire consisting of 21 items each with four possible responses that assesses different aspects of depressive symptomatology (Beck, Ward, Mendelsohn et al., 1961). Each response is assigned a score ranging from zero to three, indicating the severity of the symptom. The maximum possible score is 63. A score of  $< 15$  = Mild Depression, a score 15-30 = Moderate Depression, and a score  $> 30$  = Severe Depression. The BDI has demonstrated excellent psychometric characteristics, with a split-half reliability of 0.93,

and excellent convergent and predictive validity, e.g., significantly predicting suicide ideation and eventual suicide (Beck, Ward, Mendelsohn et al., 1961; Beck, Steer, Kovacs et al., 1985).

### ***Cognitive.***

The Beck Hopelessness Scale (BHS) is a 20-item true-false self-report questionnaire designed to assess negative attitudes about the future. Scores range from 0 to 20. The scale has been shown to have high internal consistency (Kuder-Richardson-20 coefficient alpha = 0.93) and a relatively high correlation with clinical ratings of hopelessness ( $r = 0.74$ ) in a population of 294 hospitalized patients with recent suicide attempts (Beck, Weissman, Lester et al., 1974).

The Satisfaction With Life Scale (SWLS) is a self-administered 5-item scale which is designed to assess the self-identified cognitive-judgmental aspects of global life satisfaction. The items are rated on a 7-point Likert-type scale from 1 (=strongly disagree) to 7 (=strongly agree). Scores range from 5 to 35. It has demonstrated acceptable reliability, with high internal consistency, and test-retest reliability over periods of 2 months ( $r = 0.82$ ) and 4 years ( $r = 0.54$ ), respectively. The SWLS has demonstrated convergent and discriminant validity, relating positively with other measures of well-being, relating negatively with measures of distress, and yielding no significant relationship with emotional intensity (Pavot and Diener, 1993).

The Problem Solving Inventory (PSI) is a 32-item self-report scale designed to capture the person's perception of his or her own problem-solving behaviours and attitudes (Heppner and Peterson, 1982). The PSI inventory uses a 6-point Likert-type format (1= Strongly agree to 6 = strongly disagree) and consists of 3 factors related to

self-perception of problem-solving: confidence (self- assurance while engaging in problem solving activities), personal control (determines the extent of control one has over their emotions and behaviours while solving problems), and approach-avoidance style (a general tendency to either approach or avoid problem solving activities). High scores indicate general negative self-appraisal while lower scores reflect greater perceived problem-solving abilities. Joiner, Pettit, Perez et al. (2001) reported test-retest reliabilities from their previous research; coefficient alphas for the total scale were 0.93, and for three factor subscales they ranged from 0.76 to 0.87.

### ***Impulsivity***

The Barratt Impulsivity Scale (BIS) often used in the investigation of impulsive behaviour, is useful in identifying impulsivity and evaluating the influence of this dimension on client performance without the influence of confounding factors such as anxiety traits (Barratt, Stanford, Kent et al., 1997). The 30 item BIS-11 describes common impulsive or non-impulsive (for reverse scored items) behaviours and preferences. Items are scored on a 4-point scale (1= rarely/never to 4 = almost always/always) without relation to any specific time period (a trait measure of impulsivity). Twelve items are reverse-scored, a design feature to avoid response sets. Higher summed scores for all items indicate higher levels of impulsivity. The BIS-11 consists of three sub-scales related to attentional impulsiveness (task-focus, intrusive thoughts, and racing thoughts), motor impulsivity (tendency to act on the spur of the moment and consistency of lifestyle), and non-planning impulsivity (careful thinking and planning and enjoyment of challenging mental tasks).

### ***Data analysis***

All pre- and post- responses were analyzed using descriptive statistics (frequencies, mean, median, and standard deviation). To assess the impact of the group intervention on the post-intervention we used mean scores paired sample *t* tests. Data were analyzed using SPSS 15.0 for Windows.

The percentage of change in mean scores of post-intervention scores, and pre-intervention scores were also calculated. A percentage change is a way to express the magnitude of change in a variable and it represents the relative change between the old value and the new one. The percentage of change was calculated by subtracting the pre-intervention mean score from the post-intervention score and dividing by the pre-training score and multiplying the result by 100.

Since participants were not refused the group intervention if they chose not to participant in the research, completion rates for pre and post measures do not correspond to the number of participants who completed the group intervention. Additionally, it also needs to be acknowledged that measures were introduced over time as the intervention evolved and questions became more focused. The number of completed pre-group and post-group measures are as follows: TAS-20, N = 111; SWLS, N = 100; BIS, N = 93; BDI, N = 58; BHS, N = 83; and PSI, N = 75.

## **Results**

Nearly two-thirds (249; 71.1%) of the participants “graduated” from the 20-week group intervention with 12 (3.4%) still participating in the intervention. Those who graduated had a mean attendance of 75.24% of the scheduled sessions (median, 80; mode, 90; range, 10 to 100). Of those who withdrew and did not complete the group intervention 18 (7.2%) returned at a later date to complete the intervention. As such, their data were incorporated

into the present analysis. Some 89 individuals (26.4%) withdrew prior to completion of the 20 weeks group intervention. Reasons for withdrawal included: potential problems with readiness for the group (13.4%), extraneous health, treatment, and life issues (40.4%); and no reason given or lost to follow-up (29.2%).

Pre-group and post-group measures and paired *t* test scores are presented in Table 19.3.

*Table 19.3: Comparisons of pre- and post-group affective, cognitive, and impulsivity scores*

	n	Pre- Intervention	Post intervention	p value
<i>Affective</i>				
TAS-20				
Difficulties identifying feelings	110	24.9(6.5)	22.7(7.0)	<.001
Difficulties describing feelings	110	17.8 (4.8)	16.8(5.2)	0.015
Externally oriented thinking	111	20.8(5.3)	18.9(5.5)	<.001
TAS-20 Total score	111	63.7(13.2)	57.9(15.0)	<.001
BDI		36.5(11.7)	31.5(14.6)	0.002
<i>Cognitive</i>				
PSI				
Personal Confidence	74	39.9(12.2)	37.7(10.2)	N.S.
Avoidance Approach Style	75	53.9(13.1)	55.8(10.6)	N.S.
Personal Control	75	13.6 (8.3)	15.9(7.5)	0.008
PSI Total score	75	115.0(29.4)	119.0(22.0)	N.S
BHS	83	14.8(5.1)	20.9(2.3)*	<.001
SWLS	100	10.3(5.5)	12.4(7.3)	<.001
<i>Impulsivity</i>				
BIS Total score	93	76.1(12.7)	73.7(12.0)	0.026

\* misprint in published text. Should read as per text below; pre-14.8%; post-12.8; p=.002

### *Affective*

Prior to participating in the group intervention 79.1% of the participants had TAS-20 scores indicative of moderate (total scores = 52-60) or high alexithymia (total scores  $\geq$  61). Nearly 2/3 of the participants (60%) had TAS-20 scores  $\geq$  61 and scores ranged between 61-90. Post group intervention the proportion of participants who were moderately or highly alexithymic declined to 70.1% and the proportion of those highly alexithymic dropped to 50%.

As indicated in Table 19.3, there were statistically significant differences between the pre- and post-intervention scores. The pre-intervention TAS-20 total mean of 63.7 (SD = 13.2) dropped to 57.9(SD =15.0) post-intervention ( $p < .001$ ). Overall, this indicated a shift from high alexithymia ( $> 60$ ) to moderate alexithymia (range, 52 to 60). The percentage of change in the mean scores from pre-intervention to post intervention was 9.1%. Overall, a statistically significant decrease in the three TAS-20 subscales is observed.

BDI scores 20-28 are considered to indicate a moderate depression while scores 29-63 reflect severe depression. The proportion of participants who endorsed symptoms consistent with severe depression declined post-intervention 77.1% to 62.3%. Conversely, the proportion of participants who endorsed symptoms of minimal depression post-intervention increased from 4.8% to 14.5%. As indicated in Table 19.3, there was a statistically significant decrease in the post-intervention BDI mean scores, (36.5 (SD=11.7) vs. 31.5(SD= 14.6)  $p = .002$ ). While the percentage of change between pre- and post-intervention was 13.7%, the overall BDI mean score post-intervention remained in the severe depression range (29 - 63).

### ***Cognitive***

There was no statistically significant difference in the post-intervention total mean score of the PSI (115.0(SD = 29.4) vs. 119.0(SD = 22.0),  $p = \text{N.S.}$ ). However, the extent of control one has over their emotions and behaviours while solving problems increased significantly post-intervention (13.6 (SD = 8.3) vs. 15.9(SD= 7.5),  $p = .008$ ). The percentage of change in the personal control over emotions and behaviours post-intervention increased by 16.9%.

Results of the BHS indicated significant reductions in hopelessness from pre-intervention to post-intervention (14.8(SD = 5.1) vs. 12.8 (SD = 5.9),  $p = .002$ ). The decrease in hopelessness represents a decrease of 13.5%; however, hopelessness scores remained moderate reflecting a chance of suicide (range 9 to 14). .

Pre-intervention, the majority of the participants (53.3%) indicated they were extremely dissatisfied with their life (SWLS score < 9). Post-intervention the proportion of those extremely dissatisfied with their life decreased to 46.4%. While the global life satisfaction increased significantly post-intervention (10.3 (SD = 5.5) vs. 12.4 (SD = 7.3),  $p < .001$ ) and the pre-to post- intervention percentage of change was 20.4%, the score remains within the range of moderately dissatisfied with one's life.

### ***Impulsiveness***

There was a significant decrease in BIS total mean score post-intervention (76.1 (SD = 12.7) vs. 73.7 (SD = 12.0),  $p = .026$ ). The percentage of change was 3.2%. Aside from the non-planning subscale, BIS-11 subscales showed significance in the reduction from the beginning to end of intervention.



## **Discussion**

Considering the complexities of suicide, understanding what defines a lessening of suicide risk for an individual might reside upon that particular individual. The results from this ongoing pilot study reflect that overall, for those who completed the 20-week intervention, there were significant statistical changes found in the potential risk factors and/or deficit areas that are identified as characteristic for those with recurrent suicide attempts. General life satisfaction, more emotional literacy, less depression and hopelessness and a perception of better problem solving abilities were reported as per the self-administered evaluations. Despite these changes, overall scores remain within severe or moderate ranges, likely reflecting the magnitude of challenges that persons with recurrent suicide-related behaviour are observed to manifest (Rudd, Joiner & Rajab, 1996). It also needs to be noted that despite the statistical significant changes observed, not all participants' scores changed, or changed in the positive direction. These are findings which are not often analyzed or reported and which, due to resource limitations, are not reported in this chapter. A 20-week intervention is a relatively short period of time in the larger timeline of clients' lives and although significant changes were observed, it is difficult to know at this time if, with time, further gains are made. We need to be cognizant that utilizing only quantitative data, results do not necessarily reflect, or might have little to do with the experience of the changes the participants perceive or understand. Furthering on Moroz-Franklin's (2002) suggestion, perhaps it is the participation in the intervention group that allows participants to perceive themselves more able to manage their struggles rather than the actual struggles changing. As noted elsewhere (Bergmans, Langley, Links et al., 2009) and suggested by Joiner (2005), knowing that one is not alone in having issues with

suicidality may be one of the key factors in reducing the experience of isolation and marginalization; a concept familiar to group therapy, universality, as noted by Yalom (1995, Yalom and Leszcz, 2005).

Perhaps we are asking different questions of the information being given through quantitative questionnaires. Qualitative and anecdotal evidence suggests that with support, some clients who have participated in this intervention do go on to live safer and productive lives (Bergmans, Carruthers, Ewanchuk, et al. 2009; Scrivener, 2011; Ana Cara, 2012; Selfhelpalliance, 2012; Weidner, 2012). The PISA/SFSL intervention might be only one of several possible steps toward further reduced risk of suicide in persons with recurrent suicide-related behaviour. To assume a one size fits all would deny the complexity of (1) each individual; and (2) of suicide. It is thus suggested that interventions need to meet the needs of the client at the time and if a particular modality is not appropriate at one given period in their lives, it does not suggest it will never be appropriate. With time, maturity, skill development, awareness and integration, a person may be more ready and able for a particular modality at different times on their journey as witnessed by the 18 people who left and came back.

The TAS-20 has been a useful measure of the difficulties with emotional processing that are characteristic of individuals with recurrent suicide-related behaviour and has been able to capture change following a time-limited intervention. This intervention targets emotion-processing difficulties and focuses on teaching emotional literacy, identifying and describing how one is feeling, and learning alternatives to suicide-related behaviour in response to emotional distress. In this focus, it provides a language that goes beyond the word “suicide” with the intent being that those who are

being asked to help will be able to hear “not safe” or “afraid” more calmly than “suicide” or “die.” Our results showed that with a focus on teaching the language of emotion, alexithymia scores changed significantly. It could be suggested that a person who is neither able to identify or describe his or her emotions might be more prone to acting out distress. Without a language, feelings overwhelm or flood cognitive functions. Izard (2002) suggested that in times of emotional flooding, emotion will be the driver taking a “low road,” or noncognitive move to action—a process that occurs within milliseconds. These results suggest that the TAS-20 is a useful measure to capture the emotional-processing deficits found in persons with recurrent suicide-related behaviour and, more importantly, the measure may be sensitive to change that results from psychosocial interventions.

This ongoing pilot study has several limitations which are also areas for future research. Challenges in resources impacted the following: (1) Sample sizes for each measure are both limited and vary between measures. Sample loss was affected by non-completion of both pre-group and post-group measures in part, hindered by our ability to aggressively pursue data collection of those who did not return measures at the end of group. It was also hampered by the staggered introduction of the questionnaires. (2) Failure of participants to respond to items within the measures was also a challenge, consistent with the use of self-report scales (Shrive, Stuart, Quan et al., 2006). (3) Being unable to systematically diagnose group participants, it remains unclear if this intervention is more appropriate for individuals with particular struggles than others. Time constraints, restrictions of who can apply in some granting agencies, institutional demands, clinical caseloads can all seem insurmountable in the life of an allied clinical researcher trying to

do intervention with people who are at high risk for dying by suicide. The fact remains; a future randomized controlled trial would assist in addressing the issues of limited measures, lack of a control group, and lack of outcome data on suicide-related behaviour. It is our hope that future research will be able to focus on demonstrating the efficacy of the PISA/SFSL in reducing future suicide-related behaviour.

### **Conclusion**

The PISA/SFSL pilot study continues to demonstrate that a 20-week group intervention has led to significant reductions in the cognitive, affective, and impulsivity deficits and potential risk factors associated with suicide-related behaviour. This suggests that this short-term intervention might be the first of many steps toward engaging clients with recurrent suicide-related behaviours to seek longer-term help for problems associated with a high risk for suicide.

