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CELINE REDFERN, Ba PGDip Ma

EXPLORING THE LIVED EXPERIENCES OF SUICIDE ATTEMPT
SURVIVORS.

Section A: A Meta-Ethnographic Synthesis of Qualitative Research Exploring
the Lived Experience of Suicide Attempt Survivors
7995 (212)

Section B: 'Wild' Stories of Suicide: A Narrative Analysis Exploring Attempt
Survivors' Cultural Constructions of Suicidality
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A thesis submitted in partial fulfilment of the requirements of
Canterbury Christ Church University for the degree of
Doctor of Clinical Psychology

APRIL 2015

SALOMONS
CANTERBURY CHRIST CHURCH UNIVERSITY

CANTERBURY CHRIST CHURCH UNIVERSITY
Doctorate in Clinical Psychology (D.Clin.Psychol.)

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Thesis Summary

Section A

This meta-ethnographic synthesis explored the current literature into suicide attempt survivors' lived experiences to create a model of the suicidal journey and, potentially into recovery. The model integrates individual, relational and socio-cultural theories of suicidality. In particular, humanising approaches to suicidality, and peer-support attempt survivor groups are recommended.

Section B

This narrative study explores the stories of attempt survivors and the cultural constructions they draw on to narrate their experiences. Semi-structured interviews conducted with 11 participants (nine female; two male), were analysed using an integrative approach, based on thematic, dialogical, and performative narrative analysis. The results highlighted that attempt survivors may draw on a number of cultural constructions of suicide to varying extents. These included the dominant biomedical model as well as psychological, situational, interpersonal, moral, public and spiritual approaches to suicidality. All participants used constructions of suicide to justify their experiences. One previously unexplored voice to emerge was of suicidality as having been a positive experience. In particular, findings suggest that suicidality cannot be understood from only one perspective (whether dominant or not): clinicians and policy makers need to remain open-minded about how attempt survivors might view their experiences.

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Part A

A Meta-Ethnographic Synthesis of Qualitative Research Exploring the Lived Experience of Suicide Attempt Survivors

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Abstract

Given the recent turn towards exploring suicide attempt survivors' perspectives, this review aimed to build on Lakeman and Fitzgerald's review (2008) by synthesising recent qualitative research on attempt survivors' lived experience of suicidality. A detailed search of relevant databases, theses and suicide journals yielded 19 relevant articles of good quality relating to participants across the life-span. A meta-ethnographic approach to synthesis was taken. Attempt survivors' experiences highlighted potential journeys through suicidality and an interplay between individual, relational, situational and socio-cultural factors at each point. These are discussed in terms of Lakeman and Fitzgerald's review, theories of suicide and critical approaches to suicide. Among others, recommendations are made for suicide to be considered at individual, relational and socio-cultural levels, for services and practitioners to adopt humanising approaches, and for peer-support attempt survivor groups to be set up. Further research around attempt survivors' experiences of suicide is also called for in order to explore processes of recovery, the inter-play of gender and suicide, and what cultural constructions attempt survivors might draw on in narrating their experiences of suicide.

Keywords:

Suicide; attempted suicide; lived experience; survivors; qualitative

1. Introduction

1.1 Why study suicide?

Whilst understanding, describing and explaining suicidality encompasses interesting philosophical questions (Alvarez, 2002), suicide is also an important health issue. In 2010, 5608 people in the UK aged 15 years and over died by suicide (Office for National Statistics (ONS), 2012). The NHS (2013) estimates that at least 140,000 people in England and Wales present to Accident and Emergency Departments every year having attempted suicide. Given that rates of completed suicide are hard to calculate (ONS, 2014) and that not all who attempt suicide report to hospital, these figures are likely to underestimate the issue. Accordingly, suicide is an important mental health, psychological and sociological issue.

1.2 Research into Suicidality

Suicidology is the study of suicide. It seeks to understand, describe and explain suicidality and aims to create effective interventions and prevention strategies (Webb, 2010).

1.2.1 The quantitative/qualitative divide.

Suicidology has roots in the eighteenth century. Yet the field has grown rapidly in the last 40 years corresponding with growing recognition of the extent and burden of suicidality (Hawton, 2005). The majority of this research has been quantitative and has examined epidemiology, neurobiology and interventions based on randomised-controlled trials (Leenars, 2002). Hjelmeland and Knizeck (2010) argue that such a quantitative focus - based on hypothetico-deductive approaches - assumes that it is possible to identify singular, linear causes for suicidal behaviour. In turn, this has led to a focus on predicting and preventing risk factors associated with suicide (Department of Health (DoH), 2002; DoH, 2015).

Michel et al. (2002) argue that current psychiatric, quantitative-heavy research assumes an underlying pathology, and may neglect people's experiences. Moreover, several authors argue that exploring linear causes of suicidality fails to capture the complexity of the phenomenon, leading to inadequate theorising (Maltsberger & Buie, 1996; Rogers, 2001; White, 2012). Accordingly, there have been calls to redress this balance and conduct more qualitative, idiographic research, relying on introspective or experiential accounts (Leenars, 2002; Goldney, 2002; Hjelmeland & Knizeck, 2010).

1.2.2 Qualitative research within suicide.

Recently, more research has explored subjective accounts of suicidality. This includes exploring professional perspectives of suicidality (e.g. Myers & Fine, 2007); and understanding different populations' views of suicide (e.g. Abbott & Zakriski, 2014). It has also included understanding the experiences of those bereaved by suicide (e.g. Isaac, 2007).

Service user and survivor movements within other areas of distress - such as psychosis and self-harm - have been a driving force in promoting alternative perspectives to biomedical models, encouraging person-centred practice (Crossley, 2006). Similarly, attempt survivor perspectives are crucial to gaining deeper, fuller understandings of suicidality. Accordingly, there has been a growing focus on the lived experience of suicide attempt survivors.

1.2.2.1 Qualitative research into the lived experience of suicide attempt survivors.

To date, only Lakeman and Fitzgerald (2008) have published a review collating qualitative research into attempt survivors' suicidal experiences. The review focuses on how people live with feeling suicidal, or overcome these feelings. Searching three databases electronically and four relevant journals manually between 1997 and March 2007 Lakeman and Fitzgerald found 12 papers which met the inclusion criteria; these were

assessed against Attree and Milton's (2006) quality criteria, and deemed to have no major methodological flaws.

Five common themes were found. The first was deep, emotional pain and distress when feeling suicidal. The second was that attempt survivors struggled in some way: with life, choosing to live or die, finding a meaning for life, or maintaining control. The third theme was connection: participants felt disconnected or detached from others, their culture or God when suicidal; connecting with others appeared critical to recovery. Fourth was a pivotal event helping people shift from feeling suicidal to searching for ways to recover. Turning points varied: from reconnecting with humanity, to a realisation following the suicide attempt that they did not want to die. The last theme was of coping: suicidal behaviours were considered both a means of coping, and a failure to cope.

Overall, Lakeman and Fitzgerald (2008) give a clear outline of their methodology and the themes appear to fit with the papers reviewed, suggesting analytic rigour. However, they do not consider unpublished articles, and so do not take publication bias into account. Moreover, when searching the literature, three papers were found which appeared to fit their criteria but were not included (Tzeng, 2001; Wiklander, Samuelsson & Asberg, 2003; Fullagar, 2003). Nevertheless, as a preliminary review of the literature on attempt survivors' lived experience it appears otherwise to be of good quality. Moreover, if further research replicated these findings, there would be evidence to suggest reliability and generalisability of findings.

1.3 Why Conduct Another Review?

Lakeman and Fitzgerald (2008) identified a relatively small body of work. They note that whilst some themes emerged, the studies were from relatively disparate populations,

and disparate philosophical and research traditions. Accordingly, they argue for qualitative research to continue to focus on first-hand experiences of attempt survivors.

