A NARRATIVE WEB-BASED STUDY OF REASONS TO GO ON LIVING AFTER A SUICIDE ATTEMPT: POSITIVE IMPACTS OF THE MENTAL HEALTH SYSTEM

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INTRODUCTION

My Third (or fourth) Suicide Attempt
I laid in the back of the ambulance,
the snow of too many doses of ativan dissolving on my tongue.
They hadn't even cared enough about me
to put someone in the back with me,
and so, frustrated,
I'd swallowed all the pills I had with me—
not enough to do what I wanted it to right then,
but more than enough to knock me out for a good 14 hours.
I remember very little after that;
benzodiazepines like ativan commonly cause pre- and post-amnesia, says Google helpfully
I wake up in a locked room
a woman manically drawing on the windows with crayons
the colors of light through the glass
diffused into rainbows of joy scattered about the room
as if she were coloring on us all,
all of the tattered remnants of humanity in a psych ward
made into a brittle mosaic, a quilt of many hues,
a Technicolor dreamcoat
and I thought
I am so glad to be able to see this. (*Story 187)*

The nurse opening that door will have a lasting impact on how this story unfolds and on this person's life.

Each year, almost one million people die from suicide, approximately one death every 40 seconds. Suicide attempts are much more frequent, with up to an estimated 20 attempts for every death by suicide.[1] Suicide-related behaviours range from suicidal ideation and self-injury to death by suicide. We are unable to directly study those who die by suicide, but effective intervention after a suicide attempt could reduce the risk of subsequent death by suicide.

Near-fatal suicide attempts have been used to explore the boundary with completed suicides. Findings indicated that violent suicide attempters and serious attempters (seriousness of the medical consequences to define near-fatal attempts) were more likely to make repeated, and higher lethality suicide attempts.[2] In a case-control study, the medically severe suicide attempts group (78 participants), epidemiologically very similar to those who complete suicide, had significantly higher communication difficulties; the risk for death by suicide multiplied if accompanied by feelings of isolation and alienation.[3]

Most research in suicidology has been quantitative, focusing almost exclusively on identifying factors that may be predictive of suicidal behaviours, and on explanation rather than understanding.[4] Qualitative research, focusing on the lived experiences of individuals who have attempted suicide, may provide a better understanding of how to respond in empathic and helpful ways to prevent future attempts and death by suicide.[4,5] Fitzpatrick[6] advocates for narrative research as a valuable qualitative method in suicide research, enabling people to construct and make sense of the experiences and their world, and imbue it with meaning.

A review of qualitative studies examining the experiences of recovering from or living with suicidal ideation identified 5 interconnected themes: suffering, struggle, connection, turning points, and coping.[7] Several additional qualitative studies about attempted suicide have been reported in the literature. Participants have included patients hospitalized for attempting suicide[8], and/or suicidal ideation,[9] out-patients following a suicide attempt and their caregivers,[10] veterans with serious mental illness and at least one hospitalization for a suicide attempt or imminent suicide plan.[11] Relationships were a consistent theme in these studies. Interpersonal relationships and an empathic environment were perceived as therapeutic and protective, enabling the expression of thoughts and self-understanding.[8] Given the connection to relationship issues, the authors suggested it may be helpful to provide support for the relatives of patients who have attempted suicide. A sheltered, friendly environment and support systems, which included caring by family and friends, and treatment by mental health professionals, helped the suicidal healing process.[10] Receiving empathic care led to positive changes and an increased level of insight; just one caring professional could make a tremendous difference.[11] Kraft and colleagues[9] concluded with the importance of hearing directly from those who are suicidal in order to help them, that only when we understand, "why suicide", can we help with an alternative, "why life?" In a grounded theory study about help-seeking for self-injury, Long and colleagues[12] identified that self-injury was not the problem for their participants, but a panacea, even if temporary, to painful life experiences. Participant narratives reflected a complex journey for those who self-injured: their wish when help-seeking was identified by the theme "to be treated like a person".