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## **Overview of Chapter 5**

Results from this study indicated that the intervention continued to address the identified challenges and deficits known for the RSA population, therefore, no changes were made to the SfSL/PISA intervention goals, premises and content.



## **Chapter 6: Transitioning Away From RSA**

### ***Introduction to chapter 6***

While the quantitative studies confirm positive changes in known risk factors and deficits for RSA following SfSL/PISA, they do not provide an understanding of the change process. This chapter reports on the findings of a Grounded Theory study conducted with a sample of young people who at the time of their assessment intake interview for the SfSL/PISA intervention were between the ages of 18-25 years (N=16). The choice of the sample group used in this study was determined by a funding opportunity being offered at the time, which focused on the needs of young people. The aim of the study was to gain a better understanding of the transition away from high-risk suicide-related behaviours. The study was published as: Bergmans, Y., Langley, J., Links, P.S. & Lavery, J.V. (2009). The Perspectives of Young Adults on Recovery from Repeated Suicide-Related Behavior. *Crisis*, 2009 30(3):120-127. doi: 10.1027/0227-5910.30.3.120.

### **The Perspectives of Young Adults on Recovery from Repeated Suicide-Related Behavior.**

Yvonne Bergmans, John Langley, Paul S. Links and James Lavery

**Abstract.** *Background:* This qualitative study sought to develop an understanding of how young adults between the ages of 18-25 yrs. who have a history of two or more suicide attempts, transition away from high risk suicide-related behaviours. *Aims:* To understand the transition to safer behaviours and to provide clinical suggestions for those who provide care to this population. *Methods:* Sixteen young adults under the age of 25 years, who had

completed at least one cycle of intervention for people with repeated suicide attempts, participated in this qualitative, *grounded theory* study. *Results:* The young adults described a pathway that included three major elements: (a) “living to die”, (b) ambivalence and tipping/turning points and (c) a process of recovery that included small steps or phases (pockets of recovery) toward life. The journey was not always experienced as steady movement forward, and the potential for relapse either in the young people’s behaviour or their wish to engage in their relationship with death could ebb and flow. *Conclusions:* The struggle to live is a process involving a fluid pathway moving between three key elements.

**Keywords:** clinical intervention, recurrent suicide attempts, transitions

## INTRODUCTION

Suicidal ideation and deliberate self-harm are extremely common in young people. The recent European CASE Study survey of school age adolescents found that 12.5% of males and 30.4% of females had thought about harming themselves or reported one episode of self-harm in the previous year (Madge et al., 2008). Follow up studies demonstrated that youth who present to a general hospital with deliberate self-harm had 10 times the expected rate of death by suicide as the general population (Hawton and Harris, 2007).

People with multiple episodes of suicide-related behaviour (Silverman et al. 2007) have a higher risk of dying by suicide related to a greater number of DSM-IV axis I diagnoses, an earlier onset of psychiatric disorders; elevated levels of suicidal ideation, depression, hopelessness, perceived stress; poorer social problem-solving skills; a history of childhood maltreatment; family histories of suicide attempts and psychiatric illness; and alcohol; and substance abuse issues (Rudd et al., 1996; Forman et al., 2004; Rosenberg et al., 2005).

Leitner et al. (2008) reviewed 200 primary empirical studies and 37 prior systematic reviews about what makes suicide prevention strategies effective. They identified “low key” interventions, such as regular contact with a care provider, and cognitive interventions with behavioural components may be of benefit. However, it is yet to be understood which components of therapy are of particular value. In the same article, the authors observed that the interventions were often not provided within a mainstream service, nor were they available to the majority of people presenting with suicidal behaviours, especially for youth at risk for suicide.

Sinclair and Green (2005) have argued for the need for qualitative research to better understand the perspective of youth attempting suicide to account for the resolution of self-harm behaviour and to inform the development of more effective management. In their own research, Sinclair and Green provide three narratives of resolution: the resolution of adolescent distress; the recognition of the role of alcohol as a precipitating and maintaining factor in self-harm and deliberate self-harm as a symptom of untreated or unrecognized depression. Our study builds on the work of Sinclair and Green (2005) by studying youth at risk for suicide, with a history of suicide-related behaviour characterized by significant intent to die, but who are in the process of transitioning away from these behaviours.

In this paper, we present the initial findings of a qualitative study whose aim was to develop a *grounded theory* of recovery from the perspective of young adults with a history of repeated suicide-related behaviour who completed at least one cycle of a specific treatment intervention: psychosocial/psychoeducational intervention for people with recurrent suicide attempts (PISA). Previous research suggests that participation in

this intervention has some impact on reducing risk factors for suicide-related behaviours and may enhance compliance with longer-term treatment (Bergmans and Links, 2009), though the precise mechanisms have not been elucidated. Beyond the development of a theory of recovery, this study aims to provide suggestions for physicians and other clinicians to understand and provide care to this population.

## **METHODS**

### **Sampling Frame**

Participants were young adults initially assessed for admission to the PISA intervention when they were 25 years old or younger. PISA is a multimodal group intervention for people with recurrent (two or more) self-identified suicide attempts with intent to die, regardless of diagnoses (Bergmans and Links, 2002). Eligibility into the PISA program is a self-identified history of two or more suicide attempts with intent to die. Exclusion criteria include a current psychotic disorder and/or a history of interpersonal violence toward another for which charges have been laid within the past six months. The goal of the intervention is for clients to develop the skills necessary to decrease duration, frequency and intensity of crisis episodes involving suicide-related behaviours. The eligibility criterion for participation in this study was completion of at least one 20-week cycle of the PISA program. By using this sample group it was clear that participants had completed at least one therapeutic intervention thus giving them the experience to discuss concepts, skills or modalities regarding what is, or is not, therapeutically helpful in transitioning away from high-risk suicidal behaviour. Thirty-two young adults between the ages of 18-25 years completed the intervention and thus, were eligible to participate in this study.

## **Data Collection**

Prospective participants were contacted via letter and/or e-mail with a follow-up telephone call inviting participation. At the first meeting, the study was explained to participants and consent forms were signed. This was followed by the qualitative interview that lasted between 45 minutes and two hours at the discretion of the participant. Participants were given the option to complete the quantitative descriptive items at this meeting or to come for a second session. Quantitative data was entered into SPSS-15. Interviews were transcribed verbatim.

## **Data Analysis:**

After several interviews had been transcribed, the research team met to discuss emerging concepts, lines of further exploration in future interviews, and compared the most recent interview(s) to previous ones. These discussions identified concepts and emerging lines of inquiry, which helped to guide and focus the content of subsequent interviews. The analytic approach in *grounded theory* begins with data collection and continues after all the data are collected. The approach involves 3 main steps: (1) open coding, the process of breaking down, examining, comparing, conceptualizing, and categorizing data; (2) axial coding, the process of re-assembling data into groupings or categories based on relationships discovered in the data; and (3) selective coding, the process of identifying and developing the central phenomenon as indicated by the data (Strauss and Corbin, 1996). Each “step” in the analysis involves constant comparisons of new data with existing data (Rosenfield P.L, 1992). This comparison was done independently by each author, followed by team discussions to compare and challenge concepts, codes and points

of view. A diagram, or preliminary model, depicting the relevant social processes and the relationships amongst concepts was developed and refined progressively with each new iteration, incorporating insights from the most recent interview. The evolving model was shared with each participant after his/her interview, and her / his input elicited as to whether the model seemed to reflect their own experience. In these ways, the model was refined until the research team agreed that this process was not contributing any greater conceptual depth, or illumination of the relevant social processes. At this point the preliminary draft of the model was shared with the Community Advisory Panel (CAP). The CAP is a group of community volunteers and included graduates of the program over the age of 25 years, healthcare professionals and administrators from local shelters. This volunteer group was asked for feedback on whether the model resonated with their experiences and helped them to understand the process of transitioning away from high-risk suicidal behaviour. Relevant insights were collected during a face-to-face meeting with the lead investigators (YB and JL) and then discussed with the rest of the research team. Where it was believed insights provided clarification or greater depth, these were incorporated into the model. The data were managed in the qualitative research software NVivo7.

Ethics approval was granted by our local hospital Research Ethics Review Board.

## **Results**

Sixteen young adults participated in the study, 14 females and 2 males. Table 1 compares demographic details of the participants with those of the other eligible participants of the PISA program. There were no significant differences between groups based on ANOVA and chi-square analysis. The time between completion of at least 1 cycle of the PISA

intervention and interview for this study ranged from 6 months to 6 years. At the time of this study the average age of participants was 25.8 years (SD=3.4) and 15 (94%) were single; 4 (25%) were employed either full or part-time, 9 (56%) had completed high school and or some post-secondary education and 4 (25%) were living alone. The reported mean age for first suicide attempt was 15.1 years and the reported mean number of attempts was 7.1. All participants reported a history of childhood maltreatment. Although no formal diagnostic testing was completed prior to group entry, all participants reported having been told they had between two and nine diagnoses including both Axis I and II disorders. At the time of the follow up interview, eleven (68.7%) participants reported no suicide-related behaviour since completion of the intervention and 5 (31.3%) identified a reduction in the number suicide-related behaviours over time. Time since completion of the PISA group intervention did not appear to be related to whether or not a person engaged in suicide-related behaviours.

*Table 1. Demographics Across the Groups of Eligible Participants at Time of Assessment*

Variable	Group 1*	Group 2**	Group 3***	Significance
Age (years) at time of assessment	<i>M</i> =22.3	<i>M</i> =21.3	<i>M</i> =20.8	$F(2,44)=1.33$ $p=.275$
Age (years) at time of study	<i>M</i> =25.8	-	-	-
Age at First Attempt	<i>M</i> =15.1	<i>M</i> =14.9	<i>M</i> =13.4	$F(2,44)=.393$ $p=.393$
Number of Attempts	<i>M</i> =7.9	<i>M</i> =4.1	<i>M</i> =8.4	$F(2,44)=1.73$ $p=.188$
Sex (%)				
Male	2 (12.5%)	2 (12.5%)	1(0.6%)	$\chi^2=.366$
Female	14 (87.5%)	14 (87.5%)	14 (93.3%)	$p=.833$
Marital status (%)				
single	15 (93.75%)	16 (100%)	13 (86.66%)	$\chi^2=2.304$ $p=.316$
Currently Employed	4 (25%)	5 (31.25%)	4 (26.66%)	$\chi^2=2.588$ $p=.858$
Education (%)				
High School or Post-	9 (56.25%)	10 (62.5%)	8 (53.3%)	$\chi^2=10.001$

Secondary				$p=.616$
Housing (%)				
Living Alone	4 (25%)	3 (18.75%)	5 (33.33%)	$\chi^2=5.167$
With Family	6 (37.5%)	6 (37.5%)	5 (33.33%)	$p=.952$
Supportive Housing	6 (37.5%)	7 (43.75%)	5 (33.33%)	

\*Group 1: completed intervention and interviewed (N=16), \*\*group 2: completed intervention and not interviewed (N=16), \*\*\*\*group 3: did not complete the intervention (N=15)

### A Model of Recovery

The process of their transition from higher to lower risk of suicide was conceptualized as a pathway involving three major elements that are illustrated in Figure 1: (a) “living to die”, (b) ambivalence and tipping/turning points, and (c) a process of recovery that included small steps or phases toward life (pockets of recovery) (see Figure 1). Participants used the terms healing, recovery, and journey to describe the process of transitioning away from high risk behaviour.

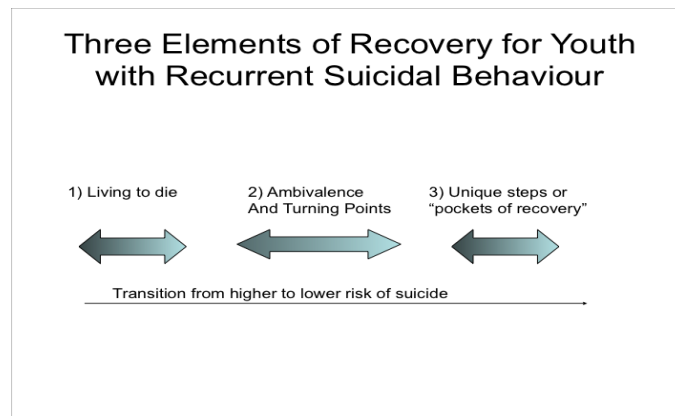


Figure 1: Three Steps of Recovery for Youth with Recurrent Suicide-Related Behaviour

#### “Living to Die”

Participants reported struggling with repeated experiences of near death by suicide and emphasized a seductive relationship with death. Death and suicide were described as (a) “the mistress” a comfort; an inevitable outcome, a solution to an intolerable life to which there was no connection; (b) as having a purpose to “never feel again” or communicate



the level of distress crying out with “I don’t know what to do someone help me,” or (c) as an identity of non-deservedness, non-worthiness, or “a promise to yourself so every time I failed an attempt I wasn’t just failing myself I was failing that promise ... which really became my whole purpose and identity”

### **Ambivalence and Turning Points**

Moving away from *the mistress*, the allure of death meant having to go through the murky waters of ambivalence, a time of being “too scared to die and I was too scared to live” with the realization for some that “I didn’t know how to live and it suddenly I think scarier and harder to live than it is to die..and it (dying) was just all I knew...” Ambivalence is a fluid state and can manifest in various ways on a person’s pathway (Harrist, 2006).

What seemed to help participants through these murky waters were a series of “tipping and turning points” that often “snuck up” on them and raised their awareness of their situation in ways that were not always welcome. One participant identified that, “(a)wareness is a curse” which made the choice to stay safer “... a bit of a battle in my head for a little while”. Some people realized they wanted to try to live only after losing someone to death or watching a family member talking about or coming to the end of their natural lives. For others, being on the brink of their own death that was seen as different from the other “close calls” and left them in a position of “believing I would die and finally not wanting to but unable to do anything to stop it.” For our participants, turning points were understood as single or gradual events or experiences (Mandelbaum, 1973) and for some, these experiences were clearly consistent with what King et al have referred to as “emotionally compelling experiences and realizations that involve meaning acquired

through the routes of belonging, doing, or understanding the self or the world” (King et al., 2003).

### **Pockets of Recovery**

Moving toward life required participants to learn and draw from a “buffet” of concepts, skills, insights, connections and various forms of awareness, unique to each client. Some concepts that were identified by participants as most relevant to their gaining awareness included: learning that there were choices and learning that feelings were a part of the human experience. Identification and tolerance of feelings needed to be understood and learned. Through learning about feelings, participants reported beginning to understand that

“it was always about the behaviour ... I wasn’t looking at the reasons behind the behaviours and the foundations for them ... I was acting out what I was feeling”

Awareness regarding one’s diagnoses and skills concerning symptom management were identified as key insights as they related to the person’s sense of who they were;

“...[I] needed people to point out to me that I was not my depression...to start to realize it.”.