Indeed the focus on attempt survivors within research - and the attempt survivor movement as a whole - has grown since their review. For example, there are a growing number of projects and blogs published online which are gaining publicity and media attention (Anna, 2014; Cray, 2014). It would be useful to build on Lakeman and Fitzgerald's (2008) review by exploring the research conducted since. Further understanding the suicidal experiences of attempt survivors can lead to more appropriate and better quality service provision as well as offering a platform to an often marginalised population.

1.4 Research Question

This synthesis aims to review research into attempt survivors' lived experience of suicidality. The aim was to build on Lakeman and Fitzgerald's synthesis (2008) so that the research reviewed was between Lakeman and Fitzgerald's review (April 2007) and the present day (September 2014). The research questions are:

- 1.) How do attempt survivors describe the experiences that led them to feel suicidal?
- 2.) How do attempt survivors describe their experiences when feeling suicidal?
- 3.) How do attempt survivors describe the experiences that helped them stop feeling suicidal?

2. Methodology

A systematic review of the literature was conducted. Applying systematic review methods to qualitative research can summarise literature on a topic, providing a more complete picture and guiding future research (Aveyard, 2010).

2.1 Search methods

Numerous attempt survivors have published books on their experiences (e.g. Blauner, 2003; Hines, 2013; Hecker, 2014). However, given the limited time and resources available, it was not possible to include these within the review. The search centred on published and unpublished qualitative studies. Several searches were conducted to ensure all relevant papers were included. Appendix 1 shows the PRISMA flow diagram (Moher, Liberati, Tetzlaff & Altman, 2009) of the full search query. Table 1 shows the criteria which were used to determine relevance.

Table 1

Relevance Criteria for Search

Inclusion Criteria	Exclusion Criteria
Studies employed a qualitative methodology.	Studies solely focused on experiences or perspectives of professionals, families or people who had not attempted suicide. This included excluding studies where the focus was on general distress rather than suicide, and studies which focused on self-harm with no intention to die.
Studies had an explicit focus on attempted suicide.	Articles relating solely to theories of attempt survivors' lived experiences, rather than asking them about their lived experience.
Studies were available in the English language	Studies which attempted to validate suicidality measures, or evaluated the efficacy of interventions or services.
Studies since March 2007.	Studies within Lakeman and Fitzgerald's search ie prior to April 2007

2.1.2 Initial search phase.

To ensure all relevant papers could be found, the initial search was broad. Table 2 shows the terms used.

Table 2

Search Terms for Initial Search Phase

Search term		Reason for search term
Suicid*	Title	Suicid* was used to incorporate the terms suicide, suicides, suicidal and suicidality; the search term was in the title to ensure that this was the main focus of the article.
Qualitative	Any	Qualitative was searched within any part of the text so as to include both mixed method and qualitative research.

Several databases were searched; these were included to account for publication bias. Article titles and abstracts were inspected for relevance to research questions. Consistent with qualitative research, these questions were considered as a compass to guide study selection (Eakin & Mykhalocskiy, 2003). Table 3 summarises the initial search.

Table 3

Databases searched in First Phase

Databases	Number of papers retrieved	Relevant papers identified
Medline; Web of Science; Applied Social Science Index and Abstracts; International Bibliography of the Social Sciences; British Nursing Index, PsychArticles; Wiley Online Library; Eric; ScienceDirect; SAGE Journals; Taylor and Francis Online.	756	39
Index Thesis	12	4

A Google Scholar search of articles citing Lakeman and Fitzgerald (2008) was conducted: of the 29 articles highlighted, 8 were considered relevant. As Hjelmeland and Knizeck (2010) also call for more qualitative research within suicidology, a Google Scholar search of articles citing this paper was conducted: of the 68 articles noted, 5 were relevant.

2.1.2 Second search phase.

A second search phase was conducted to increase rigour and robustness. Table 4 shows the methods used and relevant articles highlighted.

Table 4

Second Search Process

		Number of relevant articles
Hand searched Journals (April 2014 – September 2014)	Crisis	6
	Suicidology Online	2
	Death Studies (filtered using term: suicide* = 93)	1
	Suicide and Life-threatening Behaviour	0
Expert Suggestion		1
Researchers and attempt survivors working within suicidology contacted to enquire about published or unpublished relevant papers to be aware of.		0

Of the 66 relevant studies identified (56 from phase one and 10 from phase two), 20 were duplicates: 16 were the same papers identified by different searches and all of the identified theses had also been published. Exact duplicates were removed; the 4 published theses were excluded but their published papers included.

2.1.3 Final search phase.

In order to ensure rigour and robustness, two further searches of electronic databases were carried out using different, more specific search terms. Table 5 demonstrates this search process.

Table 5

Final Search Process

			Limitations	Number of articles retrieved
OvidSP: MEDLine, Psychinfo and Social Policy	Suicid*	Title	Articles being English speaking and published between 2007 and 2014 (inclusive)	595
	AND			
	“service use*” or patien* or clien* or survivo*	Abstract		
	AND			
	perspective* or narrative* or discours* or experienc* or perception*	Abstract		
CHINAL	Suicid*	Title	Articles are English speaking and published between 2007 and 2014 (inclusive)	395
	AND			
	“service use*” or patien* or clien* or survivo*	Key Concept		
	AND			
	perspective* or narrative* or discours* or experienc* or perception*	Key Concept		

All were either not relevant or duplicates of the studies had already been found.

Of the 46 articles found, studies sampling prison populations (n=4) and people with brain injuries (n=2) were excluded; such populations were felt to not be representative of attempt survivors' experiences more generally. Similarly, studies involving participants living in non-Western cultures were excluded (n=11) as socio-cultural experiences may be significantly different across Western and non-Western countries.

On inspection of whole texts, 2 articles were excluded as they were conference talks and whole texts were not available. 1 study was excluded because it focused on the experience of being discharged from hospital rather than suicidality; another was excluded because it focused on suicidal ideation rather than attempts.

Twenty-five studies were considered relevant to the review; 2 were from authors who had published two different papers using the same sample: for each, both papers were included, but results that spanned both papers were only reported once.

2.2 Quality Appraisal

The research questions lent themselves to review papers reflecting diverse philosophical, theoretical, and qualitative methodological traditions. Accordingly, Yardley's (2000) system of quality appraisal was used: as an open-ended and flexible approach, it is appropriate for diverse modes of qualitative inquiry. Each study was considered in terms of Yardley's four criteria: sensitivity to context, commitment and rigour, transparency, and impact and importance. Table 6 demonstrates the studies that were not considered to meet this criteria. All 19 other studies fared well under Yardley's appraisal criteria.

Table 6

Studies not meeting quality appraisal criteria

Reference	Reason for exclusion on the basis of quality appraisal
de Kernier (2012)	No explanation for how the participant was recruited for case study
Baker and Fortune (2008)	Unclear about which themes or quotations came from users of suicide or self-harm websites
Cutcliffe et al. (2012)	Unclear about which of the participants interviewed had made an attempt and which had not, but had suicidal ideation.
Holm, Lyberg, Berggren, Cutcliffe and Severinsson (2014)	Unclear about which of the participants interviewed had made an attempt and which had not, but had suicidal ideation.
Platt, Hawton, Simkin, Dean and Mellanby (2012)	Unclear about which of the participants interviewed had made an attempt and which had not, but had suicidal ideation.
Deuter, Procter and Rogers (2013)	Unclear about which of the participants interviewed had made an attempt and which had not, but had suicidal ideation.

2.3 Data Abstraction and Syntheses

A meta-ethnographic approach to data abstraction and synthesis was employed (Britten et al. 2002). This approach sees synthesis as an activity bringing together separate parts to form a whole. As an interpretative approach, the main concern is with integrating concepts to develop a wider model or theory; accordingly this methodology was considered appropriate to explore the main concepts involved in the lived experience of suicidality.