There has also been a focus on the role and potential impact of psychiatric/mental health nursing. Through interviews with experienced in-patient nurses, Carlen and Bengtsson[13] identified the need to see suicidal patients as subjective human beings with unique experiences. This mirrors research with patients, which concluded that the interaction with personnel who are devoted, hope-mediating and committed may be crucial to a patient's desire to continue living.[14] Interviews with individuals who received mental health care for a suicidal crisis following a serious attempt led to the development of a theory for psychiatric nurses with the central variable, reconnecting the person with humanity across 3 phases: reflecting an image of humanity, guiding the individual back to humanity, and learning to live.[15]

Other research has identified important roles for nurses working with patients who have attempted suicide by enabling the expression of thoughts and developing self-understanding[8], helping to see things differently and reconnecting with others,[10] assisting the person in finding meaning from their experience to turn their lives around, and maintain/and develop positive connections with others.[16] However, one literature review identified that negative attitudes toward self-harm were common among nurses, with more positive attitudes among mental health nurses than general nurses. The authors concluded that education, both reflective and interactive, could have a positive impact.[17]

This paper is one part of a larger web-based narrative study, the Reasons to go on Living Project (RTGOL), that seeks to understand the transition from making a suicide attempt to choosing life. When invited to tell their stories anonymously online, what information would people share about their suicide attempts? This paper reports on a secondary research question of the larger study: what stories do participants tell of the positive role/impact of the mental health system. The focus on the positive impact reflects an appreciative inquiry approach which can promote better practice.[18]

METHODS

Design and Sample

A website created for The RTGOL Project (www.thereasons.ca) enabled participants to anonymously submit a story about their suicide attempt and recovery. Participants were required to read and agree with a consent form before being able to submit their story through a text box or by uploading a file. No demographic information was requested. Text submissions were embedded into an email and sent to an account created for the Project without collecting information about the IP address or other identifying information. The content of the website was reviewed by legal

counsel before posting, and the study was approved by the local Research Ethics Board. Stories were collected for 5 years (July 2008-June 2013).

The RTGOL Project enabled participation by a large, diverse audience, at their own convenience of time and location, providing they had computer access. The unstructured narrative format allowed participants to describe their experiences in their own words, to include and emphasize what they considered important.

Of the 226 submissions to the website, 112 described involvement at some level with the mental health system, and 50 provided sufficient detail about positive experiences with mental health care to permit analysis. There were a range of suicidal behaviours in these 50 stories: 8 described suicidal ideation only; 9 met the criteria of medically severe suicide attempts[3]; 33 described one or more suicide attempts. For most participants, the last attempt had been some years in the past, even decades, prior to writing.

Thematic analysis was guided by the work of Lieblich and colleagues[19] and Braun and Clarke.[20] Because participants could tell the story they wanted to tell, and data collection occurred over 5 years, data analysis occurred in several phases over the course of the study. Initially, the original investigators, working with nursing research students, immersed themselves in the data as stories came in, searching for themes. Thus began the identification of data that were inputted into an Excel file. Over the next 6 years, 14 groups of nursing research students (3–4/group), and the lead author, reviewed each story that was submitted and added to the master table of data, providing the opportunity to focus on specific data sets. This analysis used stories where participants described positive involvement with the mental health system (50 stories). Two members of the research team next reviewed the stories to identify themes related to positive experiences, and these were categorized into 3 themes.

RESULTS

Stories of positive experiences with mental health care described the idea of a door opening, a turning point, or helping the person to see their situation differently. Themes identified were: (1) relationship and trust with a Health Care Professional (HCP), (2) the role of family and friends (limited to in-hospital experiences), and (3) the opportunity to access a range of services. The many reflective submissions of experiences told many years after the suicide attempt(s) speaks to the lasting impact of the experience for that individual.

Trust and Relationship with a Health Care Professional

A trusting relationship with a health professional helped participants to see things in a different way, a more hopeful way and over time. *"In that time of crisis, she never talked down to me, kept her promises, didn't panic, didn't give up, and she kept believing in me. I guess I essentially borrowed the hope that she had for me until I found hope for myself." (Story# 35) My doctor has worked extensively with me. I now realize that this is what will keep me alive. To be able to feel in my heart that my doctor does care about me and truly wants to see me get better." (Story 34).*

The writer in Story 150 was a nurse, an honours graduate. The 20 years following graduation included depression, hospitalizations and many suicide attempts.

> "*One day after supper I took an entire bottle of prescription pills, then rode away on my bike. They found me late that night unconscious in a downtown park. My heart threatened to stop in the ICU."*
>
> Then later, *"I finally found a person who was able to connect with me and help me climb out of the pit I was in. I asked her if anyone as sick as me could get better, and she said, "Yes", she had seen it happen. Those were the words I had been waiting to hear! I quickly became very motivated to get better. I felt heard and like I had just found a big sister, a guide to help me figure out how to live in the world. This person was a nurse who worked as a trauma therapist."*

At the time when the story was submitted, the writer was applying to a graduate program.