Learning to identify and state what they were experiencing when in crisis, identifying boundary issues, recognizing their personal rights and highlighting the ways in which they spoke to themselves were all important skills in participants’ transitions. Family, friends, and professionals were identified as important for support and education. Helpful professionals were identified as

“Sincere...open”, “just having them listen”, “understanding”, “always up front and ... completely consistent”.

Transitioning, healing, the journey or recovery was described as:

“to be able to do daily tasks”; “to be more comfortable with myself...”; “living a life that is really mine by the choosing, not by what society deems successful”; or something astronomical and my first thought won’t be dying, or cutting or getting drunk or getting high, it will be to cry and move on.”.

The process of transition was incremental through small steps or “pockets of recovery.” One participant described this as “having a heavy back pack and you take out one book at a time until you can carry it.”

Participants summarized their journey as moving from “living to die” to “dying to live”; having to “fight the demons every day, so that you see tomorrow...step by step, moment by moment”. It means “I have the skills and the agony.” For one participant, the process means: “I’m like a colouring book, black and white pages but every day I fill in another picture or a piece of a picture with colours.”

All participants identified participation in the PISA group as the single-most significant experience, providing a peer group of understanding, commonality, and as Yalom identifies, universality (Yalom and Lescsz, (2005). There were no discernible differences amongst participants in terms of rate of transitioning or change based on the number of interventions participated in prior to or since graduation from the PISA program. What seems evident is that transitioning away from high-risk suicide-related behaviour is an ongoing process that requires several years.

## **Discussion**

Three key elements make up the pathway of the transition from higher to lower risk of suicide for youth with recurrent suicide-related behaviour. These elements may inform clinicians on the development and implementation of more effective management strategies. In particular, clinicians must recognize that the transition for youth with recurrent suicide-related behaviour involves these three elements: (1) the process starts

with moving from a wish to die and attraction to death; (2) moves through a period of ambivalence that leads to turning points that increase self-awareness and (3) “pockets” of recovery that are unique to each individual. “Living to Die” reflects the individual’s persistent relationship with death and if asked, or given the choice, the person would identify the “wish to die” or “to be dead”. Ambivalence occurs in the period between choosing to live and choosing to die rather, characterized by the simultaneous wish to live and a wish to die (Orbach, 2008). “Dying to Live” could be identified as the individual’s conscious decision to choose to live despite their growing awareness of the challenges that entails.

“Turning Points” included becoming aware of choices, diagnostic education, becoming aware of emotions, understanding the role of emotion as part of human experience, and learning to identify and tolerate emotions. Participants, without exception, identified themselves as struggling with identification and tolerance of intense feelings, which represents a major obstacle to making safer choices to manage their way through the intensity. The PISA group intervention and significant caregivers, both professional and personal had a positive impact on our participants. Yet, some participants also identified the importance of letting go of significant relationships if they were to move toward life as expressed by this participant:

“I had to let go of the relationship that I had with my mother. For me to live each day to the fullest...she cannot be part of my life. She’s too toxic.”

Each participant identified experiencing “turning points” that had deep personal meaning, suggesting that what fosters the clients’ process of change is highly individual. An

individual's movement along the pathway can be both forward and back and involve many small steps over time.

### **Implications for Practice**

In our model, an individual with repeated suicide-related behaviour has a long-standing, intimate relationship with death that serves a purpose or provides the youth with an identity. Dismissing or invalidating the individual's relationship to death would be ignoring one of the most important relationships the person experiences at that point in his/her life. Within the therapeutic environment, accepting, hearing, and using the words "death" and "suicide" where it is understood as a communication, not an inevitable action is necessary. Within the developed therapeutic relationship it is important to ask questions like, "do you feel at risk" or, "are you thinking of ending your life?"; followed by asking "what would suicide do for you right now?" or "How would ending your life be helpful?" Of course, the clinician should engage in a full risk assessment when current suicidal ideation, intent and/or planning are evident (Rudd, 2006). Equally important at this phase is recognizing that difficulty and challenges are inherent in working with young people with recurrent suicide-related behaviours and we strongly encourage that careproviders seek and create their own network for consultation and support.

Participants in this study identified that moving away from death began as an ambivalent process often experienced as a state of "limbo"; having some idea that they didn't want to die, yet not knowing how to live. When encountering ambivalence with a patient, it can portend a "turning point" in and of itself. Ambivalence suggests that the person's relationship with suicide/death has become unsettled or destabilized. The potential loss of this relationship could create another crisis and yet, within the crisis may

lie the opportunity for a new self-awareness and understanding and potentially for a new choice to emerge. The clinicians' understanding of this transitional dynamic may be the key to assisting a person through the phase of ambivalence. As the person expresses ambivalence the clinician has two tasks: allow for the discussion of the person's relationship with death and also to introduce concepts and skills that will move the client toward living. Participants identified that turning points enable them to move away from death and beyond ambivalence to a new level of self-awareness. Validation of the struggle, identifying the complexity and fear of what lies ahead, identifying the "normalcy" of ambivalence as part of the healing process and being consistent in the concern for the individual's safety while introducing options and skills for keeping safe are important.

Finally, the clinician must understand that the process of transition involves many "small steps." The journey will not always be experienced as steady movement forward, and it is unlikely that two individuals will experience the flow in exactly the same way. Clinicians need to be aware of the potential for youths in their care to relapse, either in their behaviour or in their wish to engage in the relationship with death once again:

"Suicide is not something I think of every day like I used to but there is days that it's still very um close to surface and the idea seems very appealing... just to stop the fighting, the struggling, just the stress that each day comes with...but I know that deep inside that's not all what I want, even so some days it just seems like the only thing I want."

Suicidology has not addressed "recovery" from repeated suicide-related behaviours despite ample knowledge that this repeated behaviour is associated with psychiatric disorders and psychopathology. Recovery from psychiatric disorders has been studied and there are some analogous findings in that context, for example, turning points,

whether they be defining moments or gradual awareness; a process of personal discovery of how to live in the presence of enduring symptoms or vulnerabilities; having choice; healing; and connection with others or with one's role in the larger world (Ralph et al., 2002; Roberts and Wolfson, 2004; Allott, Loganathan & Fulford, 2002; Rakfeldt and Strauss, 1989; O'Hagan, 2001; Jacobson and Greenley, 2001; Jacobson, 2001). Similarly, concepts such as connections with others, hope, and seeing a future have been noted in other studies dealing with people with a history of suicide-related behaviour (Bostik and Everall, 2006; Hoover and Paulson, 1999; Paproski, 1997; Fergusson, Beautrais, Horwood, 2003; Everall, Altrows, Paulson, 2006; Everall, Bostik, Paulson, 2006; Everall, Bostik, Paulson, 2005; Taylor, 2002). Overall these studies captured the experience of individuals who are no longer at risk for self-harm and who likely displayed minimal suicidal intent during their periods of self-harm. The current study extends this research by examining youth who are still in the process of "recovery" and who were highly intent on suicide during their periods of greatest risk.

Our model suggests that the clinical management of young adults with recurrent suicide-related behaviour will be improved by understanding the function and the relationship with death experienced by these young people; being present during the period of ambivalence and perceiving the transition process as "pockets of recovery" in which the component parts are unique to each individual. Finally, the clinician needs to be aware that potential relapse either in the behaviour or the wish to engage in the relationship with death might be part of the person's process but can be consistent with recovery (Harrist, 2006; Roberts and Wolfson, 2004; Rakfeldt and Strauss, 1989; Everall, Bostik, Paulson, 2005). Further research will be required to test our model and refine it to

enhance our understanding of the transition process, and to develop more effective intervention strategies for youth with recurrent suicide-related behaviour.

### **Limitations**

The main limitation of this study is that we drew from a limited sampling frame which may have implications for the exportability or transferability of these findings to other populations who might be at risk. However, we have taken steps to maximize the trustworthiness and validity of our findings, such as ensuring that experienced clinicians played a significant role through all of the stages of data collection and analysis, and that participants and our CAP had the opportunity to examine and provide input on our evolving model. Ultimately, the value of our model will be determined by the reader/clinician who finds a new appreciation for the issues discussed in this paper (Polkinghorne, 2006) and the extent to which our findings provide useful direction in clinical practice.

### **Conclusions**

For young people with recurrent suicide-related behavior, transitioning away from death toward life for young people with recurrent suicide-related behaviour is a three-step process involving: “living to die”, ambivalence and turning points, and incremental “pockets of recovery”. Clinicians need to be able to tolerate and be comfortable with the concept of death and the intensity of the relationship with death. Clinicians need to accept, be attentive to, and use the words “death” and “suicide” to communicate an understanding of this relationship, not to suggest an inevitable outcome. Patients can live without suicide-related behaviour but this does not mean they stop thinking about suicide as an option, or that death ceases to hold an allure. The study results support the therapeutic



approach utilized in Dialectical Behaviour Therapy (Linehan 1993) and PISA. Initially the therapist's work is to validate the experience of the client and subsequently keep the person actively engaged. Our model suggests that these are crucial elements to the recovery of youth with repeated suicide-related behaviour and skills/cognitive work cannot happen until this has taken place. Clinicians need to be aware that the struggle to live is a process involving a fluid pathway moving between the three elements.

### **Author's Note**

Contributors: Rahel Eynan and Hayley Eisenberg participated by obtaining participant consent, collecting measures and demographic data and participating in team discussions. The study was funded by a research grant from the Wellesley Institute, Toronto, Ontario

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### ***Overview of Chapter 6***

While socially and clinically ambivalence often carries negative connotations about the suicidal person being “attention-seeking” or not being “serious” about wanting to die, this study highlighted that it is an integral part of transition away from RSA. This finding aroused curiosity about the lived experience of ambivalence, leading to a second qualitative study which explored this phenomenon using an IPA methodological approach, with a participant sample that was more reflective of the average age of group attendees, 36 years.

## **Chapter 7: The Experience of Ambivalence**

### ***Introduction to Chapter 7***

Following the previous qualitative study identifying how young adults viewed and experienced themselves transitioning away from RSA, this IPA study sought to examine the experience of adult participants living in the ambivalent space between life and death in the context of RSA. All participants had also completed the SfSL/PISA intervention. At the time of the submission of this thesis this study had been submitted for publication in *Psychology and Psychotherapy: Theory, Research and Practice*.

### **Surviving Moment to Moment: The experience of living between life and death for those with repeat suicide attempts.**

Yvonne Bergmans, Evelyn Gordon, Rahel Eynan

#### **Abstract:**

#### **Objective:**

The present study aimed to explore and capture the lived experience of living between life and death for adults with recurrent suicide attempts (RSA). The study sought to extend an earlier study which explored the process of transitioning away from RSA among young adults.

#### **Design**

The qualitative study used Interpretive Phenomenological Analysis (IPA); a methodology designed to explore lived experiences which enabled interpretations of the multidimensional subjective experiences of individuals living between life and death with RSA.

## **Methods**

In-depth semi-structured interviews were conducted with nine adults (eight women, one man) with a history of RSA who participated in the therapeutic group intervention Skills for Safer Living: A Psychosocial-Psychoeducational Intervention for People with Recurrent Suicide Attempts (SfSL/PISA). The six stages of IPA were used to analyse the transcribed interviews.

## **Findings**

The analysis of the interviews revealed the superordinate theme, “surviving moment to moment.” This describes a state of extreme ambiguity characterised by uncertainty and fear of life, death and the future. It also identifies two sub-states that can be occupied in this state of ambiguity: “choosing not to die” when one is more invested in dying than living and “choosing to live” when invested more in living than dying.

## **Conclusion**

The study illuminated the complex non-linear process of making destiny choices on a moment to moment basis, and how it can be both torment and provide a lifeline opportunity for those with RSA. Shifting between dying and living can be facilitated by clinicians who recognize the subtle distinctions associated with this in-between state and tailor their interventions accordingly.

## **Clinician Points**

- Living between life and death with RSA is characterised by a state of flux and indecision about one’s destiny, where the person has not fully committed to either life or death.

- Within this state there are two interlinked sub-states, whereby the person is leaning more toward death or life.
- A critical feature in working with RSA clients in this in-between state is to recognise the ambiguous state that the person occupies, demonstrate understanding of their struggles therein and tailor intervention that fits with the nuances of this way of being.
- Therapeutic responses require a fluid intersection of interventions relative and concordant to the need to make destiny choices from moment to moment, thus the practitioner has an opportunity to be a catalyst in the momentum toward life.

## **Introduction**

Among the group of people who attempt suicide, there is a subset who engages in recurrent suicide attempts (RSA). These individuals are considered by some to be a “unique population” (Monnin, Thiemard, Vandel et al., 2012; Da Cruz, Pearson, Saini et al., 2011), when compared to individuals with a single suicide attempt or no previous suicide attempt (Jakobsen, Christianson, Larson, et al., 2011; Gibb, Andover & Miller, 2009; Rosenbaum, Asarnow, Baraff et al., 2008; Forman, Berk, Henriques et al., 2004). They are reported to exhibit more severe psychological and social challenges that include struggling with future oriented thinking (McLeod, 1997); emotion dysregulation (Linehan, 1993); decreased levels of emotional awareness (Levine, 1997); difficulties in problem solving (Hawton and Kirk, 1998); and challenges in interpersonal relationships (Kern et al., 1997). Such distinctions have been associated with higher complexity and comorbidities of severe psychiatric disorders (Da Cruz, et al., 2011; Monnin, et al., 2012); interactions of neurobiological factors with stress (Mann, 1998); and / or psychological and social risk

factors including histories of trauma (Links, Kolla, Guimond et al, 2013; Yip et al., 2011; Beautrais, 2004), living in poverty (Sinclair et al., 2010; Da Silva Cais et al, 2009), and being female (Scoliers, Portsky, van Heeringen et al., 2009; Brådvik and Berglund 2009; Vijakamur et al., 2008). How these risk factors for RSA interact is not clear, nor do they predict suicide on an individual basis or illuminate the experience of living with RSA. Hence, there is little known to guide meaningful intervention with this population.

Treatment interventions for suicidality vary in targeted outcomes and the central components include reducing symptoms, risk factors, and / or suicidal behaviours (Sledge, Plakun, Bauer et al., 2014; Ward-Ciesielski & Linehan, 2014; Cuijpers, De Beurs, van Spijker et al., 2013; Brent, Greenhill, Compton et al., 2009; Harned, Chapman, Dexter-Mazza et al., 2009). Some interventions focus on addressing the needs of a population with a specific diagnosis such as Borderline Personality Disorder (BPD) including, Good Psychiatric Management (GPM), an integrated psychotherapy incorporating behavioral and psychoanalytic theory (Links, Ross & Gunderson, 2015; Sledge, Plakun, Bauer et al., 2014) or Dialectical Behaviour Therapy (DBT) (McMain, Links, Gnam et al., 2012; Linehan, 1993). Conversely, others target a particular deficit such as problem-solving (Hawton and Kirk, 1998) or focus on fostering competencies and strengths such as solution focused brief therapy (Fiske, 2008). One therapeutic intervention, Skills for Safer Living: A Psychosocial-Psychoeducational Intervention for People with Recurrent Suicide Attempts (SfSL/PISA) (Bergmans, Koorn, Eynan, & Pacey, 2014; Bergmans & Links 2002) was developed specifically for and with the RSA population, a brief description of which is provided below.