Meta-ethnography involves three different approaches to synthesising data (Barnett-Page & Thomas, 2009):

- i.) Reciprocal translation analysis identifies key themes and translates concepts into each other;

- ii.) Refutational synthesis identifies key themes, examining and understanding refutations and contrasting these;
- iii.) A line of argument synthesis involves building a general interpretation, theory or model grounded in the findings of separate studies.

To become familiar with the papers, each was read through twice. Papers were ordered in alphabetical order in terms of author. To translate concepts between studies and start comparing and contrasting these, the first three papers were read and concepts and themes coded as initial nodes using QSR International's NVivo 10 software (2012). These nodes were inspected to see how they might be translated into or contrasted against each other. Rather than finding contradictions between papers, papers seemed to use similar language to describe suicidal experiences. Accordingly, nodes which described similar experiences were aggregated together as a means of translation. For example, initial nodes which had been labelled as 'loneliness' and 'isolation' were labelled as 'feeling alone'.

Results from following papers were subsequently analysed individually with identified nodes inspected and compared against the data already gathered for further translation or contrasting. The process was continued until all papers had been read and all concepts compared. As the process continued, aggregated node labels changed and developed to ensure that they still adequately described the nodes they summarised. For example, as 'withdrawal', 'alienation', 'not belonging' were added to 'loneliness' and 'isolation, the aggregated node labelled changed from 'feeling alone' to 'disconnection from others'.

To retain the richness of context, themes as identified by specific nodes were inspected to see how many different papers they related to as well as which papers they related to. Following translation of themes, and comparing and contrasting findings, results were synthesised into a line of argument. Different nodes from different papers seemed to focus on different time-points of suicidality, so that the line of argument took the form of an overarching model subsequently referred to as the journey through suicidality.

3. Results

The 19 papers included participants across the lifespan and from various countries. Access to participants was from mental health services and the community. Table 7 summarises the methodological approaches taken. In summary, two papers included only women participants, seven only men; the remaining 10 interviewed both genders. One paper focused on older adults, one on adolescents, and the remaining 17 interviewed working-age adults.

Table 7

Summary of Methodological Approaches in Papers Reviewed

Author	Method	Sample	Data analysis					Main Themes
		Country	Gender	Age	Yrs since attempt	Recruitment	Analytic Methodology	
Biddle et al. (2010)	Individual interview	UK	12 men; 10 women	20s – 50s	N/K	Hospital	Thematic analysis	Accessibility and media affect decisions of how to end life
Biddle et al. (2012)								
Bergmans, Langley and Lavery (2009)	Individual interview	Canada	14 women; 2 men	18-25 year olds	Shortly after attempt	After specific intervention	Grounded theory	Ambivalence. Turning points towards recovery.
Biong and Ravndal (2009)	Individual interview	Scandinavia	4 men	30-40 years old	At least 5 years	3 through treatment centres; 1 word of mouth	Hermeneutic phenomenology	Insecurity and loss; turning points to recovery.
Bonnewyn et al. (2014)	Individual interview	Belgium	6 women; 2 men	Over 65 years	Shortly after attempt	Inpatient psychiatric ward	Grounded theory	Loss; Loneliness.

Cleary (2012)	Individual interview	Ireland	52 men	18-30 years old	Shortly after attempt	Hospitals	Grounded theory	Emotional pain, difficult life events and perceptions of being a man lead to wanting to die.
Fitzpatrick (2014)	Individual interview	Australia	6 men; 6 women	18-64 years old	Shortly after attempt	Community mental health centres	Narrative analysis	Suicidality viewed as stemming from internal, psychic processes.
Ghio et al. (2011)	Focus groups	Italy	7 men; 10 women	Adults; mean age 44.5	Shortly after attempt	Inpatient psychiatric ward	Thematic analysis	Isolation, family conflict, psycheache, hopelessness. Need empathy from others.

Gordon, Cutcliffe and Stevenson (2011)	Individual interview	Ireland	17 men	19-34 years old	N/K	Mental health facilities	Grounded theory	Isolation, feeling worthless; negotiate turning points towards recovery.
Holm and Severinsson (2011)	Individual interview	Norway	13 women	25-53 years old	N/K	Mental health organisations	Thematic analysis	Difficult life events; Recovery by finding strength and identity.
Jordon et al. (2012)	Individual interview	UK	36 men	N/K	N/K	Hospital	Grounded theory	Disconnection from humanity; recovery through connections and belonging.

Lees, Proctor, Fassett (2013)	Individual interview	Australia	3 men 6 women	Average age of 41	Recent	Hospital	Critical discourse, constant comparison and classical content analysis	Multi-factorial inter and intra-personal reasons for suicide; recovery through lessen isolation.
McAndrew and Warne (2010)	Individual interview	UK	4 men	35-41 years old	Past (as adolescents)	Mental health services and community	Free association narrative interviewing	Loneliness and isolation leads to wanting to die.
Oliffe, Ogradnicz, Bottorff, Johnson and Hoyak (2014)	Individual interview	Canada	38 men (6 suicidal behaviour)	24-50 years old	N/K	Community	Grounded theory	Despair, loneliness. Internal and external stigma and perceptions of being a man affect choice.

Orri et al. (2014)	Individual interview	Italy	8 men 8 women	17-24 years old	1-10 years	Hospitals	Interpretative Phenomenological Analysis	Devalued self, shame, guilt, loneliness, hopelessness. Suicide as a freeing.
Pavulans, Bolmsjo, Edberg and Ojehagen (2012)	Individual interview	Sweden	5 men 5 women	20-61 years old	Recent	Inpatient psychiatric ward	Qualitative Content Analysis	Loss of control and suicide as a way of regaining control.
Vatne and Naden (2011) Vatne and Naden (2014)	Individual interview	Norway	6 men 4 women	21-52 years old	Recent	Emergency services	Hermeunetic phenomenology	Difficult events; feeling alone; struggling to cope leads to suicide. Supportive responses were helpful.