Role of Family and Friends

Several participants described being affected by their family's response to their suicide attempt. Realizing the impact on their family and friends was, for some, a turning point. The writer in Story 20 told of experiences more than 30 years prior to the writing. She described her family of origin as "*truly dysfunctional,"* and she suffered from episodes of depression and hospitalization during her teen years. Following the birth of her second child, and many family difficulties, *"It was at this point that I became suicidal."* She made

a decision to kill herself by jumping off the balcony (6 stories). "*At the very last second as I hung onto the railing of the balcony. I did not want to die but it was too late. I landed on the parking lot pavement.*"

She wrote that the pain was *indescribable,* due to many broken bones.

> *"The physical pain can be unbearable. Then you get to see the pain and horror in the eyes of someone you love and who loves you. Many people suggested to my husband that he should leave me in the hospital, go on with life and forget about me.*
>
> *During the process of recovery in the hospital, my husband was with me every day. . .With the help of psychiatrists and a later hospitalization, I was actually diagnosed as bipolar. . .Since 1983, I have been taking lithium and have never had a recurrence of suicidal thoughts or for that matter any kind of depression."*

The writer in Story 62 suffered childhood sexual abuse. When she came forward with it, she felt she was not heard. Self-harm on a regular basis was followed by "*numerous overdoses trying to end my life.*" Overdoses led to psychiatric hospitalizations that were unhelpful because she was unable to trust staff. "*My way of thinking was that ending my life was the only answer. There had been numerous attempts, too many to count. My thoughts were that if I wasn't alive I wouldn't have to deal with my problems."* In her final attempt, she plunged over the side of a mountain, dropping 80 feet, resulting in several serious injuries. "*I was so angry that I was still alive."* However,

> *"During my hospitalization I began to realize that my family and friends were there by my side, I began to realize that I wasn't only hurting myself. I was hurting all the important people in my life. It was then that I told myself I am going to do whatever it takes."*

A turning point is not to say that the difficulties did not continue. The writer of Story 171 tells of a suicide attempt 7 years previous, and the ongoing anguish. She had been depressed for years and had thoughts of suicide on a daily basis. After a serious overdose, she woke up the next day in a hospital bed, her husband and 2 daughters at her bed.

> *"Honestly, I was disappointed to wake up. But, then I saw how scared and hurt they were. Then I was sorry for what I had done to them. Since then I have thought of suicide but know that it is tragic for the family and is a hurt that can never be undone. Today I live with the thought that I am here for a reason and when it is God's time to take me then I will go. I do believe living is harder than dying. I do believe I was born for a purpose and when that is accomplished I will be released. . . .Until then I try to remind myself of how I am blessed and try to appreciate the wonders of the world and the people in it."*

RANGE OF SERVICES

The important role of mental health and recovery services was frequently mentioned, including dialectical behavioural therapy (DBT)/cognitive-behavioural therapy (CBT), recovery group, group therapy, Alcoholics Anonymous, accurate diagnosis, and medications.

The writer in Story 30 was 83 years old when she submitted her story, reflecting on a life with both good and bad times. She first attempted suicide at age 10 or 12. A serious post-partum depression followed the birth of her second child, and over the years, she experienced periods of suicidal intent:

> *"Consequently, a few years passed and I got to feeling suicidal again. I had pills in one pocket and a clipping for "The Recovery Group" in the other pocket. As I rode on the bus trying to make up my mind, I decided to go to the Recovery Group first. I could always take the pills later. I found the Recovery Group and yoga helpful; going to meetings sometimes twice a day until I got thinking more clearly and learned how to deal with my problems."*

Several participants described the value of CBT or DBT in learning to challenge perceptions. *"I have tools now to differentiate myself from the illness. I learned I'm not a bad person but bad things did happen to me and I survived."(Story 3)* "*The fact is that we have thoughts that are helpful and thoughts that are destructive. . ... I knew it was up to me if I was to get better once and for all." (Story 32)*:

> *"In the hospital I was introduced to DBT. I saw a nurse (Tanya) every day and attended a group session twice a week, learning the techniques. I worked with the people who wanted to work with me this time. Tanya said the same thing my counselor did "there is no study that can prove whether or not suicide solves problems" and I felt as though I understood it then. If I am dead, then all the people that I kept pushing away and refusing their help would be devastated. If I killed myself with my own hand, my family would be so upset.*

DBT taught me how to 'ride my emotional wave'. . . .. DBT has changed my life. . .. . My life is getting back in order now, thanks to DBT, and I have lots of reasons to go on living."(Story 19)

The writer of Story 67 described the importance of group therapy.