There is a dearth of published research literature focusing on this high risk and high service user RSA group. It has been noted that people considered at risk of attempting suicide are often excluded from research studies (Lakeman, 2010). Research that has been completed most often subsumes this group within samples of those with suicidal ideation, those who have made a single suicide attempt, or those who have died by suicide, often without noting intent to die. This has resulted in a sub-optimal knowledge base to guide the clinician and contributes little to influence attitudes towards a group who are stigmatized by the general population and health care professionals alike (Jo, Lee, Yim et al., 2011; Miret, Nuevo, Morant et al. 2010; Spence, Bergmans, Strike et al., 2008; Schnyder, Valach, Bichsel et al., 1999) and who are at high risk of dying by suicide (Ruengorn, Sanichwankul, Niwatananun et al., 2011; Wong, Steward, Claassen et al., 2007; Cedereke & Ojehagen, 2005).

This Interpretative Phenomenological Analysis (IPA) study set out to address some of these issues by exploring the experience of living between life and death for adults with RSA who had identified intent to die (Posner, Brodsky, Yershova et al., 2014) and who participated in the SfSL/PISA intervention. It builds on a previous qualitative study that explored the process of transitioning toward a life orientation among young adults (18-25 years) with RSA who also participated in this intervention (Bergmans, Langley, Links & Lavery, 2009). That study revealed that this transition is characterised by three interlinked phases wherein the person shifts from a strong desire to die, “living to die”, to a desire to live, “dying to live”. The current study aimed to gain a more in-depth insight and illuminate “the subjective perceptual processes involved when [participants] try to make sense of the meaning of the experience” of living between life and death for an adult RSA

group and to capture the complexities of this experience (Smith, Jarman & Osborn, 1999; p. 219).

## **Methods**

IPA was chosen given its congruency with the exploratory aims of this study and for offering an approach that prioritizes depth of analysis over breadth when the concern is complex (Smith & Osborn 2008; 2003). It was deemed the most appropriate approach to understanding the multi-dimensional subjective experiences of individuals living between life and death with RSA. With its theoretical roots in phenomenology, hermeneutics and idiography (Pietkiewicz & Smith, 2014) the primary aim of IPA is to explicate the meaning individuals' make of their subjective experience, which the researcher then tries to make sense of (Smith & Osborn, 2008; 2003). Considering the small sample size of the study, its contextual nature and the philosophical assumptions underlying qualitative research, no attempt is made here for generalization of findings.

## **Participants**

A purposive, reasonably homogenous sample (Smith & Osborn, 2008; 2003) of nine participants was used. The participants were assigned pseudonyms Susan, Aria, Penelope, Madge, Vera, Mahani, Keesha, Adrianna (females) and Pat (Male). Madge and Vera were in committed relationships and Keesha was engaged at the time of the interviews. Susan, Aria, Madge, Mahani, Adrianna and Pat identified as heterosexual. The sociodemographic status of the research participants (Table 1) is consistent with the RSA population reported in the research literature, for example, a higher number of women participating in treatment (Farrimond, 2012; Strike et al., 2006) and who are single (Kapur & Gask, 2009). All participants were over the age of 25 years with a mean age of 43 years (range 30-60 years),

had histories of RSA that spanned from 2-21 attempts beginning between the ages of 12-45 years. Participants identified having experienced initial thoughts of suicide between the ages of 6 and 45 years. All had completed at least one cycle of the SfSL/PISA intervention in the 13 years (between 1 and 12 years) prior to the interview. SfSL/PISA is a transdiagnostic, transtheoretical 20-week, once weekly, outpatient therapeutic group intervention. The goals of the intervention are to a) engage participants in considering the possibility of choosing to live and exploring how to live more safely and b) reduce the duration, intensity, and frequency of suicide attempts by enhancing awareness and skills in the spheres of affect, impulsivity, and cognition. The approach focuses on possibilities versus absolutes, views behavior as a choice, and fosters the belief that participants have the capacity to navigate suicidality safely and can connect with their own human-ness (Bergmans & Links, 2009; Bergmans, Koorn, Eynan & Pacey, 2014).

Participants were included in the study regardless of their current suicidal status. All participants reported continued unremitting or intermittent thoughts of ending their lives, and had been hospitalized for a suicide attempt, with the majority being admitted at least once to a medical intensive care unit (MICU) due to the severity of their attempt. This is consistent with research reporting that the lethality of attempts tends to be high for those with RSA (Kaslow, Jacobs, Young et al., 2006).

### **Data Gathering**

Semi-structured one-to-one interviews were used for data collection, allowing for in-depth accounts to be generated (Smith et al., 2003). The researcher was informed by an interview guide with sufficient flexibility in its use to allow participants to share their experiences in their own way while ensuring a basic line of inquiry was followed. Interviews lasted 45 to

90 minutes and were conducted with consenting participants by the lead author (YB). Following the interview participants met with the Research Co-ordinator to receive a \$30 honorarium and to ensure emotional and physical safety as per the study safety protocol (Vannoy, Whiteside & Unützer, 2010).

The interviews began with an open ended exploratory question inviting participants to talk as widely as possible about their experience of living in the space between life and death in the context of RSA. As the interview progressed, probing questions were used to help participants to elaborate and clarify their story. Interviews were audio-recorded, transcribed verbatim, and then verified to ensure accuracy of transcription. All potential identifying details were removed and the transcribed text was assigned an identification number.

### **Data Analysis**

To enhance researcher reflexivity memo writing and discussions among the author analysts were used to expose preconceptions that might unduly influence the analytic process. IPA analysis involves an overall two-stage process: firstly, the research participants convey their personal experiences, and then the researcher tries to understand and convey the meanings participants have ascribed to various phenomena in their lives. Consequently, analysis involves a “double hermeneutic” (Smith & Osborn, 2003 p. 53) whereby a meaningful narrative is co-constructed between the participant’s phenomenological account and the researcher’s interpretations of that account. The central purpose of the analysis was to discern meaning through a close and interpretive relation with the data. In IPA each transcript is analyzed separately before completing analysis across data sets (Smith &

Osborn, 2003). The six steps of analysis described in detail by Smith et al., (2008) were utilized .

#### **Step one: Initial reading of the text**

To commence the interpretation process, the transcript was read numerous times by the lead researcher to fully immerse herself in the text. Initial notes captured the essence of the participant's account and reflected the lead researchers observations and reactions to the data.

#### **Step two: Identification of emergent themes**

Labels were generated to capture the essence of the ideas or patterns within the data, and were subsequently clustered into themes, paying particular attention to issues significant to the participant experience of living between life and death in the context of RSA (Smith et al., 2013).

#### **Step three: Clustering of themes**

The themes were then collated and categorized into groups of connected material under headings representing the superordinate theme of each cluster of the initial themes. From the list, minor themes were clustered into major themes.

#### **Step four: Production of summary table**

To obtain a clear and systematic overview the clusters and associated subordinate themes were formulated into a table, which connected them to relevant participants' quotes. This process involved carefully identifying higher order themes and eliminating non-relevant or sub themes not found prevalent throughout the text.

#### **Step five: Continuing Analysis with Other Cases**

In keeping with the ideographic emphasis, the foregoing stages were then repeated for each remaining transcript, discerning repeating patterns and acknowledging convergences and divergences in the data (Smith & Osburn, 2008).

### **Step six: Integration**

The agreed upon superordinate themes from each transcript were collated and reduced to a final table of one superordinate and two subordinate themes (Diagram 1), based on their prevalence within the text and ability to describe the richness within and across the data (Smith et al., 2003).

### **Ethical Considerations**

The study was approved by the Research Ethics Board at St. Michael's Hospital in Toronto, Canada. Recruitment and consent to participate in the study was assigned to the Research Co-ordinator to guard against confusion on the part of participants regarding the distinction between clinical intervention and research, as the interviewer was known to all participants in her clinical capacity. An inter-professional team reviewed transcripts and analysis to facilitate the researcher in holding this boundary (Asselin, 2003; Hewitt, 2007, Lykkeslet & Gjengedal, 2007).

Considering the content of the interviews and the personal nature of the questions, a possibility existed that the interview would be distressing or anxiety-provoking for participants. Several steps were taken to minimize this risk: meeting with the Research Co-ordinator prior to the interview to review expectations and limitations of the interview; providing the opportunity to take breaks or to terminate the interview at any time if necessary; giving the option to decline discussing a particular line of inquiry; having a post-interview meeting with the Research Co-ordinator to ensure emotional and physical safety.

If escalation occurred, a more in-depth risk assessment would take place by a clinician on site and if necessary, the participant would be escorted to the Emergency Department for further assessment and intervention by the Psychiatric Emergency Service. Participants were also offered the opportunity to call the Research Co-ordinator if discomfort arising from the interviews occurred when they returned home. None of the research participants reported increased distress or required further intervention for potential safety issues.

### **Findings:**

This IPA study explored living between life and death for those with RSA and revealed the superordinate theme “Surviving moment to moment”. This describes a state of extreme ambiguity that is characterised by uncertainty and fear of life, death and the future. This state is endured by making choices about their life and destiny on a moment to moment basis, either “*choosing not to die in the moment*” or “*choosing to live in the moment*”. The person moves between these two interlinked states depending on their life circumstances and subjective wellbeing. While not a staged process per se, successful navigation through crisis episodes in “*choosing not to die in the moment*” creates a foundational scaffold toward the possibility of “*choosing to live in the moment*”. Thus, participants are more likely to inhabit the state of choosing not to die when they are more invested in dying than living, while they occupy the state of choosing to live when invested more in living than dying.

*“but I found a lot of the time I was kind of in a should I, shouldn’t. You know like I need a reason why I shouldn’t kill myself today and you know it’s really looking like a good idea right now but I really need to know why I shouldn’t do this right now. So I had a lot of internal discussion with myself you know okay this is my plan and I always had elaborate plans and I’d think (clears throat) for some things it was like well I can’t do that right now ...I’m going to come back to this thought because it’s really sounding good to me.”*  
(Madge)

While this state is one of torture and uncertainty, the ambiguity about both life and death provides a potential lifeline to participants as they come to a decision to not end their lives or to take the risk of living in an uncertain world.

*“Well clearly whatever methods I’ve used weren’t successful...so if that’s my way of leaving the scene because things become too difficult ...[it] doesn’t even work. So um it kind of traps you in life (laughs) and then you have a choice which I guess I always had of making life worth living or finding another way [to end my life].” (Vera)*

### **Choosing not to die in the moment**

Past experiences have taught clients with RSA the lesson that there are no certainties in life and death seems preferable to their current life experience.

*“I don’t like it here but this is just temporary you know.” (Aria)*

*“There’s a multiplicity of reasons for suicide attempts that I’ve had. I just don’t, I don’t like it here.” (Pat)*

Experiences of not being understood; loss of relationships, employment, housing and finances; iatrogenic experiences with care providers; inability to imagine the possibility of a different future; and doubting one’s own competencies perpetuates the tension of having to make destiny choices in the moment. Furthermore, shame and stigma, within oneself and by others, negatively impacts perceptions of self, interferes with the ability to understand and communicate thoughts of suicide and thwarts the ability to reach out for help.

*“...I wasn’t able to talk about any of those things nor was anyone I knew in my immediate universe able to talk about those things. ... I think the biggest thing I still struggle with 100% is shame and stigma, like it’s still a big problem for me...” (Keesha)*

“Choosing not to die in the moment” is a highly tentative, fragile, precarious state of perceiving and experiencing a tenuous existence without fulfillment or satisfaction. It is physically and attitudinally demanding, holding within it a tension between the desire to end life without full conviction that this is the right choice yet not having a belief in the



possibility of a different more fulfilling future. Participants suffer the torment of desperately wanting to rid themselves of “*having to live like this*”; believing death may be the only option for relief. They struggle to see possibilities of what life could be like and feel they have lost the life they once had.

*“I wanted all the noise in my head and the um crying and the inability to function, to get out of bed, I wanted that to end. I wanted to be happy and active and the way I had used to be um but I didn’t know how to get back to that so I had given up on that. I’d think ‘oh I’m never going to be happy again. I’m going to live like this forever. Ah I don’t want to live like this for the next 50 years of my life’, and it was just such a horrendous thought um that you know it seemed like a reasonable thing to do at the time.”* (Madge)

In this state the internal monologue of participants concerns negative self-judgments such as being a bad person, parent or friend, being mentally ill or abnormal, being someone who will never meet familial or social expectations, and feeling bereft and socially isolated. This self-perpetuating monologue is taken as evidence that the person is helpless in terms of influencing a potential future, leaving them with a strong sense of doom. Thus, while uncertain about death they cannot commit to life as this seems equally uncertain and frightening.

*“... I’m alone, I can’t do this. No one really knows what I’m going through. I can’t bear this burden any longer.”* (Penelope)

*“I mean medications don’t last for a long time either so, y’know I’m just enjoying now while I can ... . But I really do think I’ve dealt with this a long time; a lot of years of my life and so, in that respect, ... I’m being realistic in terms of the fact, that I mean there’s no guarantees I’m never going to feel like that again... yeah I might recognize earlier on when I make the choice to... do things differently but I wouldn’t necessarily say I’m not going to play Russian roulette again...It’s, it’s a loaded gun.”* (Aria)

Making the decision not to die in the moment is facilitated by a beginning recognition of one’s signs of vulnerability and triggers for a suicide attempt, and learning a vocabulary that is sufficient to articulate their emotional distress to those with whom participants feel

safe and understood.

*“Knowing that when I wasn’t safe, being able to come in here and say I wasn’t safe, having people listen to me when I said I wasn’t safe and that was basically all I could say at that point...When I’m able to say quite simply to somebody that I know speaks the same language and for me to say I’m not safe, I knew that he knew what I was saying. Whereas if I had gone anywhere else and said I’m not safe they might’ve just you know turned around and said ‘what the hell are you talking about?’ and thrown me back out.” (Adrianna)*

*“...if I’m going through a lot of self-harm thinking then I say okay let’s stop, let’s put the brakes on this and find out what’s going on and try to name the feeling. So I’m at the point now where I can do this on my own and figure out okay once I know where it’s coming from, I can usually deal with it and it will calm me down and um make it easier to live. So it’s basically putting the brakes on, name the feeling, figure out where it’s coming from and then okay I can deal with this or figure out ways to, to deal with it. Deal with it through my support, my, my caseworker.” (Mahini)*

Reaching out to others is new, therefore, it also required participants to challenge practices that increased their sense of shame and lack of trust, such as previous experiences of sub-optimal care, and perceptions of not being deserving of help or that nothing will work.