Zayas (2010)	Individual interviews	USA (New York)	27 women	11-19 years old	2-26 weeks after attempt	Mental health agency; psychiatric outpatient, inpatient and emergency services; several hospitals	Within and across case analysis	Emotional despair, powerlessness and anger.
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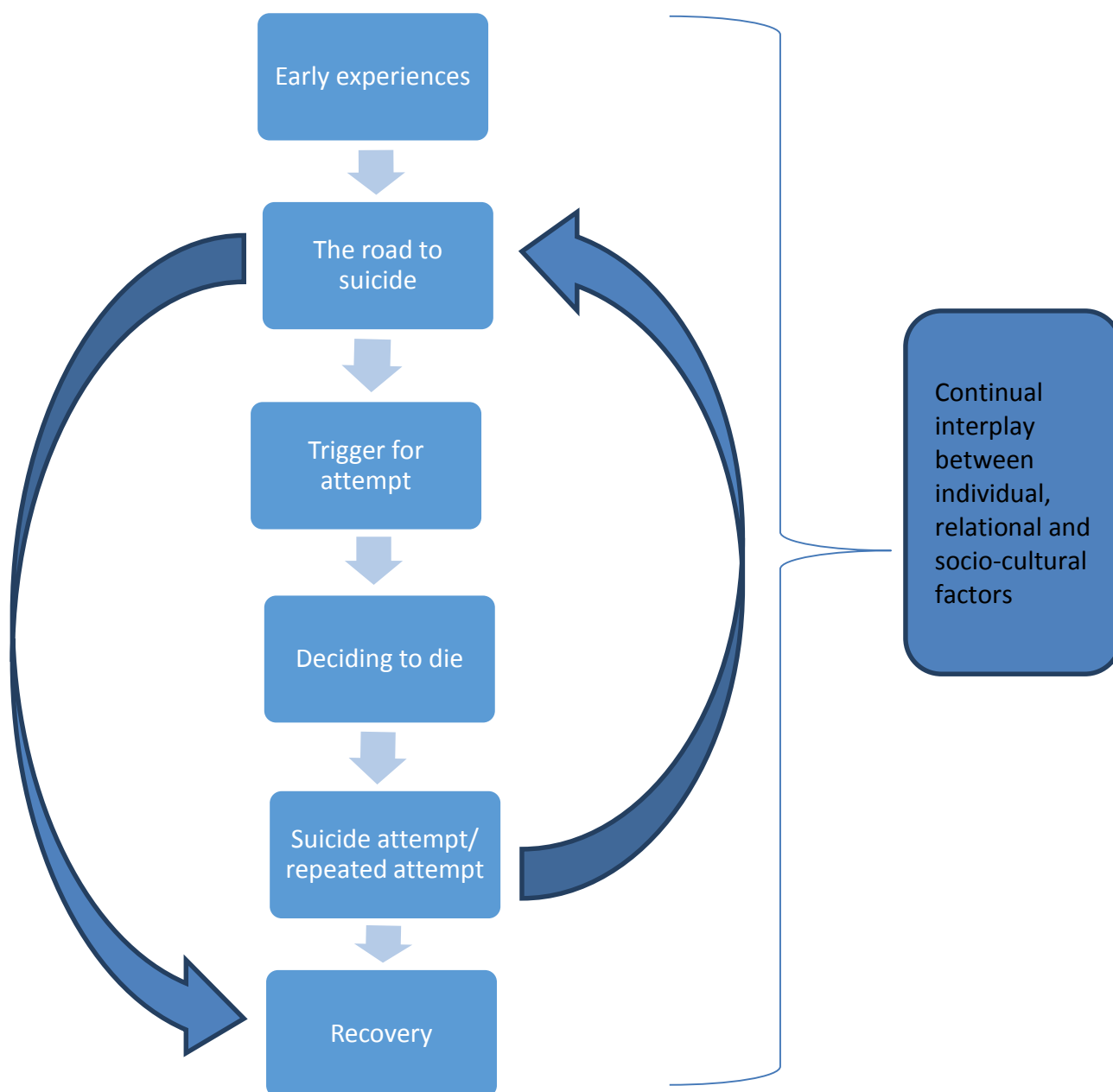
In conducting the synthesis, papers' findings did not appear to contradict each other. Rather, different studies used similar language to describe similar experiences at different points in time. Appendix 1 summarises the concepts and different points of suicidality that each paper focused on. In summary, six of the 19 papers explored early life experiences, 15 explored experiences leading up to suicide attempts, 18 focused on attempts and 10 on recovery.

In creating a line of argument, the different points of suicidality suggested that attempt survivors underwent a journey leading them to make attempts, and sometimes leading to recovery. Overall, the suicidal journey was considered to be complex and non-linear. Figure 1 highlights a model describing how parts of the journey may be connected.

In summary, difficult early experiences could lead to – though were not necessary for – being on the road to suicidality. People on the road to suicidality considered suicide but did not act on their thoughts. A trigger led participants to decide to die, and subsequently make an attempt on their life. Some participants did not consider suicide again after their first attempt, but moved towards recovery. Others contemplated suicide again, thereby being back on the road to suicide. This could then lead to a trigger, a decision to die and a repeated attempt; but a turning point could also occur, leading to recovery. Similarly, a repeated attempt could lead towards recovery, or to being back on the road to suicide.

Different factors were important at different parts of the suicidal journey. Crucially, at each point, the factors spanned individual, relational and societal levels. Moreover, individual, relational and societal factors influenced each other. In the following sections, I describe the factors highlighted across the papers at each point of the model. The quotes provided are illustrative, not summative.

Figure 1

Model of the Journey through Suicidality**3.1 Experiences Leading Up to Feeling Suicidal****3.1.1 Early experiences.**

All papers focusing on early experiences described these as punctured by painful events. Named events included adoption, abuse, alcohol and drug use, bullying, parental behaviours, hospitalisation, loss of parents and feelings of insecurity. Such events affected

how participants saw themselves: they might have internalised the abuse, developed lower self-esteem or been unsure of their direction in life. For some participants, the journey into suicidality started in early life: “On the first occasion, I was 5 years old and wanted to jump from the second floor because I realized that something was wrong with my mother” (Holm & Severinsson, 2011).

Also influential – though less talked about - was what participants learnt about society when young. All papers mentioning the influence of society on early experiences focused on the influence of gender or sexuality. For example, both Cleary (2012), and Oliffe et al. (2014) noted that male participants learnt from an early age that masculinity did not involve talking about feelings. Similarly, McAndrew and Warne’s (2010) study involving gay men highlighted that participants learnt it was unacceptable to be gay: “I didn’t fit the role model that a little boy’s supposed to be...I was just always made to feel exceptional, in a negative way. I was the odd one out.” Learning what was acceptable in society influenced how participants saw themselves and their experiences, including suicidality.

In some cases, then, early experiences may shape people’s understandings and how they cope. However, only six of the 19 papers discussed early experiences: whether this is because the authors did not ask participants, or because it was not considered relevant by participants, is unclear.

3.1.2 The road to suicide.

Several interrelated themes and concepts were identified within the general theme of the road to suicide.

3.1.2.1 Ambivalence.

The road to suicide was characterised by ambivalence: the option of dying seemed present in participants’ minds but they struggled between choosing life or death:

“Profound ambivalence shows itself in a belief that they have nothing to offer the world and that they do not deserve to live, while simultaneously they yearn for a different life” (Gordon, Cutcliffe, & Stevenson, 2011).

Pavulans et al. (2012) suggested that participants weighed up the pros and cons of dying versus living; not wanting to hurt others was the principal motivation for living. However, “It was easier to find reasons to stay alive in the early stages of the suicidal process. As time went by... the counter-suicide arguments...seemed to lose in weightiness.”

3.1.2.2 Precipitating Events to Embarking on the Road to Suicide.

Participants in nine papers named precipitating events. These included having high expectations which were not met, increasing stress at work or home, and loss of health through illness or disability: “What was happening is that I work in a fairly high stressed job and I always coped quite well with the stress, but I found myself being overloaded more and more” (Fitzpatrick, 2014).

Relationship breakdowns and losses through bereavement were mentioned in five papers as precipitating factors. Loss was particularly noted by older people (Bonnewyn et al, 2014). Abuse (emotional, sexual and physical) – noted in a few papers - was a prominent event leading to Latina adolescents feeling suicidal (Zayas et al, 2010). Only one participant appeared unsure of what had precipitated his suicide attempt: “I couldn’t tell you why it started or what happened” (Cleary, 2012).

3.1.2.3 Emotions felt.

Participants across 13 papers named several emotions. All were negative and painful: anxiety, anger, confusion, depression, defeat, despair, feeling lost, guilty, helpless, hopeless, self-loathing, and shame. Eight papers referred to participants feeling an

unendurable emotional distress: “The women’s suicidal behaviour was a struggle to stay alive and to survive a situation dominated by unbearable emotional pain” (Holm & Severinsson, 2011).

Whilst Cleary (2012) noted that some male participants had referred to emotional pain, she described some men’s difficulties identifying emotions, instead, “[Framing] psychological symptoms as physical illness.”

3.1.2.4 Holding negative perspectives.

11 papers highlighted participants’ had pessimistic perspectives: “I [felt] that life was just totally shit... really was horrible” (McAndrew & Warne, 2010). Participant’s also demonstrated a negative sense of self and identity: being a failure, hating themselves, feeling worthless, feeling sinful and bad, having no better future or being unclear about their identity: “I somehow found no meaning in anything, then I felt: was I worth nothing at all?” (Vatne & Naden, 2014).