"Group therapy was the most helpful for me. It gave me something besides myself to focus on. Empathy is such a powerful emotion and a pathway to love. And it was a huge relief to hear others felt the same and had developed tools of their own that I could try for myself! I think I needed to learn to communicate and recognize when I was piling everything up to build my despair. I don't think I have found the best ways yet, but I am lifetimes away from that teenage girl." (Story 67)

The author of story 212 reflected on suicidal ideation beginning over 20 years earlier, at age 13. Her first attempt was at 28. "*I thought everyone would be better off without me, especially my children, I felt like the worst mum ever, I felt like a burden to my family and I felt like I was a failure at life in general."* She had more suicide attempts, experienced the death of her father by suicide, and then finally found her doctor.

"Now I'm on meds for a mood disorder and depression, my family watch me closely, and I see my doctor regularly. For the first time in 20 years, I love being a mum, a sister, a daughter, a friend, a cousin etc."

DISCUSSION

The 50 stories that describe positive experiences in the health care system constitute a larger group than most other similar studies, and most participants had made one or more suicide attempts. Several writers reflected back many years, telling stories of long ago, as with the 83-year old participant (Story 30) whose story provided the privilege of learning how the author's life unfolded. In clinical practice, we often do not know – how did the story turn out? The stories that describe receiving health care speak to the impact of the experience, and the importance of the issues identified in the mental health system. We identified 3 themes, but it was often the combination that participants described in their stories that was powerful, as demonstrated in Story 20, the young new mother who had fallen from a balcony 30 years earlier.

Voices from people with lived experience can help us plan and conceptualize our clinical work. Results are consistent with, and add to, the previous work on the importance of therapeutic relationships.[8,10,11,14–16] It is from the stories in this study that we come to understand the powerful experience of seeing a family members' reaction following a participant's suicide attempt, and how that can be a potent turning point as identified by Lakeman and Fitzgerald.[7] Ghio and colleagues[8] and Lakeman[16] identified the important role for staff/nurses in supporting families due to the connection to relationship issues. This research also calls for support for families to recognize the important role they have in helping the person understand how much they mean to them, and to promote the potential impact of a turning point. The importance of the range of services reflect Lakeman and Fitzgerald's[7] theme of coping, associating positive change by increasing the repertoire of coping strategies.

These findings have implications for practice, research and education. Working with individuals who are suicidal can help them develop and tell a different story, help them move from a death-oriented to life-oriented position,[15] from "why suicide" to "why life."[9] Hospitalization provides a person with the opportunity to reflect, to take time away from "the real world" to consider oneself, the suicide attempt, connections with family and friends and life goals, and to recover physically and emotionally. Hospitalization is also an opening to involve the family in the recovery process. The intensity of the immediate period following a suicide attempt provides a unique opportunity for nurses to support and coach families, to help both patients and family begin to see things differently and begin to create that different story. In this way, family and friends can be both a support to the person who has attempted suicide, and receive help in their own struggles with this experience.

It is also important to recognize that this short period of opportunity is not specific to the nurses in psychiatric units, as the nurses caring for a person after a medically severe suicide attempt will frequently be the nurses in the ICU or Emergency departments. Education, both reflective and interactive, could have a positive impact.[17] Helping staff develop the attitudes, skills and approach necessary to be helpful to a person post-suicide attempt is beginning to be reported in the literature.[21]

Further implications relate to nursing curriculum. Given the extent of suicidal ideation, suicide attempts and deaths by suicide, this merits an important focus. This could include specific scenarios, readings by people affected by suicide, both patients themselves and their families or survivors, and discussions with individuals who have made an attempt(s) and made a decision to go on living.

All of this is, of course, not specific to nursing. All members of the interprofessional health care team can support the transition to recovery of a person after a suicide attempt using the strategies suggested in this paper, in addition to other evidence-based interventions and treatments.

Findings from this study need to be considered in light of some specific limitations. First, the focus was on those who have made a decision to go on living, and we have only the information the participants included in their stories. No follow-up questions were possible. The nature of the research design meant that participants required access to a computer with Internet and the ability to communicate in English. This study does not provide a comprehensive view of in-patient care. However, it offers important inputs to enhance other aspects of care, such as assessing safety as a critical foundation to care. We consider these limitations were more than balanced by the richness of the many stories that a totally anonymous process allowed.

CONCLUSION

Stories open a window into the experiences of a person during the period after a suicide attempt. The RTGOL Project allowed for an understanding of how we might help suicidal individuals change the script, write a different story. The stories that participants shared give us some understanding of "how" to provide support at a most-needed critical juncture for people as they interact with health care providers immediately after a suicide attempt. While we cannot know the experiences of those who did not survive a suicide attempt, results of this study reinforce that just one caring professional can make a crucial difference to a person who has survived a suicide attempt. We end with where we began. Who will open the door?

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