*“... I think it takes a lot of guts for a person to say ‘I’m feeling very depressed or I’m isolating’ or whatever, ‘it would be really helpful if you did x, y, z’, like that’s a really hard conversation to have with people.” (Keesha)*

### **Choosing to Live in the Moment**

In order to move away from the focus on death toward a possibility that life could be different, participants come to realize that alternative options exist and can then contemplate these options before engaging in making a choice to risk something new. This often left them feeling bereft and de-stabilized, not knowing how to live or what living might mean and being aware of the struggle to change old patterns of being.

*“I mean behavior you can change, not always the thought processes is what I’m finding. ... it’s a big struggle and, ... it becomes a bigger struggle after you have more insight...You figure out that dying isn’t as easy as maybe you had hoped it was at the time and living is a little easier but it’s still overall a lot of work, a hell of a lot of work.” (Vera)*

This process is facilitated when the participant was able to reflect upon previous suicide attempts, make some kind of sense of these and incorporate them into their lives without shame, which can be helped by others showing compassion and understanding.

*“And he said ‘well don’t apologize, keep your dignity and just move forward. You’ve done something you shouldn’t have done um, but look at it that way, as something to learn from almost you know’... Think ‘oh crap I came that close, did I really want to end my life?’” (Madge)*

With a different understanding, it is then incumbent upon the participant to share this learning with those around them so that they can be reminded of this alternative view when necessary.

*“... Once I learned that... ‘this too shall pass, ... a feeling is just a feeling’, ... You say these things a hundred times over in your head enough times and that’s when you learn ... and then you go talk to your friends, family, your partner or whoever and get them to help reiterate that stuff with you, ... you gotta teach yourself ...that’s what’s destabilizing...give a vocabulary to yourself and then help others learn the vocabulary and accept the vocabulary as well. It’s a lot of work and it can be very...like you know...upsetting and sad...end points and high points.” (Keesha)*

Participants also realize that they are not alone in their in-between world, which changes their negative perspective of themselves as aberrant and allows them to open up to others about their fears and anxieties.

*“...when I could understand that people struggle with suicidality, that it’s not uncommon, that people struggle with depression, that people struggle with thoughts of harming themselves, ... it just wasn’t me because for a long time I just thought it was me ... Once I learned that there were folks walking with heavy boots all over the place then, I just felt like I could say to my friends, my parents, like ya know, ‘I’m not a freak here’.” (Keesha)*

*“...,the reason for a lot of [suicide attempts] was that I believed that I failed my brothers and my sister because of how their lives turned out ...X said...it’s unrealistic for you to expect that you could’ve done anything different. You were only a child...then I said you know, I’m scared if I failed then I might fail my own kids and he said you’ve got to stop blaming yourself for your brother and sister...and nobody had ever said that before*

*either...I've never thought of things like this before you know like want, wanting to secure my boys future. ... never thought that you know I could do it but now I've proven to myself I can do it"* (Susan)

In summary, living in the in-between world is an ambiguous state wherein participants vacillate between choosing not to die and choosing to live on a moment to moment basis, with a gradual move toward more consistent times of choosing to live in the moment. This shift is facilitated by learning how to communicate their distress to those who will accept and understand them and gaining an increased sense of personal control and agency as they develop skills to keep themselves safe.

## **Discussion**

The subjective experience of suicidality has been under-researched with the majority of the published research focused on risk factors and underlying pathology (Hjemeland, 2016; Lakeman and Fitzgerald, 2008). However, there are a small number of previous qualitative works investigating the trajectory toward and away from suicidality in addition to living with suicidality that resonate with key findings from this study. Such works identify the themes of emotional pain (Selby, 2014) and suffering (Lakeman & Fitzgerald, 2008) when living with suicidality, and the importance of connection, coping, and turning points when overcoming suicidality (Chung, Caine, Barron et. al., 2015; Gordon, Stevenson, Cutcliffe, 2014; Han, Chiu, Liu et al., 2014; Leitner, Barr & Hobby, 2008; Cutcliffe & Barker, 2002; Schnyder, et al. 1999). Furthermore, many of these studies identified that clinician attitudes and behavioural responses impacted on the persons' ability to seek, engage with and benefit from professional help (Gordon, Stevenson, Cutcliffe, 2014; Sun, Long & Tsao, 2014; Samuelsson et al., 2000; Talseth, 1999).

In this study the “struggle” is reflected through survival being on a moment to moment basis for people with RSA. Survival in this ambiguous state is both a lifeline and a torture and may partially explain RSA, as death remains an option while the person remains uncertain about both life and death. “Suffering” is evident as surviving is characterized by fear, being trapped in truncated thinking with little sense of control, not knowing what options are available and what choices can be made to survive challenging moments, or what the future might entail. It is also a state of opportunity when choices are realized and can be actualized.

The theme of “connection” was evident in this study also as participants identified that an inability to trust oneself or others, and/or fear of recrimination and negative responses may prevent them from reaching out and seeking help. Participants identified the critical role of nonjudgmental, available support persons who understood their unique experience in re-connecting with self, other and the world around them.

Prior research suggests that the essence of intervention goes beyond attenuating risk factors, pharmacotherapy and instrumental care to include collaboration, respect, individualized approaches, and an inherent belief in the value of the suicidal person (Gordon, et al., 2014; Cutcliffe, Stevenson, Jackson et al., 2006) where the pain has been acknowledged and validated (Gordon et al., 2014; Sun, Long & Tsao, 2014; Samuelsson et al., 2000; Talseth, 1999). Participants in this IPA study provided further evidence that the kind of responses that clinicians provide can influence their momentum toward life and that understanding and compassion are central features of care-giving that is valued by them.

This study adds to existing literature by providing an insight into the experience of living between life and death for those with RSA. This experience, surviving moment to

moment, incorporates two sub-states which people vacillate between depending on their life circumstances and feeling of subjective wellbeing, thus it is important that clinicians understand the precarious nature of this position and intervene in ways that assist the person to tolerate their pain and possibly promote a shift toward a stronger engagement with living.

### **Implications for Clinical Practice**

Clinicians working with clients who are in this survival state need to tailor their responses depending on whether the person is leaning more toward living or dying. They have an opportunity to intervene in ways that facilitate movement towards choosing not to die when in crisis states, or choosing to live when the person is less distressed. Thus, this in-between state can be a turning point in a person's decision-making process about their destiny whereby the clinician acts as a catalyst toward living. As noted in previous works, skill development and enhanced self-understanding (Han et al., 2014; Gordon et al., 2014; Leitner et al., 2008; Bostik & Everall 2007; Everall et al. 2006; Bennett, Coggan, & Adams, 2002; Taylor, 2002, Paproski, 1997) are associated with healing from suicidality. However, the emphasis placed on each of these key areas needs to fit with the sub-state of survival of the client living between life and death with RSA.

When choosing not to die in the moment participants elucidated that, regardless of chronological age, the ability to identify or articulate their emotional distress in a way that can be understood by themselves or others cannot always be retrieved or, in some cases, known. This stage is fraught with fear, vulnerability and fragility, and yet also great strength and determination in making the choice not to die right now. During this period intervention centres on early stage treatment strategies including safety planning,

development of a therapeutic alliance, containment and stabilization (Livesley & Clarkin, 2016; Najavits, 2015; Courtois, 2007). De-escalation of the intensity through crisis management strategies (Granello, 2010) alongside the identification of the experienced emotions and their life context assist in creating a “story” for understanding the experience for the client.

The clinician can help the person to develop a vocabulary for and understanding of their intense emotional turmoil and enhance skills for managing their daily lives, given that “undifferentiated states of high emotional arousal - *unstoried emotions*—are almost always experienced as disorganizing, distressing, and frightening by participants” (Angus & Greenberg 2007 p.21). When intervening with the client who is choosing not to die in the moment, recognizing the client’s perception of little or no personal agency (Pascual-Leone and Greenberg, 2007) is essential.

Explicitly acknowledging the person’s agency in making a choice to not die in the moment and the deep-seated fear and shame that exists facilitates re-connection and are initial important steps available to the clinician. Participants also benefited from being able to connect with others who lived with RSA, hence the group factor of universality (Yalom & Leszcz, 2005) allowed participants who attended SfSL/PISA to be heard and understood by others who shared the same struggle, aiding in diminishing the perception of the struggle being unique to them.

When the person is in a state of choosing to live, intervention is a fluid combination of raising awareness of the function of suicide and one’s unique vulnerabilities, expanding the vocabulary of emotions, identifying emerging needs, and developing de-escalation and problem solving skills in the event of a future crisis. However, gaining a sense of agency

and control is an evolving process that requires time and it is worth bearing in mind that becoming suicide attempt free could take up to a median 7.18 years (Perry, Fowler, Bailey, et al., 2009; Cedereke & Öjehagen, 2007), thus clinician patience is necessary so that s/he can move at the clients' pace. It also needs to be recognized that with greater awareness, there will also be de-stabilization until the individual is accepting of their own agency and ability to make choices and take moments of control.

When choosing not to die in the moment, interpretations might not be salient rather, only when choosing to live in the moment, or when “the iron is cold” (Pine, 1986), can interpretations or observations that are “useable” (Pine, 1986) be introduced. Participants in this study elucidated that when choosing to live in the moment, exploration into the meaning of their suicidality is more possible. This can be facilitated by examining the possible functions of RSA, for example that the behaviour represents: a communication intended to externally express the internal experience or ask for help (Latakiene, Skruibis, Dadašev et al., 2015; Zayas & Gulbas, 2012; Hjelmeland, Knizek, & Nordvik, 2002; Knizek & Hjelmeland, 2007); a coping strategy to distract from negatively attributed emotional states (Linehan, 1993, Selby et al., 2014); an effort to eradicate perceptions of imperfection when believing that the expectations of others or self could never be met (Flett, Hewitt & Heisel, 2014); or a perception of oneself as a burden (Joiner, 2005).

Finally, negative attitudes among clinicians can serve to diminish the extremely fragile state of participants, resulting in clients perceiving themselves as inherently flawed. Therefore, clinicians need to challenge their own assumptions about this client group.

## **Conclusions**



This study provides a unique insight into the ambiguous state of survival between living and dying for those with RSA as participants grappled with the angel of death while also grappling with the demons in their lives. It identifies two sub-states that can be occupied in this position, one that is more reflective of being primarily invested in dying and one that reflects being more invested in life. It sheds light on the complex, non-linear process of making destiny choices on a moment to moment basis, highlighting how it can both torment and provide a lifeline opportunity for those with RSA. The study demonstrates that the person moves between these two states depending on their life circumstances and subjective wellbeing. Finally, it illuminates how shifting toward the latter can be facilitated by clinicians who can demonstrate understanding and acknowledge the struggle associated with this in-between state and intervene in a validating and authentic manner to meet the person where they are at any point in time.

This requires the clinician to be aware of their own assumptions about RSA and their attitudes and behavioural responses toward this client group. The clinician's role is to empathize with the fragility and uncertainty of the client, acknowledge their resourcefulness and assist in expanding their understanding, insight and emotional literacy, and to enhance skills to manage their lives in the context of RSA.

**Table 1: The sociodemographic profile of participants**

Gender:	8 women, 1 man
Age:	Mean: 43 years; Range: 30-60 years
Sexual Orientation:	Lesbian: 2; Bisexual: 1; Heterosexual: 6
Relationship Status:	Married: 1; Engaged: 1; Single: 1; Separated: 1; Divorced: 4; Common- Law: 1
Age of First Suicide Attempt:	Mean: 29 years; range: 12-45 years
Age of Initial Suicidal Thinking:	Mean: 18 years; range: 6-45 years
Number of Suicide Attempts:	Mean: 6.75; range: 2-21 attempts

**Diagram 1: Superordinate & Sub-ordinate Themes**

Surviving Moment to Moment  (Making choices about one's life and destiny on a moment by moment basis without clear commitment to either life or death)	
Choosing not to die in the moment  (A precarious state of enduring a life without fulfillment or satisfaction, not being sure that the experienced pain can be survived without death, nor certain that life can be different from what they have experienced. All energies are put toward not dying in the moment.)	Choosing to live in the moment  (A state where there is a perception of having control in managing risk of a suicide attempt, despite experiencing challenging feelings and thoughts of suicide.)

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## **Chapter 8: Discussion: Understanding and Responding to Recurrent Suicide Attempts**

### ***8.0 Introduction to chapter 8***

This final chapter of the thesis will discuss the combined results of the reported four studies, drawing together what is concordant with the published research on suicidality in general and what the studies in this research project have highlighted as potentially unique for individuals with RSA who have participated in the SfSL/PISA intervention. The chapter will identify how SfSL/PISA is similar to and differs from identified best practice interventions for suicidality; concluding with implications for practice, future directions for study in this area and the strengths and limitations of this research project.

### ***8.1 Overview of the Project***

The studies comprising this research project highlight the complexities of life and treatment intervention for the RSA population and add to the existing body of literature in the area of suicidology, thus their unique contribution is highlighted.

#### **The Quantitative Studies:**

The quantitative studies identified that key areas of risk, deficit and challenge known to be associated with the RSA population can change with appropriate intervention, such as SfSL/PISA, as evidenced in significant decreases in scores related to depression, hopelessness, impulsivity and alexithymia. Increases in the ability to problem solve and improved satisfaction with life were also evident. Therefore, SfSL/PISA is a beneficial

response for RSA. Furthermore, the need for ongoing routine clinical evaluation using these measures is recommended.

### **The Qualitative Studies:**

The qualitative studies support previous recovery oriented work and add to the current knowledge base regarding this process for RSA. They also identify factors associated with impeding and facilitating transitioning away from RSA. They highlighted the need to understand the client's meaning making of their behaviour, that the person may have no, or limited, ability to name or describe emotion, and that problem solving cannot occur until the intensity of the emotions has de-escalated. The Grounded Theory study highlighted that the process of transition from a death to a life orientation involves experiencing a phase of ambivalence that contains significant moments of insight and space to contemplate change and the future prior to committing to living. The IPA study re-confirmed that ambivalence is a crucial aspect of living with RSA and that recovery is a complex, fluid, non-linear process where the person oscillates between leaning toward death or leaning toward life depending on their life circumstances and personal sense of wellbeing at a moment in time. This process involves two interlinked phases providing a practice model for those working with RSA populations, whereby different interventions are required at each phase as discussed below.