Negative internal perceptions were sometimes considered by participants as indicative of mental illness: “Thoughts being automatically produced by a mental illness or state of mind, and thoughts that could not be escaped from, were present in the informants’ narrations” (Pavulans et al, 2012).

Other participants interpreted negative perceptions in relation to difficult circumstances in which they found themselves: “I had been raped and bashed . . . I felt that down I couldn’t go any lower. I had no-one I could trust, and no one would listen to me. I’m just no good”(Lees, Proctor & Fassett, 2013).

Alternatively, participants considered how others’ perceptions could be internalised: “As conflicts continued, the internalisation of this abuse often influenced girls’ decisions to attempt suicide” (Zayas et al, 2010). Societal and cultural expectations that they were not

living up to – or could not live up to – also impacted on how participants felt about themselves: “The sense of being a failure, both according to the expectations of the society of origin and in the new context, and being isolated and left without hope for the future, led towards the final action” (Biong & Ravndal, 2009).

Oliffe et al. (2014) further highlight how stigma and social marginalization exacerbate distressing feelings within individuals. One participant was told by his father to leave the community after finding out about his experiences of suicidality: “In this poignant example, external social control and censure further ostracized the man, which in turn exacerbated internal shame, blame, fear, guilt, stress, social isolation, low self-esteem, loss of confidence, and negative self-identity.”

3.1.2.5 Disconnection from others.

Participants from nine papers felt disconnected from others: alienated, isolated, not belonging, and lonely. Explanations for participants’ disconnection varied. For example, participants could become isolated after the loss of a major relationship. This was particularly pertinent to adolescents and older people: “With F. I had finally found that kind of stability...but, I guess it was only a stopgap, a stopgap that covered up all my problems...and in fact, when he was gone, they all reappeared on the surface” (Orri et al, 2014).

Sometimes, participants sought isolation themselves, either because they felt the need to, or to protect others: “I longed for safety, but got another defeat. I withdrew more and more, rejected everyone around me, had no sense of belonging” (Biong & Ravndal, 2009).

When others tried to reconnect, participants may have shunned them or not felt able to reconnect: “I was lonely, but I hold myself responsible for that in some

way. When the children invited me over for an afternoon, I always said no, let me be, I am fine" (Bonnewyn et al, 2014).

At the same time, some gave explanations – particularly adolescents and older adults - of not feeling understood, accepted for who they were, or that others did not try to connect with them: "Our participants' narratives of their family relationships focused on the description of an impasse, a sort of gridlock dominated by the absence of acceptance or trust and the perception of being written down or even off" (Orri et al, 2014).

3.1.2.6 Trouble communicating distress.

Participants across nine papers had trouble communicating distress. 4 sources noted that participants could not communicate distress to others: "But you don't even feel like saying, 'Hello' to people, let alone sitting down with someone and saying, 'I'm really not well and I really don't want to live anymore'" (Jordan et al, 2012). Participants sometimes felt others were not listening or responding if they talked about their distress: "I had no one I could trust, and no one would listen to me" (Lees, Proctor & Fassett, 2013).

Professionals could also be considered as not listening if they misrepresented or rejected how participants viewed the desire to end their lives: "I go to the pain clinic and they ask me mental health questions thinking I'm mentally ill or something. But I'm saying 'I am in agony; that is why I am trying to get rid of my life'" (Fitzpatrick, 2014).

All studies where only men were interviewed found that participants described how men did not communicate distress. Authors and some participants understood this in terms of masculinity: "I think because [men are] afraid to. Not to seem weak. We're afraid of seeming weak or something. Because we have to have this image of being macho, we have to have this image of not being girls" (Cleary, 2012).

In contrast, one of the two studies focusing solely on female participants highlighted that women feared that they might be negatively construed if they disclosed their distress and thoughts about dying: “They felt angry because they had to fight other people’s misconceptions” (Holm & Severinsson, 2011). Therefore, societal concerns around suicide being frightening to talk about might also apply to women as well as men.

3.1.2.7 Not coping.

11 papers noted that participants expressed feelings of losing control and not being able to cope in general, or overcome specific problems:

A loss of control was also described by the informants in relation to their total life situation prior to the suicide attempt; a situation that was recurrently described as chaotic and filled with unsolvable problems, which contributed to a sense of spiralling downwards and out of control. (Pavulans et al, 2012).

Only Cleary describes how participants could be, “Restricted in bringing about change by a lack of financial resources and educational qualifications.” However, whether this is due to participants or authors not focusing on socio-economic factors is unclear.

Participants in six studies turned to alcohol and drugs to cope with emotional distress and difficult life circumstances: “Drugs were described as being a doorway to relaxation, escaping from the pressure and insecurity of daily life, stopping them thinking about problems and creating some good feelings” (Biong & Ravndal, 2009).

Alcohol and drug use were particularly relevant to studies with male participants. Cleary hypothesizes that this method of coping is more socially acceptable to men than talking about feelings.

3.1.3 Summary of experiences leading to suicidality.

Early difficult life experiences could lead to – though were not necessary for – participants finding themselves on the road to suicide. Being on the road to suicide was characterised by difficult events, feeling negative, painful emotions, holding negative perspectives, having trouble communicating distress and not coping. Throughout the themes, individual, relational and socio-cultural factors were present and affected each other.

3.2 Experiences When Suicidal

3.2.1 Triggers for suicide.

Participants named a range of events that they considered triggers for attempts. These included abuse, loss of a core relationship, multiple losses, physical pain and conflict in the family. Such triggers were also said to “[activate] an overwhelming rush of emotions” (Zayas et al, 2010), which could also lead to suicidal acts. Indeed, participants named a range of mental states acting as triggers: unmet expectations, not thinking straight, psychological exhaustion and feeling worthless. The triggers for a suicide attempt appear similar to the precipitants. However, a precipitant was the first event leading to suicidality; triggers occurred within ongoing pattern of instability, tension and distress.

3.2.2 Deciding to die.

A suicidal setting was created at the point where the desire to die outweighed the desire to live. The decision could take a long time or be abrupt: “Most tell about a condition where the darkness gradually increased and the decision to commit suicide emerged, ‘I had simply given up’.... For some, the decision was more abrupt, as a consequence of ‘an immense feeling of hopelessness’” (Vatne & Naden 2011).

When the decision was made, it often occurred in isolation and was not communicated to others: “Psychiatrists? Who thinks about going to them? I don’t think about speaking to a doctor, I don’t even think about talking to a friend, I don’t tell them I’m depressed” (Ghio et al, 2011).

Some participants justified their decision to themselves, countering possible reasons for not dying by thinking, “Others would be better off without [them], [they] cannot go on just for the sake of others, [there is] no other solution, and suicide is brave” (Pavulans et al, 2012).

The decision to end one’s life was typically considered unchangeable, and consideration of others was deemed unlikely to sway a decision:

I think that even if my husband had walked in on me when I was about to take the pills and said that: ‘No, don’t do it, you can’t do that’” I would simply have said that, ‘you can’t tell me what to do or not. It’s my life, and I decide over it.’”

(Pavulans et al, 2012)

Participants remained secretive about their decisions, but in hindsight recognized potentially acting differently after deciding to make an attempt: “I’d spent the whole day before listening to really sad music ...my parents were worried I might do something . . . but by that stage I was determined and I took a load of pills” (Ghio et al, 2011).

3.2.3 Suicide attempts.

Death appeared to be an allure for most participants. The most frequently cited descriptions of death and suicide were as an escape which would remove unbearable pain, as a comfort, as regaining control, and as a solution. Attempts could also be seen as bringing relief:

As I swallowed the sleeping pills down with red wine, I was thinking, ‘Ah, now

it'll be over'. Then the feeling came, that you get a little happy, because you know somehow that now the race is run, now you're finished. (Vatne & Naden, 2011).