### ***8.2 Situating the Study Findings and Implications for Clinicians***

These studies illuminate the turbulent experience of living with RSA and highlight the complexity of transitioning away from RSA. They expand upon Lakeman & Fitzgerald's (2008) themes of "getting over being suicidal"; suffering/psychache, struggle, connection,

turning points and coping. The struggle strongly identified by young adult participants was nested in ambivalence characterized as the simultaneous wish to live and wish to die (Orbach, Jobes & Tanney, 2008) and has been suggested as characteristic of suicide attempts (Leenaars, 2010). O'Connor, and colleagues (2012) suggest that there are different typologies of suicide that include ambivalence nested between a wish to die and a wish to live, with each potentially requiring diverse treatment options (Lento, Ellis, Hinnant & Jobes, 2013). This project suggests that rather than typologies, Living to Die, Ambivalence, and Dying to Live are fluid and interlinked phases that people with RSA experience, with ambivalence being further distilled to two separate phases, each with its own emphasis in a death or life orientation.

Klonsky and May (2015) identify a knowledge gap between those who make nonfatal attempts and those who die by suicide, hypothesizing that there may be important differences in clinical presentation, motivation or other characteristics between those with ideation and those who die by suicide. What remains a gap, is understanding what in their three-step theory, pain and hopelessness, connectedness or capacity is different for the RSA population. This project suggests that there may be a further differentiation between those who make repeated attempts from those with single attempts or who die by suicide, an impediment to providing the most effective interventions for potential subgroups within the RSA population.

Study findings illuminate challenges in identifying and understanding emotions, resulting in the individual not being able to articulate their life story, thus having no coherent story to tell themselves or others (Muller, 2000). Hence distress is communicated through suicidal behaviours (Vanheule, Verhaeghe, & Desmet, 2011), potentially

contributing to misunderstandings or misattributions by clinicians, family and friends (Cutcliffe and Barker, 2002; Spence et al. 2008). These studies highlight the critical role of participating in an intervention with others who have similar experiences and the need for nonjudgmental clinicians whilst learning a language to communicate and understand their internal distress. This is important as negative behaviour patterns and responses from others are thought to fuel engagement in further RSA (Levi, Horesh, Fischel et. al. 2008) potentially creating a self-perpetuating cycle.

Concordant with previous studies, themes of entrapment, fear, and being out of control complicated by a perceived or real inability to problem-solve and to access social supports (O'Connor et al., 2013) were identified for study participants. This finding supports previous literature noting problem-solving interventions as showing some efficacy (Comtois, 2002; Leitner et al., 2008). However, within the context of the SfSL/PISA intervention such skill development occurs later in the intervention, after crisis de-escalation strategies have been learned and the components of emotional literacy developed. Furthermore, problem-solving strategies are introduced after the purpose and role of support networks have been fully examined.

The results of this research project suggest that the SfSL/PISA intervention provides a safe environment for personal growth, destabilizing an entrenched belief system that fosters RSA. As noted by Strike and colleagues (2006), participation in the SfSL/PISA engendered a greater openness to engaging with formal mental health and addictions services, thus it can be an initial gateway for change for some people while for others it can be a sufficient intervention in itself to foster the transition away from RSA. It is important for clinicians working in the area of RSA to appreciate the complexity of this

state of being, particularly whilst surviving in the moment and to tailor intervention to meet the unique needs of the individual, incorporating peer support where possible as this fosters change and provides much needed support. The studies in this research project highlight that individuals with RSA lack the actual skills addressed by the SfSL/PISA intervention to live more safely thus, skill training is an important component of interventions for this population. Routine and ongoing evaluation from the beginning of intervention is needed in order to create a robust data base for further research with this highly vulnerable population.

### ***8.3 Implications for Research***

Future research arising from these studies could include:

1. Testing the grounded theory of transitioning away from RSA with other samples of the RSA population, such as older people and with those presenting with single SA.
2. Utilizing a combination of self-report, qualitative interviews and researcher directed measures to enable a stronger evidence base to discern if there are specific subgroups among the RSA population who make progress, do less well, or make no changes.
3. Incorporating measures of suicidality beyond proxy measures such as the Beck Scale for Suicide Ideation or the Sheehan Suicidality Tracking Scale (2015), which would capture the frequency, intensity, and duration of suicidal crises for participants.
4. Conducting follow up studies with those who fail to complete the SfSL/PISA intervention to discern who might not engage with or benefit from this intervention.

#### ***8.4 Comparing SfSL/PISA with Effective Intervention for Suicidality***

Key components considered necessary for effective intervention for suicidality (not specific to RSA) (Rudd, 2014; Sledge et al., 2014) are met within this intervention for RSA as follows:

1. A conceptual framework for understanding and intervening that can be easily understood by participants to help them make sense of their suicidal behavior and hopelessness. SfSL/PISA begins by working to name and understand the emotional pain underlying suicide attempts by working from the position that suicidality arises out of great emotional pain (Selby et al., 2014; Shneidman, 1993) and those emotions require naming in order to be understood (Angus and Greenberg, 2007).

2. Targeting identifiable skill deficits in the areas of emotion regulation, anger management, problem solving, cognitive thinking errors and interpersonal relations. This is addressed after the initial work regarding the meaning of safety, a person's rights and initial de-escalation strategies have been identified. Skill enhancement is promoted through the predictable structure of starting each session with a voluntary sharing of skill utilization, "aha moments" and challenges experienced since the previous session whereby the participant(s) is encouraged to relate their discussion through the framework of identifying a situation, the emotions, thoughts, choices and behaviours. Group members are invited to offer insights and observations, expanding the repertoire of emotion identification and choices available if they were to, or have experienced a similar situation. Over the course of the 20 week intervention, each session has a skill teaching component with each 'module' (crisis de-escalation, emotional literacy, problem solving and interpersonal relationships) building on content from previous sessions.



3. Participants taking personal responsibility for growing awareness and control for their treatment and safety is attended to via the explicit promotion of personal agency and choice and expectation that participants and facilitators will be mutual learners and teachers in the intervention. Choices are respected and alternative viewpoints are offered as options that can be rejected or accepted.

4. In recognizing and insisting on the participants' taking responsibility for their safety and growth in the therapy, group rules emphasize: a. each persons' right and responsibility to ensure their own and the safety of others; b. behaviour is a choice; c. they are responsible for their decision to live. Facilitation team members are clear from the outset that they are unable to enforce change in attendees feelings, thoughts, or decisions.

5. Treatment compliance through a structured and consistent manner, as noted by Rudd (2014) is enacted in the consistency by team members through attitude, behaviour and adherence to principles of adult learning models (Canadian Learning and Literacy Network, n.d.). The 3 C's- Competency of the individual, Choice and Control in the context of keeping as safe as possible are at the core of each discussion. Choices are not dichotomized in terms of good/bad rather as safe or not as safe and this language is fastidiously adhered to.

6. Using the therapeutic relationship to engage and address suicidal behaviour actively and explicitly; prioritizing suicidal behaviour as a topic that needs to be addressed when it emerges and provision of support for the therapist are intervention components noted only by Sledge and colleagues (2014), yet are key to the SfSL intervention. Each participant is aware that they are admitted to the group because they have engaged in suicide attempts with intent to die thus, although methods and means are not discussed in

session, unsafe, safer, and safe behaviours are discussed. Check-ins routinely ask a person to identify their current state as informed by the reported studies - from living to die, choosing not to die, choosing to live, or dying to live. Team members actively work at developing a therapeutic relationship and alliance through interest, curiosity, caring, empathy, and an active desire to learn and understand from the challenges, skills, and insights participants share. Provision of support for the therapist occurs through mandatory weekly team supervision and informal support for team members when the need arises.

7. Access to crisis and emergency services with an understanding of the unique circumstances constituting a crisis for each individual is reflected in early session content, the development of a hierarchy of personal networks, access to available and willing facilitators, and the requirement that each participant have an individual therapist.

8. As noted by Rudd (2014), the requirement of consistent documentation of what happens in treatment is met in SfSL/PISA through the provision of weekly minutes of the previous session to participants as it is understood that most participants will feel some level of distress within a session or some will dissociate thus, there is a high potential of cognitive processing abilities not being at their most optimal in session.

Therefore, in summary SfSL/PISA meets with guidelines for best practice in suicidality intervention.

### **8.5 Tensions between the Roles of Clinician and Researcher**

As a researcher/clinician I had multiple roles within this project, including being the creator of the SfSL/PISA intervention, the facilitator of multiple groups and the researcher in this

project. Therefore, I needed to remain mindful of my relationships with the intervention, the participants and the study process in order to ensure that my biases did not unduly influence the research process or outcomes.

Strategies incorporated to manage this included explicitly stating the boundary between researcher and clinician with participants at the initial recruitment conversation and explaining the purpose of the interview, which was done by the research co-ordinator. My role as researcher was respected by all participants and no clinical issues were raised during the interviews. To ensure as far as possible that the practice model and themes developed within the qualitative studies were reflective of the data gathered, interprofessional research team discussions were incorporated into the analytic process. Measures to further strengthen an awareness of my biases or potential lapse into a clinical interview included the utilization of a reflective journal and supervisors reading the interviews and analysis. Remaining true to the constant comparative method and theoretical sensitivity in the grounded theory study and utilizing a theoretical context to check and bracket preconceptions in the IPA study, further assisted in mitigating preconceptions that might have been present.

However, my background and experience also contributed positively to the process. It promoted sensitivity to client issues allowing me to address questions that had not previously been asked of this population. Furthermore, having had a prior relationship with participants may have contributed to participant openness in the research conversations that might not otherwise have been possible.

## 8.6 Strengths and Limitations

Within research, limitations are to be expected and often the strengths of a study include uncovering knowledge that supports previous research or takes the field to a new or different understanding of the area of study. The overall strength of this research project is a deeper understanding of the experience of RSA and the process of transition, and recognition that participation in an intervention created with and those with RSA does result in changes in risk factors and deficit areas. Conducting four studies and utilizing different methods allowed weaknesses in methodologies to be addressed.

In relation to the quantitative studies, the use of self-report measures can raise challenges with regard to completion (Shrive, Stuart, Quan et al., 2006), social desirability, self-evaluation biases or acquiescent responding whereby responses are an agreement to statements without regard for the content (Paulus & Vazire, 2007). Reference biases might also exist in terms of unique comparative standards whereby one person might understand a single question differently from someone else (West, 2014). A reason for incomplete or a refusal to complete pre-group measures were anecdotally reported as a belief that, *“I figured I wouldn’t be alive by 20 weeks so why waste the paper.”* Others report that when completing post group measures *“I filled them out based on how I have been feeling for so many years, not recognizing my own changes. I had to start all over again when I realized things were different”*, concordant with previous writing on the limitations of self-report measures, while at the same time, being a finding in and of itself regarding perceptions of transitioning not being immediately obvious to participants.

Further limitations in the qualitative studies included a selection bias in terms of participants self-selecting to take part, which excluded information regarding the experience of those who might not have been able to, or wanted to discuss their process. The gender imbalance might also be considered a limitation as the voices of males were not strongly represented in the studies.

### ***8.7 Summary***

This research project comprises four distinct yet interlinked studies that explore the changing relationship with suicide among RSA participants who were involved in an intervention developed specifically for and with this population. It demonstrates that those attending the SfSL/PISA intervention made significant changes in key areas of challenge and deficit. It also highlights that the change process for RSA is complex and unique to each participant, without a clear pathway that follows a linear step-by-step formula. However, there are some key ingredients that enhance the transitioning process, such as recognizing: that change requires time; that the person needs to be met at their unique place on the suicide trajectory; and that understanding and compassion from peers and clinicians can be a catalyst toward life a orientation. Thus, the project contributes to knowledge and practice in the area of suicide, in particular RSA.

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## APPENDICES

### Appendix A: Research Ethics Board Annual Renewed Approval

LI KA SHING KNOWLEDGE INSTITUTE KEENAN RESEARCH CENTRE LI KA SHING INTERNATIONAL HEALTHCARE EDUCATION CENTRE

Research Ethics Office  
Telephone: (416) 864-6060 Ext. 2557  
Facsimile: (416) 864-6048  
E-mail: [gate@smh.toronto.on.ca](mailto:gate@smh.toronto.on.ca)

**St. Michael's**

Inspired Care.  
Inspiring Science.

June 12, 2012

Ms. Yvonne Bergmans,  
Department of Psychiatry,  
St Michael's Hospital

Dear Ms. Bergmans,

Re: REB# 11-062 - Transitioning From Repeated Suicide Attempts

<b>REB APPROVAL:</b>	<b>Original Approval Date</b>	<b>May 25, 2011</b>
	<b>Annual/Interval Review Date</b>	<b>May 25, 2013</b>

Thank you for your communications dated **May 25, 2012** requesting an annual review and approval regarding the above named study.

This letter will serve as an extension of the St. Michael's Hospital (SMH) Research Ethics Board (REB) approval for the study for a period of 12 months effective from May 25, 2012 – May 25, 2013. Continuation beyond that date will require further review of REB approval.

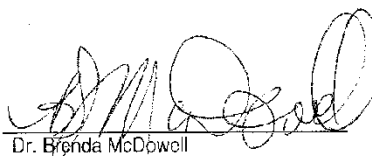
During the course of this investigation, any significant deviations from the approved protocol and/or unanticipated developments or significant adverse events should immediately be brought to the attention of the REB.

The St. Michael's Hospital (SMH) Research Ethics Board (REB) operates in compliance with the Tri-Council Policy Statement Ethical Conduct for Research Involving Humans, the Ontario Personal Health Information Protection Act, 2004, and ICH Good Clinical Practice Consolidated Guideline E6, Health Canada Part C Division 5 of the Food and Drug Regulations, Part 4 of the Natural Health Product Regulations, and the Medical Devices regulations. Furthermore, all investigational drug trials at SMH are conducted by Qualified Investigators (as defined in the latter document).

Good luck with your investigations.

With best wishes

☐ Dr. Bob Hyland  
Chair, Research Ethics Board  
BH/BJM/dk

☒   
Dr. Brenda McDowell  
Vice Chair, Research Ethics Board

Ms. Yvonne Bergmans (REB# 11-062)

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30 Bond Street, Toronto, ON M5B 1W8 Canada 416.360.4000, Fully affiliated with the University of Toronto. [stmichaelshospital.com](http://stmichaelshospital.com)

## **Appendix B: Sample Letter To Participants**

### **Letterhead**

**Dear \_\_\_\_\_**

You are being asked to consider taking part in a study at St. Michael's Hospital entitled "Transitions for Individuals with Recurrent Suicide Attempts." Participation in this research study is voluntary and you do not have to participate if you do not wish to.

#### **What is this study all about?**

In this study we are trying to understand the process(es) that people who have experienced repeat suicide attempts undergo in their transition away from repeated suicide attempts.

#### **What will I be asked to do?**

If you agree to participate in this research study, you will be asked to come to the offices of the Suicide Studies Unit at St. Michael's Hospital once.

You will first meet with the research co-ordinator for an explanation of the study and to go over the consent form. After you have signed the consent form, you will have a face to face meeting with the researcher which will last between 1-1.5 hours. You will be asked some general questions about your transitions in general. With your permission, the session will be audio-taped. If you do not agree to have the interview audio-taped, the researcher will write notes during your interview.

You will be given a maximum of \$30 to cover any costs incurred as a result of participation in this study

#### **Who does this study benefit?**

Your responses will help us improve our understanding of the process of transitioning away from high risk suicide-related behaviours so we can provide more meaningful clinical interventions to individuals who experience repeated suicide attempts.

#### **How can I get more information?**

Our research co-ordinator will contact you in the next 3 weeks or you can call Rahel Eynan (416-864-6060 ext. 2695) to find out more about the study or to arrange a time to meet. If you do not wish to participate, please: 1. leave a message at 416-864-6060 ext. 4078. Or 2. Let the researcher know at the time of the telephone contact. I am looking forward to hearing from you and meeting with you soon.

Sincerely,

Rahel Eynan, MA, PhD (cand.)

Research Co-Ordinator

Suicide Studies Unit; Arthur Sommer Rotenberg Chair in Suicide Studies

St. Michael's Hospital – University of Toronto

**Appendix C: Sample Letter of Information and Consent to Participate in a Research Study**

**St. Michael's**  
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**LETTER OF INFORMATION and CONSENT TO PARTICIPATE IN A  
RESEARCH STUDY**

**Study Title:**

Transitioning From Repeated Suicide Attempts

**Principal Investigator:**

**Yvonne Bergmans, MSW, RSW**, Suicide Intervention Consultant  
Arthur Sommer Rotenberg Chair in Suicide Studies,  
St. Michael's Hospital-University of Toronto  
416-864-6060 ext. 4078 (Monday to Friday, 9:00am to 5:00pm)

**Study Supervisory Team:**

**Eveyn Gordon, RPN**,  
Reg. Fam. Ther. (FTAI.), MSc., PhD,  
Dublin City University, Dublin, Ireland  
Email: evelyn.gordon@dcu.ie  
Tel: +353 1 700 7704 Room: H235

**Paul S. Links, M.D. FRCP (C)**,  
Professor, Department of Psychiatry and  
Chair of the Arthur Sommer Rotenberg  
Chair in Suicide Studies,  
St. Michael's Hospital-University of Toronto  
416-864-6060 ext. 6099

**Professor John R. Cutcliffe**, RMN, RGN,  
RPN, RN, BSc(Hon) Nrs, PhD  
'Acadia Professor of Psychiatric and Mental  
Health Nursing', University of Maine, USA.  
Adjunct Professor of Nursing, University of  
Ulster, UK; University of Malta, Malta and  
University of Coimbra, Portugal.  
Associate Editor (Americas): International  
Journal of Mental Health

You are being asked to consider taking part in a PhD student research study. Yvonne Bergmans is a PhD student who will conduct the research under the supervision of Dr. Evelyn

Gordon faculty supervisor at Dublin City University, Dr. Paul Links, Chief of Psychiatry, London Health Sciences Centre, London Ontario, and Dr. John Cutcliffe, Professor of Psychiatric and Mental Health Nursing, University of Maine, USA.

Before agreeing to take part in this study, it is important that you read the information in this research consent form. It includes details we think you need to know in order to decide if you wish to take part in the study. If you have any questions, ask a study investigator or study staff. You should not sign this form until you are sure you understand the information. All research is voluntary. You may also wish to discuss the study with a family member or close friend.

### **Background and Purpose of the Study**

People with repeated suicide attempts have been identified as being at higher risk for dying by suicide. They often have more psychiatric diagnoses, more suicidal ideation, depression, hopelessness and other risk factors that increase their risk. Professionals are not able to predict suicide at an individual level yet, how clients understand their suicidality and what is required to help them move beyond the risk of suicide remains relatively unknown.

By having a conversation with individuals, we can gain insights into how people move (or “transition”) from high risk suicide-related behaviours. With a better understanding, we may be able to identify best practices for clinicians or make recommendations that may improve the health care received by others who have had similar experiences to yourself.

### **Description of the Study**

- If you agree and consent to participate in this study, you will be asked to participate in an interview. Before the primary interview begins, you will meet with the research co-ordinator who will go through a short demographic form with you that will ask questions like your age, education, and intervention experience. These questions will give us a bit of a background information about you. You will then meet with the researcher for an interview where you will be asked to answer questions to help us learn more about transitioning from high risk suicide related behaviours. In particular, we are very interested in your understanding of the process of this experience. You will be asked to discuss your experiences and discuss factors that may have helped or hindered your process of transition.
- The interview session will be at a convenient time and place and should last approximately 1-2 hours.
- The interview will be audio taped and transcribed to allow the researcher to remember the information shared throughout the interview. Written notes may also be taken during the interview.
- If you do not give permission for audio-taping, the researcher will make notes of your comments to capture general thoughts and themes.
- We will send you preliminary model/findings if you wish, to confirm the thoughts or meaning expressed to ensure that it makes sense to you.
- Your St. Michael's Hospital chart will be reviewed to corroborate that you have been admitted to hospital for a suicide attempt.

### **Potential Harms (Injury, Discomforts or Inconvenience):**

- Talking about your thoughts and experiences may be upsetting. If you are upset at any time, you can stop the interview and support/assistance will be offered to you.

- If you feel uncomfortable answering any of the questions, you may refuse to answer any question and the interviewer will skip to the next question. You may stop the interview at any time.
- In the event that you disclose safety concerns (for example, any notions of self-harm, suicidal and/or homicidal ideation), the interview will not continue in order to secure assistance. You will be asked if we can contact someone on your personal network, such as a case manager, psychiatrist for support. If necessary, you will be taken for further assessment to the Emergency Department. If this is the case, we will inform the treating team that you identified elevated risk while participating in a research interview. Whatever you disclose to the clinician would be included in your clinical record.

**Potential Benefits:**

- You may or may not benefit from participating in this study.
- Participating in this study may or may not provide greater insight to your transition process.
- Participating in this study may or may not contribute to knowledge concerning from your illness.
- Results from this study may be used to make recommendations to improve the health care received others who have had similar experiences to yourself.

**Alternatives to Participation:**

The alternative to participating in this study is to not participate. You will continue to receive the standard of care available for your condition regardless of whether you participate in the study or not.

**Confidentiality and Privacy:**

- Confidentiality will be respected.
- The research team is committed to respecting your privacy. They will make every effort to keep your study information private and confidential in accordance with all applicable privacy legislation. No information that reveals your identity will be released or published without your permission.
- You are requested not to state your name or the names of anyone else or any institutions during the audio-recording of the interview. However, if this happens, you should know that the audio-taped interview will be transcribed (typed out) in such a way that any potentially identifying information is removed or coded.
- Identifiable information like your name, your address, names of your family members, physicians, hospitals etc. will not be included in the final interview notes/transcript or in any reports.
- Your voice, when audio-taped, is considered to be identifying personal information.
- If your interview is audio-taped, the tape will be destroyed once it has been transcribed (typed out word for word) and verified to be accurate. All links between your name and study data will be broken once the information has been verified. The only information that will be kept will be what was transcribed/interview notes and any questionnaires that were completed.
- The study data (e.g. interview transcripts, completed questionnaires etc.) will be securely stored until the study results have been presented or published at the Suicide Studies Research Unit, here at St. Michael's. Access will be limited to authorized persons, members of the research team and the St. Michael's Hospital Research Ethics Board, who may look at study records (such as the consent form), for the purpose of monitoring the study.
- The results of the research will include information from many people grouped together so that no one person can be identified. For example, we might use a quote by you and say in the publication that the quote was from someone with your perspective (e.g. F1). Your name will not be revealed, and a nickname or a generic description (e.g. F1) will be used.

Any responses, records or personal information that could be linked to you will not be reported or shared with anyone outside of the research team, unless required by law.

- It is important to understand that despite the confidentiality and privacy protections being in place, there continues to be the risk of unintentional release of information. Members of the research team will protect your consent form, the audio-tape and transcripts to the greatest degree possible. The chance that your study information would be accidentally released to anyone outside of the research team is small.
- If you share information about an ongoing child abuse situation or tell us information that might be harmful to yourself or others we are required by law to tell this kind of information to the appropriate people.
- It is important to understand that a researcher's job of confidentiality is not definite. In certain exceptional and compelling circumstances, researchers may have legal and ethical obligations to make known information revealed in confidence.

### **Publication of Results**

- If the results of this study are published, presented at conferences or other public meetings, none of your personal information will be shared without your permission.
- We may present this study and/or the information generated from this study at a scientific conference and we intend to write an article about this study for a scientific journal.

### **Participation and Withdrawal**

Participation in any research study is voluntary. If you choose not to participate, you and your family will continue to have access to customary care at St. Michael's Hospital. If you decide to participate in this study you can change your mind without giving a reason, and you may withdraw from the study at any time without any effect on the care you and your family will receive at St. Michael's Hospital.

### **Costs to Participation and Reimbursement**

You will be given a maximum of \$30 to help cover any costs incurred (e.g. travel expenses) by taking part in this study.

### **Research Ethics Board Contact**

The study protocol and consent form have been reviewed by a committee called the Research Ethics Board at St. Michael's Hospital. The Research Ethics Board is a group of scientists, medical staff, individuals from other backgrounds (including law and ethics) as well as members from the community. The committee is established by the hospital to review studies for their scientific and ethical merit. The Board pays special attention to the potential harms and benefits involved in participation to the research participant, as well as the potential benefit to society. This committee is also required to do periodic review of ongoing research studies. As part of this review, someone may contact you from the Research Ethics Board to discuss your experience in the research study.

If you have any questions about your rights as a study participant, please contact Dr. Hyland, Chair of the St. Michael's Hospital Research Ethics Board at (416) 864-6060 Ext. 2557 during regular business hours.

### **Contact Information**

Any questions about this study now or in the future can be addressed by contacting Yvonne Bergmans, St. Michael's Hospital, 30 Bond St., Shuter Wing-2010c, 416-864-6060 ext.4078.

## STATEMENT OF CONSENT

**Study Title:**

Transitioning From Repeated Suicide Attempts

**Consent:**

The research study has been explained to me, and my questions have been answered to my satisfaction. I have been informed of the alternatives to participation in this study. I have the right not to participate and the right to withdraw without affecting the quality of medical care at St. Michael's Hospital for me and for other members of my family. As well, the potential harms and benefits (if any) of participating in this research study have been explained to me.

I have been told that I have not waived my legal rights nor released the investigators, or involved institutions from their legal and professional responsibilities. I know that I may ask now, or in the future, any questions I have about the study. I have been told that records relating to me and my care will be kept confidential and that no information will be disclosed without my permission unless required by law. I have been given sufficient time to read the above information.

**I consent to participate. I have been told I will be given a signed copy of this consent form.**

\_\_\_\_\_  
*Name of Participant*  
*(please print)*

\_\_\_\_\_  
*Signature*

\_\_\_\_\_  
*Date*

*I have explained the study to the above participant explained the nature and purpose, the potential benefits, and possible risks associated with participation in this research study. I have answered all questions that have been raised about the stud.*

\_\_\_\_\_  
*Name of Person Obtaining*  
*Consent (please print)*

\_\_\_\_\_  
*Signature*

\_\_\_\_\_  
*Date*

## Appendix D: Measures used in Quantitative Studies 1 & 2

### BDI-II

#### Beck Depression Inventory

Name \_\_\_\_\_

Date \_\_\_\_\_

Instructions: This questionnaire consists of 21 groups of statements. Please read each group of statements carefully, and then pick out the **one statement** in each group that best describes the way you have been feeling during **the past two weeks including today**. Circle the number beside the statement you have picked. If several statements in the group seem to apply equally well, circle the highest number for that group. Be sure that you do not choose more than one statement for any group, including Item 16 (Changes in Sleeping Pattern) or Item 18 (Changes in Appetite).

#### 1. Sadness

- 0 I do not feel sad.
- 1 I feel sad much of the time
- 2 I am sad all of the time.
- 3 I am so sad or unhappy that I can't stand it.

#### 2. Pessimism

- 0 I am not discouraged about my future
- 1 I feel more discouraged about my future than I used to be.
- 2 I do not expect things to work out for me.
- 3 I feel my future is hopeless and will only get worse

#### 3. Past Failure

- 0 I do not feel like a failure.
- 1 I have failed more than I should have
- 2 As I look back, I see a lot of failures
- 3 I feel I am a total failure as a person

#### 4. Loss of Pleasure

- 0 I get as much pleasure as I ever did from the things I enjoy.
- 1 I don't enjoy things as much as I used to.
- 2 I get very little pleasure from the things I used to enjoy.
- 3 I can't get any pleasure from the things I used to enjoy.

#### 5. Guilty Feelings

- 0 I don't feel particularly guilty.
- 1 I feel guilty over many things I have done or should have done.
- 2 I feel quite guilty most of the time.
- 3 I feel guilty all of the time

#### 6. Punishment Feelings

- 0 I don't feel I am being punished.
- 1 I feel I may be punished
- 2 I expect to be punished

- 3. I feel I am being punished

#### 7. Self-Dislike

- 0 I feel the same about myself as ever.
- 1 I have lost confidence in myself.
- 2 I am disappointed in myself
- 3 I dislike myself.

#### 8. Self Criticalness

- 0 I don't criticize or blame myself more than usual
- 1 I am more critical of myself than I used to be.
- 2 I criticize myself for all of my faults.
- 3 I blame myself or everything bad that happens.

#### 9. Suicidal Thoughts or Wishes

- 0 I don't have any thoughts of killing myself
- 1 I have thoughts of killing myself, but I would not carry them out.
- 2 I would like to kill myself.
- 3 I would kill myself if I had the chance.

#### 10. Crying

- 0 I don't cry anymore than I used to.
- 1 I cry more than I used to.
- 2 I cry over every little thing.
- 3 I feel like crying, but I can't

#### 11. Agitation

- 0 I am no more restless or wound up than usual.
- 1 I feel more restless or wound up than usual.
- 2 I am so restless or agitated that it's hard to stay still



3. I am so restless or agitated that I have to keep moving or doing something.

#### **12. Loss of Interest**

0. I have not lost interest in other people or activities.
1. I am less interested in other people or things than before.
2. I have lost most of my interest in other people or things.
3. It's hard to get interested in anything.

#### **13. Indecisiveness**

0. I make decisions as well as ever.
1. I find it more difficult to make decisions than usual.
2. I have much greater difficulty in making decisions than I used to.
3. I have trouble making any decisions.

#### **14. Worthlessness**

0. I do not feel I am worthless
1. I don't consider myself as worthwhile and useful as I used to
2. I feel more worthless as compared to other people
3. I feel utterly worthless

#### **15. Loss of Energy**

0. I have as much energy as ever.
1. I have less energy than I used to have.
2. I don't have enough energy to do very much.
3. I don't have enough energy to do anything.