Nine of the 19 papers noted specific methods used and found that there was a range. Biddle et al (2010) reported a variety of factors influencing choice of suicide methods. For example, some participants chose hanging thinking it was a clean method which would not hurt them and would work quickly; others shied away from this method as they considered it messy. Access to means and ease of implementation were further factors contributing to choice of method.

Biddle et al (2012) explored what influenced people's choice of suicide attempt method. Results included personal knowledge of other's attempts, previous self-harm, professional knowledge, fictional book sources, lay knowledge of suicide methods, media sources, celebrity suicides and internet searches. This suggests that people's knowledge of potential methods of suicide is drawn from a range of source.

Cleary (2012), and Oliffe et al (2014) noted that some of their participants considered male suicides to be particularly lethal: "It was clear that lethal suicidal behaviours were perceived and affirmed as masculine terrain, whereas nonfatal suicidal behaviours had negative gender connotations for many men" (Oliffe et al, 2014).

3.2.4 Failed attempts.

After a failed attempt, participants described feeling angry, guilty, disappointed, and a failure. However, some participants were ambivalent about having not died: they regretted having lived, yet feared engaging in another attempt.

Whilst some participants felt able to talk to others about their attempt, some did not. There appeared to be a sense of privacy, shame or stigma around participants'

attempts: “I didn’t want to go through what I went through. Like go to the hospital. Because it is for mental people, I felt like embarrassed” (Zayas et al, 2010).

Some participants experienced negative reactions from others following their attempt, including isolation, rejection, denial, or characterization of their act as selfish or morally reprehensible: “They remembered being told that they must think about the feelings of their husbands/partners and significant others and not to be so selfish” (Holm & Severinsson, 2011).

Such reactions led to some participants feeling less connected or understood by others, thereby reinforcing the distress that led them to attempt suicide. However, one participant noted that the suicide attempt had motivated another person to interact differently with them, thereby ending their feelings of disconnection (Orri et al, 2014).

3.2.5 Repeated suicide attempts.

Participants noted moments where another attempt seemed an option. These included the period immediately after the failed attempt, following admission to hospital and after hospital discharge. Loneliness and lack of empathy from others were risk factors for another attempt (Ghio et al, 2011). Holm and Severinsson (2011) noted that attempt survivors might feel significantly more vulnerable if they were unable to exert the change they yearned for in their lives due to their social situation.

Protective factors following hospital discharge included being monitored regularly by nurses, and other people empathising with their situations (Ghio et al, 2011).

3.2.6 Summary of experiences when feeling suicidal

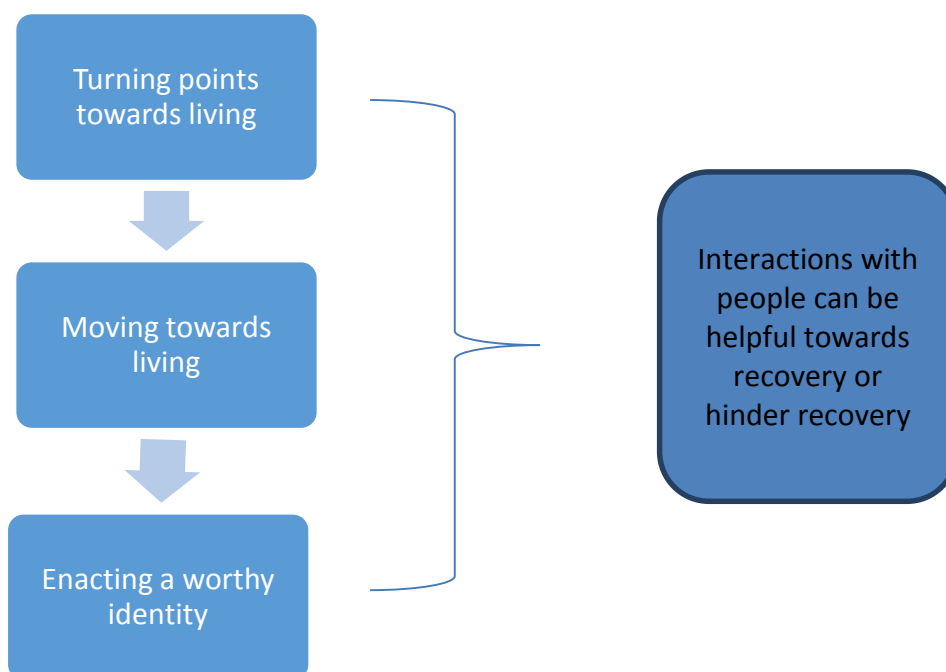
The main points considered by participants when feeling suicidal were: triggers for suicide attempts, the decision to die, suicide attempts and repeated attempts. Again, influential factors were across individual, relational and socio-cultural levels.

3.3. On the road to recovery

Recovery was described in different ways: a long-term journey, being comfortable with oneself, wanting to live, reorienting towards life, managing the pain of life without using harmful coping mechanisms, bringing to life dormant aspects of one's being, and searching for strength. Recovery was considered incremental, occurring in small steps over time. Figure 2 highlights a potential journey through recovery. In summary, the papers drew on three themes of recovery, and noted that people could help or hinder attempt survivors at each point.

Figure 2

The Journey through Recovery



3.3.1 Turning points towards living.

Turning points - away from death and towards living – were considered; these could be one-off or gradual events. They included someone close dying, not wanting to be in crisis again, reflecting on the crisis, and hospitalisation.

Gordon, Cutcliffe and Stevenson (2011) argued that turning points shifted the locus of control from external to internal, thereby helping participants to take responsibility for themselves, their lives and actions: “These pivotal moments that challenge their negative self-conception initiate a change from looking externally to looking internally for a solution, and begin to shift their perceived locus of control from external.”

A past attempt could be a turning point if it led to a realisation that others cared: “The attempt led some girls to realize that “there are people who care, because a lot of people wanna help me” (Zayas et al, 2010). A past attempt could also motivate attempt survivors’ families or friends to communicate with them differently: “The communication that developed after the suicide attempt led to the explicit recognition of feelings, emotions, and thoughts that had been present before the attempt, but never successfully communicated” (Orri et al, 2014).

3.3.2. Moving towards living.

The second point of recovery involved moving towards life and included self-development at the individual level. This involved gaining emotional and cognitive awareness, gaining control in life, finding strength to recover, renewing self-trust and believing in a positive future: “I’m hoping I will be able to at least organize a few things and get control of that so that I do feel I can try [disabling this narrative of failure]” (Fitzpatrick, 2014). Learning that life could be rewarding despite its challenges, finding stability, and re-engaging with life were also considered important. Biong and Ravndal (2009) noted that attempt survivors, “Managed to make new and different choices for the future.”

At the relational level, moving towards life included signaling to others a wish to change, and making positive re-orientations towards others: “Vigilance for imperfections in self and others is replaced with an openness to seeing positive opportunities for connecting,

shifting them from being victims to being authors of their lives and inter-subjective selves, and from isolation to belongingness” (Gordon, Cutcliffe & Stevenson, 2011).

Others’ reactions impacted on attempt survivors’ ability to recover: recovery was nurtured by hope; being in contact with others who had attempted suicide could normalize their experiences.

3.3.3 Enacting a worthy identity.

Only two papers focused on the long-term recovery journey. Both highlighted that this involved attempt survivors shifting their perspectives towards their past experiences, and enacting a new identity, away from suicidal crises towards feeling worthy: “As the young men re-engage with their selves, others and life again, they become ready to establish and enact their new sense of identity in their daily lives” (Gordon, Cutcliffe & Stevenson, 2011).

This process could occur soon after, or many years after, a survivors’ last attempt. The process involved making realistic appraisals of achievements, seeking new perspectives, re-evaluating the past, and making sense of suicidality: “There was a distinct process of leaving ‘what has gone’ in the past, to some extent reframing how some of this past was viewed, and seeking a new perspective on their present and future” (Jordon et al, 2012).

3.3.4 How others can help and hinder throughout the journey to recovery.

Throughout the recovery journey, others - including family, friends, peers and professionals – were considered to act as facilitators of, or impediments to, recovery.

3.3.4.1 How others can help.

Facilitators of recovery were open, understanding, supportive, sensitive, respectful and empathic; they believed in the person. An environment where attempt survivors felt safe and understood was considered vital: “Sincere . . . open, just having them listen,

understanding, always up front and . . . completely consistent” (Bergmans, Langley & Lavery, 2009).

Professionals were considered helpful if they took time to listen, appeared caring and addressed the matter of suicide, rather than shying away from it: “I wanted someone to sit down and talk with and go through it all . . . to just support me and ask me about it and how I was feeling” (Lees, Proctor & Fassett, 2013).

Attempt survivors also valued discussing their experiences with each other. For example, Jordon et al (2012) note:

Peers provided a conceptual and practical ‘route map’ to a rewarding and hope-filled future. They also served to further challenge specific understandings of what it is to be a ‘real man,’ given that these real men described personal problems, fears, unhappiness, suicidal behaviour, and ultimately, survival. Finally, hearing these testimonies served as a protective factor against future suicide attempts.

3.3.4.1 How others can hinder.

Many factors impeding recovery were the direct opposite of attitudes that helped: blaming, lack of empathy, pitying, dehumanizing, being dismissive, or conveying a lack of interest or understanding. Responses which minimized attempt survivors’ pain were also considered unhelpful: “I had a terrible experience in the emergency ward of G. hospital. I was semi-conscious and I heard staff commenting about they’re having to waste time on me when there were other patients more in need”(Ghio et al, 2011).

Whilst hospital could act as a temporary refuge from the world, forced hospitalization could also lead to participants feeling trapped thereby increasing suicidality.

The process of hospitalization could also be humiliating (Vatne & Naden, 2011). Even talk of hospitalisation could reduce dialogue:

Then the therapist said, 'We can see that you are so sick, if you don't get yourself out of this, then you'll have to be hospitalized by force, perhaps in another place'. The participant described how this response increased her fear of what might happen: 'and then you close up even more' (Vatne & Naden, 2014).

Professionals engaging with attempt survivors was key to making the hospitalization process helpful. Medicalisation of a person's distress could lead to participants not feeling seen or trusted by others. Some participants held mixed views of diagnosis:

They had nothing against being diagnosed per se, but objected to being diagnosed as 'bad girls'. At that time, they had no strength to fight, felt frustrated and violated, as well as ashamed of being classified as terrible patients who nobody could stand. (Holm & Severinsson, 2011).

Professional practices which prioritized managing risk over understanding attempt survivors could also be unhelpful: "It's difficult for people to understand where you're coming from. They're not really interested in why you are doing it. They are only interested in you not doing it" (Fitzpatrick, 2014).

Professionals who did not appear to know enough about psychological approaches were also considered unhelpful as were those who persisted in understanding a person's attempt in a different way:

I had lots of things going on, and I didn't think a pill would fix that. . . . They thought that it was just the depression that was clouding my thoughts, but it

wasn't that simple, and I needed to talk about that. (Lees, Proctor & Fassett, 2013).

3.3.5 Summary of the journey towards recovery.

Papers which explored recovery highlighted three points towards recovery: turning points towards living, moving towards living and enacting a worthy identity. In particular, people could help or hinder attempt survivors at each point. Yet again, factors influencing recovery spanned individual, relational and socio-cultural levels.

4. Discussion

Attempt survivors' experiences highlight potential suicidal journeys, and potential factors involved at each point. Factors highlighted as leading towards and within an attempt seemed to be more negative events, feelings or thoughts; factors leading out of suicidality and towards recovery were more positive. Across the model, there was an interplay between individual, relational, and socio-cultural factors.

4.1 Relating the current review to Lakeman and Fitzgerald

The current review was conducted to explore recent literature into the lived experiences of attempt survivors, thereby updating Lakeman and Fitzgerald's (2008) review. Given the different approaches to synthesis taken, not including the Lakeman and Fitzgerald papers in the present synthesis may be seen as a limitation. However, due to time constraints, this was not possible. Nevertheless, it is important to consider whether and where the results of both syntheses do or do not overlap.

All themes raised by Lakeman and Fitzgerald were echoed in the current review. For example, emotional suffering was mentioned by participants in both reviews. Similarly, the

theme of struggle was apparent in both: most notably a struggle between life and death, and a more general existential struggle.

Echoing Lakeman and Fitzgerald's (2008) finding that connection and disconnection, respectively, helped and hindered attempt survivors' experiences of suicidality, the importance of relationships was a key theme in the current review. Turning points away from and towards suicide were also considered crucial amongst both. Similarly, both reviews considered the role of coping or not coping within the suicidal journey and recovery.

The similarities suggest some reliability and generalisability of findings. However, the current synthesis reviewed a greater number of papers and was able to go into greater depth, creating a model of suicidality based on attempt survivors' experiences. This difference may partly be due to the different approaches taken in each review: the meta-ethnographic approach adopted by the current review allows for a deeper synthesis than Lakeman and Fitzgerald's (2008) thematic approach.

4.2 Relating Attempt Survivors' Perspectives to Theories of Suicide

The attempt survivors' perspectives highlighted here build on theories of suicide proposed by professionals and researchers across a variety of disciplines.

4.2.1 Psychological theories.

Attempt survivors touched upon individual, psychological theories of suicide. For example, in highlighting the extreme emotional pain linked with suicide, participants and authors appeared to evoke Schneidman's (1996) conception of suicide as stemming from unbearable psychological pain.

The entrapment model (Williams, 2001), based on a cognitive approach, proposes suicidality as an escape, emphasising a person's helplessness and inability to escape from

aversive environments. Many participants described experiencing such feelings of hopelessness and inability to escape in relation to the overwhelming emotions experienced in the time leading up to or immediately before the attempt. Similarly, participants' negative perceptions - including feeling worthless and the future being hopeless – are consistent with cognitive theories of suicide, which stress the role of negative thought patterns (e.g. Beck, Brown, Steer, Dahlsgaard, & Grisham, 1999).

Personality models highlight possible personality traits which might increase the likelihood of suicidality, for example a tendency to pessimism and an external locus of control (e.g. O'Connor & Sheehy, 2001). Participants highlighted that such factors were important in leading to suicidality.

4.2.2 Biomedical theories.

Some survivors drew on the idea of mental illness, particularly depression, in describing what had led them to attempt suicide. This parallels research focusing on a biomedical perspective, linking suicidal behaviour to specific diagnoses. For example, Appleby, Swinson, and Kapur (2003) view suicide as a possible symptom of hypothesised mental disorders, particularly depression.

4.2.3 Relational theories.

Participants described suicide as being predisposed by loneliness or lack of belonging – and recovery as related to the opposite. This is consistent with Joiner's (2005) theory of an interpersonal-psychological theory of suicidal behaviour.

The interpersonal and intrapersonal considerations evident in participants' accounts seem to reflect Aldridge's (1998) systemic perspective of suicide. Aldridge argues that suicidal behaviour is an attempt to communicate with others: this was highlighted by some participants also. Aldridge further considers that suicidal acts tend to occur in response to

others' behaviour. Some participants highlighted having internalised families', peers' or societies' negative perceptions. Last, Aldridge argues that when the relational focus is disturbed, a person can become threatened with isolation, alienation or banishment: this is a principle theme highlighted by attempt survivors.