#### **16. Changes in Sleeping Pattern**

0. I have not experienced any change in my sleeping pattern
  - 1a. I sleep somewhat more than usual.
  - 1b. I sleep somewhat less than usual.
  - 2a. I sleep a lot more than usual.
  - 2b. I sleep a lot less than usual.
- 

- 3a. I sleep most of the day.
- 3b. I wake up 1-2 hours early and can't get back to sleep.

#### **17. Irritability**

0. I am no more irritable than usual
1. I am more irritable than usual.
2. I am much more irritable than usual.
3. I am irritable all the time.

#### **18. Changes in Appetite**

0. I have not experienced any change in my appetite.
  - 1a. My appetite is somewhat less than usual.
  - 1b. My appetite is somewhat greater than usual.
  - 2a. my appetite is much less than before.
  - 2b. my appetite is much greater than usual.
  - 3a. I have no appetite at all.
  - 3b. I crave food all the time.
- 

#### **19. Concentration Difficulty**

0. I can concentrate as well as ever.
1. I can't concentrate as well as usual.
2. It's hard to keep my mind on anything for very long.
3. I find I can't concentrate on anything.

#### **20. Tiredness or Fatigue**

0. I am no more tired or fatigued than usual.
1. I get more tired or fatigued more easily than usual.
2. I am too tired or fatigued to do a lot of the things I used to do.
3. I am too tired or fatigued to do most of the things I used to do.

#### **21. Loss of Interest in Sex**

0. I have not noticed any recent change in my interest in sex.
1. I am less interested in sex than I used to be.
2. I am much less interested in sex now.
3. I have lost interest in sex completely.

### Beck Hopelessness Scale

For each of the following items that measure positive or negative beliefs about the future, indicate your agreement or disagreement by circling either (T) or false (F).

- |     |  |   |   |
|-----|--|---|---|
| 1.  | I look forward to the future with hope and enthusiasm                                    | T | F |
| 2.  | I might as well give up because I can't make things better for myself                    | T | F |
| 3.  | When things are going badly, I am helped by knowing they can't stay that way forever.    | T | F |
| 4.  | I can't imagine what my life would be like in 10 years.                                  | T | F |
| 5.  | I have enough time to accomplish the things I most want to do.                           | T | F |
| 6.  | In the future, I expect to succeed in what concerns me most.                             | T | F |
| 7.  | My future seems dark to me.  | T | F |
| 8.  | I expect to get more of the good things in life than the average person                  | T | F |
| 9.  | I just don't get the breaks, and there's no reason to believe I will in the future.      | T | F |
| 10. | My past experiences have prepared me well for my future                                  | T | F |
| 11. | All I can see ahead of me is unpleasantness rather than pleasantness.                    | T | F |
| 12. | I don't expect to get what I really want.  | T | F |
| 13. | When I look ahead to the future, I expect I will be happier than I am now                | T | F |
| 14. | Things just don't work out the way I want them to.                                       | T | F |
| 15. | I have great faith in the future.  | T | F |
| 16. | I never get what I want so it's foolish to want anything                                 | T | F |
| 17. | It is very unlikely that I will get any real satisfaction in the future                  | T | F |
| 18. | The future seems vague and uncertain to me.  | T | F |
| 19. | I can look forward to more good times than bad times.                                    | T | F |
| 20. | There's no use in really trying to get something I want because I probably won't get it. | T | F |

## Problem Solving Inventory

Read each statement, and indicate the extent to which you agree or disagree with that statement, using the following alternatives:

- 1= Strongly agree
- 2= Moderately agree
- 3= Slightly agree
- 4= Slightly disagree
- 5= Moderately disagree
- 6= Strongly disagree

- \_\_\_\_\_ 1. When a solution to a problem was unsuccessful, I did not examine why it didn't work.
- \_\_\_\_\_ 2. When I am confronted with a complex problem, I do not bother to develop a strategy to collect information so I can define exactly what the problem is.
- \_\_\_\_\_ 3. When my first efforts to solve a problem fail, I become uneasy about my ability to handle the situation.
- \_\_\_\_\_ 4. After I have solved a problem, I do not analyze what went right or what went wrong.
- \_\_\_\_\_ 5. I am usually able to think up creative and effective alternatives to solve a problem.
- \_\_\_\_\_ 6. After I have tried to solve a problem with a certain course of action, I take time and compare the actual outcome to what I think should have happened.
- \_\_\_\_\_ 7. When I have a problem, I think up as many possible ways to handle it as I can until I can't come up with any more ideas.
- \_\_\_\_\_ 8. When confronted with a problem, I consistently examine my feelings to find out what is going on in a problem situation.
- \_\_\_\_\_ 9. When I am confused with a problem, I do not try to define vague ideas or feelings into concrete or specific terms.
- \_\_\_\_\_ 10. I have the ability to solve most problems even though initially no solution is immediately apparent .
- \_\_\_\_\_ 11. Many problems I face are too complex for me to solve
- \_\_\_\_\_ 12. I make decisions and am happy with them later.

- \_\_\_\_\_ 13. When confronted with a problem, I tend to do the first thing that I can think to solve it.
- \_\_\_\_\_ 14. Sometimes I do not stop and take time to deal with my problems, but just kind of muddle ahead.
- \_\_\_\_\_ 15. When deciding on an idea or possible solution to a problem, I do not take time to consider the chances of each alternative being successful.
- \_\_\_\_\_ 16. When confronted with a problem, I stop and think about it before deciding on a next step
- \_\_\_\_\_ 17. I generally go with the first good idea that comes to my mind.
- \_\_\_\_\_ 18. When making a decision, I weigh the consequences of each alternative and compare them against each other.
- \_\_\_\_\_ 19. When I make plans to solve a problem, I am almost certain that I can make them work.
- \_\_\_\_\_ 20. I try to predict the overall result of carrying out a particular course of action.
- \_\_\_\_\_ 21. When I try to think up possible solutions to a problem, I do not come up with very many alternatives.
- \_\_\_\_\_ 22. In trying to solve a problem, one strategy I often use is to think of past problems that have been similar.
- \_\_\_\_\_ 23. Given enough time and effort, I believe I can solve most problems that confront me.
- \_\_\_\_\_ 24. When faced with a novel situation I have confidence that I can handle problems that may arise.
- \_\_\_\_\_ 25. Even though I work on a problem, sometimes I feel like I am groping or wandering, and am not getting down to the real issue.
- \_\_\_\_\_ 26. I make snap judgements and later regret them.
- \_\_\_\_\_ 27. I trust my ability to solve new and difficult problems.
- \_\_\_\_\_ 28. I have a systematic method for comparing alternatives and making decisions.

- \_\_\_\_\_ 29. When I try to think of ways of handling problems, I do not try to combine different ideas together.
- \_\_\_\_\_ 30. When confronted with a problem, I don't usually examine what sort of external things in my environment may be contributing to my problem.
- \_\_\_\_\_ 31. When I am confronted by a problem, one of the first things I do is survey the situation and consider all the relevant pieces of information.
- \_\_\_\_\_ 32. Sometimes I get so charged up emotionally that I am unable to consider many ways of dealing with my problems.
- \_\_\_\_\_ 33. After making a decision, the outcome I expected usually matches the actual outcome.
- \_\_\_\_\_ 34. When confronted with a problem, I am unsure of whether I can handle the situation.
- \_\_\_\_\_ 35. When I become aware of a problem, one of the first things I do is to try to find out exactly what the problem is.

### SWLS (Satisfaction with Life Scale)

Below are five statements with which you may agree or disagree. Using the scale below, indicate your agreement with each item by placing the appropriate number on the line preceding that item. Please be open and honest in your responding.

- 1= Strongly disagree
- 2= Disagree
- 3= Slightly disagree
- 4= Neither agree or disagree
- 5= Slightly agree
- 6= Agree
- 7= Strongly agree

- \_\_\_\_\_ 1. In most ways my life is close to my ideal.
- \_\_\_\_\_ 2. The conditions of my life are excellent.
- \_\_\_\_\_ 3. I am satisfied with my life.
- \_\_\_\_\_ 4. So far I have gotten the important things I want in life.
- \_\_\_\_\_ 5. If I could live my life over, I would change almost nothing.

Gender:

Age:

Date:

I.D.#

## TAS-20

Using the scale provided as a guide, indicate how much you agree or disagree with each of the following statements by circling the corresponding number. Give only one answer for each statement.

Circle 1 if you STRONGLY DISAGREE  
Circle 2 if you MODERATELY DISAGREE  
Circle 3 if you NEITHER DISAGREE NOR AGREE  
Circle 4 if you MODERATELY AGREE  
Circle 5 if you STRONGLY AGREE

	<b>Strongly Disagree</b>	<b>moderately disagree</b>	<b>neither disagree nor agree</b>	<b>moderately agree</b>	<b>strongly agree</b>
1. I am often confused about what emotion I am feeling.	1 _____	2 _____	3 _____	4 _____	5 _____
2. It is difficult for me to find the right words for my feelings	1 _____	2 _____	3 _____	4 _____	5 _____
3. I have physical sensations that even doctors don't understand.	1 _____	2 _____	3 _____	4 _____	5 _____
4. I am able to describe my feelings easily.	1 _____	2 _____	3 _____	4 _____	5 _____
5. I prefer to analyze problems rather than just describe them.	1 _____	2 _____	3 _____	4 _____	5 _____
6. When I am upset, I don't know if I am sad, frightened or angry.	1 _____	2 _____	3 _____	4 _____	5 _____
7. I am often puzzled by sensations in my body.	1 _____	2 _____	3 _____	4 _____	5 _____
8. I prefer to just let things happen rather than to understand why they turned out that way.	1 _____	2 _____	3 _____	4 _____	5 _____
9. I have feelings that I can't quite identify.	1 _____	2 _____	3 _____	4 _____	5 _____
10. Being in touch with emotions is essential	1 _____	2 _____	3 _____	4 _____	5 _____
11. I find it hard to describe how I feel about people	1 _____	2 _____	3 _____	4 _____	5 _____
12. People tell me to describe my feelings more.	1 _____	2 _____	3 _____	4 _____	5 _____

	<b>Strongly Disagree</b>	<b>moderately disagree</b>	<b>neither disagree nor agree</b>	<b>moderately agree</b>	<b>strongly agree</b>
13. I don't know what is going on inside me	1 _____	2 _____	3 _____	4 _____	5 _____
14. I often don't know why I am angry	1 _____	2 _____	3 _____	4 _____	5 _____
15. I prefer talking to people about their daily activities rather than their feelings.	1 _____	2 _____	3 _____	4 _____	5 _____
16. I prefer to watch "light" entertainment shows rather than psychological dramas.	1 _____	2 _____	3 _____	4 _____	5 _____
17. It is difficult for me to reveal my innermost feelings, even to close friends.	1 _____	2 _____	3 _____	4 _____	5 _____
18. I can feel close to someone, even in moments of silence.	1 _____	2 _____	3 _____	4 _____	5 _____
19. I find examination of my feelings useful in solving personal problems.	1 _____	2 _____	3 _____	4 _____	5 _____
20. Looking for hidden meanings in movies or plays distracts from their enjoyment	1 _____	2 _____	3 _____	4 _____	5 _____



## Personal Evaluation: BIS-11

Name \_\_\_\_\_

Date \_\_\_\_\_

Directions: People differ in the ways they act and think in different situations. This is a test to measure some of the ways in which you act and think. Read each statement carefully and check the appropriate box to the right of the statement. Answer quickly and honestly.

	Rarely/never	Occasionally	Often	Almost always
1. I plan tasks carefully _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. I do things without thinking _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. I make up my mind quickly _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. I am happy-go-lucky _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. I don't "pay attention" _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. I have "racing" thoughts _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. I plan trips well ahead of time _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. I am self-controlled _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. I concentrate easily _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. I save regularly _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. I "squirm" at plays or lectures _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. I am a careful thinker _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. I plan for job security _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. I say things without thinking _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. I like to think about complex problems _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. I change jobs _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. I act "on impulse" _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. I get easily bored when solving problems _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. I act on the spur of the moment _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. I am a steady thinker _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21. I change where I live _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22. I buy things on impulse _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23. I can only think about one problem at a time _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24. I change hobbies _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25. I spend or charge more than I earn _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26. I have outside thoughts when thinking _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
27. I am more interested in the present than the future _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
28. I am restless at lectures or talks _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
29. I like puzzles _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
30. I plan for the future _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## *Appendix E: Sample Interview Guides,*

### **Interview guide: Qualitative young adult's study**

#### **Exploratory Question(s)**

“Can you begin by telling how you understand your process of transition from repeated suicide attempts?”

#### **Probing questions might include:**

“tell me about the role of x whom you mentioned earlier”;

“what were the things you were doing for yourself?”;

“when you discuss y, could you help me understand what y means for you.”

#### **Confirmatory Questions**

In discussing z, you identified xxxxxxxx ; are you saying -----?

Other participants have identified === Does this resonate in any way for you?

## Interview guide: Qualitative IPA study

### **Exploratory Question(s)**

Can you tell me about the experience of how you remember yourself when we first met and where you are now?

Can you describe what this experience was like for you?

What were some of most challenging parts for you getting to where you are today?

What did you find stood in the way?

What was helpful during this time?

### **Probing questions might include:**

How did you do x?

How do you understand y happening?

What were the things you were doing for yourself during this time?

When you discuss y, could you describe what y means for you.

### **Confirmatory Questions**

In discussing z, you identified xxxxxxxx ; are you saying -----?

Other participants have identified a.b.c. Does this resonate in any way for you?

**Appendix F: Table of Themes: (IPA study)**

<b>Themes</b>	<b>Clusters</b>	<b>Subordinate theme</b>	<b>Superordinate theme</b>
Awareness. Something has to change. Unfamiliar, alone, afraid, A glimpse	Turning points	<b>Choosing not to die in the moment</b>	
Disconnected, floundering Lost, ashamed, Alone. Unseen; unheard Moment by moment. No control; no choices End Secrets Trapped, doubt, stigma Don't know	Suffering and alone		
Need to learn. Don't know how No voice, no words, don't understand Hard. Struggle. Lot of work. Uncertain, scared Letting go of larger goals. Get out of bed Compassion, understanding, believed. Guts	Torture of possibility		
Permission to ask; to try, to fail Need reminders Can't make the pie Connecting Communicating Name the losses Don't trust self Insight Choosing Risking Understanding	The demons of living	<b>Choosing to live in the moment</b>	<b>Choosing in the Moment</b>
Hard to live, learn the lingo Teach others Hypervigilance No quick fixes No Guarantees Persistent Thoughts Fear and accept	Struggle and Try		