4.2.4 Socio-cultural theories.

Durkheim (2006) suggests that "egoistic suicide" occurs when there is inadequate social integration of the individual self into society and indeed many participants in the studies described feeling isolated from their families, cultures or societies.

Similarly, there were references to social perspectives of suicidality as a taboo and a stigma; a review by Sudak, Magma, and Carpenter (2008) notes suicide remains stigmatised in comparison to mental health issues as a whole.

4.2.5 What the model adds to theories of suicide.

Such academic and professional theories tend to focus on understandings at either the individual, relational or socio-cultural level. In contrast, the model proposed here explores factors across individual, relational and socio-cultural levels. This highlights the complexity of suicidal experiences which lends to a more holistic approach to working with attempt survivors, and suicidality in general.

4.3 A Critical Approach to Attempt Survivors' Accounts of Suicidality

This review highlights the growing field of research into attempt survivors' perspectives of suicidality. By privileging first person experience, researchers have aims to reinstate the value of the personal by positioning attempt survivors away from previously marginalised positions and towards positions of authority on suicidality (Shapiro, 2011). However, attempt survivors may not necessarily hold more authority on suicidality by virtue of their experiences. In particular, whilst people might view their own stories as objectively

true, how they remember, review and come to understand their experiences is never literal (Shapiro, 2011). Rather, re-telling of experiences is always constrained by the power of dominant cultural narratives.

Just as researchers and professionals are influenced by their personal and cultural standpoints in understanding and explaining suicidality, attempt survivors also tell their stories and share their experiences in particular ways and for a particular purpose; both personal and professional stories cannot be separated from the beliefs, values and expectations of cultural narratives (Shapiro, 2011). Moreover, there is also a danger that some survivor perspectives may be privileged over others, particularly if they are in-line with dominant narrative conventions or meta-narratives (Shapiro, 2011).

Accordingly, whilst the model presented here highlights how attempt survivors might experience their journey through suicidality, it does not explore what might influence their telling about this journey. Therefore, the intent is not to suggest that this model holds more authority or authenticity than others. Rather, in accordance with narrative humility (Shapiro, 2011), the aim is to bring together personal meanings and experiences of attempt survivors to add to the literature, and to practice. This is particularly important given past research has privileged professional accounts and neglected attempt survivor perspectives.

5 Implications

5.1 Implications for Practice

Attempt survivors stressed that suicidality is influenced by individual, relational and socio-cultural factors. Whilst current suicide prevention interventions tend to focus on the individual level (prescribing medication and offering individual, psychological therapy), some projects aim to reduce stigma and increase public awareness of suicidality (World Health

Organisation, 2014). However, despite highlighting that rates of male suicide coincided with peaks in indicators of the economic recession, Department of Health (DoH, 2015) advocates largely individual interventions to suicide. Accordingly, socio-cultural and relational approaches, as well as individual ones, need to be considered. For example, more systemic approaches to help suicidal people - including family and relational interventions – should be considered. Moreover, just as attempt survivor movements have gained opportunities to affect policy and research in the United States (National Action Alliance for Suicide Prevention, 2014), the UK also needs to give voice to attempt survivors to affect socio-cultural perspectives.

Attempt survivors' experiences of professionals appeared mixed. However, it seemed most crucial to provide humanising services and practice; these involve staying empathic, open, and creative. A number of therapeutic approaches may do this. However, practitioners should consider how to maintain a humanising approach within more pressured or risk-averse contexts, particular given the current context of the NHS within the recession. Wilson (2015) notes that, "It is the manner of meeting that signifies a humanising attitude to practice" (p. 12). Accordingly, he suggests several ways clinicians may approach complex issues with humanity: first, to be aware of possible differences in interactions with clients; second, to allow events to be lived and felt in therapeutic interactions; third, to meet and hear clients without being preoccupied with theories; fourth, to maintain creativity, and consider different ways forwards; last, to not follow specific pre-planned, formulaic interventions, but respond to what clients bring.

Given participants also considered peer involvement helpful, peer groups could be set-up for attempt survivors to talk about their experiences openly. Moreover, given the role of socio-cultural perceptions of suicidality, professionals might further act at more public and political levels to further reduce stigma around suicidality. In particular, publicising multiple perspectives (e.g. professionals, attempt survivors, those bereaved by suicide) could facilitate a wide range of conversations about suicidality, thereby helping to combat stigma and encourage more complex understandings of suicidality.

5.2 Implications for Research

Despite increased interest in attempt survivors' lived experience, the papers in this review still span relatively different populations and approaches to qualitative methods: further qualitative research with attempt survivors would be useful.

In particular, it would be useful to consider how suicide and femininity are intertwined: research with men has already suggested that they may have difficulties talking about emotions, thereby increasing risks to suicidal behaviours, but it is not clear how and when women may talk about suicidality. Similarly, many studies focused more on people who had recently attempted suicide. Further research might usefully explore experiences of recovery, or those who repeat attempts over long periods of time. Moreover, given the focus on research from Western cultures, it would be useful to consider literature from other cultures to consider the larger impact of cultural context.

The model proposed here highlights that suicidality can be understood at individual, relational and socio-cultural levels. However, whilst this model highlights how attempt survivors might experience their journey through suicidality, it does not explore what cultural constructions influences their narrations of their journeys. This is important as

understanding to what extent survivors draw on dominant constructions may also give voice to more subjugated understandings. Narrative analysis could help elucidate the cultural constructions attempt survivors draw on when narrating their experiences of suicide.

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Section B

Stories of Suicide: A Narrative Analysis Exploring Attempt Survivors' Cultural Constructions of Suicidality

Word count: 7999 (392)

Abstract

Suicide is a major problem in society and remains a challenge for services. Approaches to suicidality occur across individual, inter-personal and socio-cultural levels. However, the dominant narrative remains a biomedical one. Excessive reliance on a biomedical approach is problematic as complex phenomena may be reduced to linear causes. Service user perspectives may highlight alternative understandings and interventions but can also be constrained by dominant cultural constructions. Accordingly, this study aimed to explore the cultural constructions which survivors drew on in narrating their experiences of suicidality. Eleven attempt survivors who had recovered from suicidality were interviewed. A narrative analysis was conducted and highlighted a polyphony of survivor voices and cultural constructions. Six stories drawing on a variety of constructions were explored in detail. These included biomedical, psychological, situational, interpersonal, moral, public and spiritual. Participants used constructions of suicide to justify their experiences. One previously under-explored voice to emerge was of suicidality as having been a positive experience. Results are discussed with respect to previous studies, narrative typologies of illness, clinical implications, limitations and future research.

Keywords: Attempt survivor; Narrative analysis; Cultural constructions; Dominant narrative; Suicide

1. Introduction

1.1 Current Approaches to Suicidality

Suicidality has been conceptualised differently at different points in history and within different cultures (Marsh, 2010). I explored the current literature, and consider theories of suicidality as dividing into three typologies:

- 1.) Individual approaches
- 2.) Inter-personal approaches
- 3.) Socio-cultural approaches.

1.1.1 Individual approaches.

Individual approaches seem to view suicidality as stemming from problems within individuals; a person's wider context may trigger internal phenomena but the latter lead to suicidality.

1.1.1.1 Biomedical and psychiatric theories

These draw on medical styles of thought which construct suicidality as a disease, or symptom of a disease. Biomedical theories consider that there is a genetic basis for suicide (Zai et al, 2012), and that suicidal people have brain abnormalities and deficits in specific neural transmitters (Bach & Arango, 2012; Ordway et al, 2012). Psychiatric theories consider suicide as a symptom of mental illness (Mann, 2003).

1.1.1.2 Psychological theories

Psychological theories focus on problematic mental and emotional processes. Psychodynamic perspectives consider suicidality as a conflict between life and death instincts (Litman, 1996).

Cognitive approaches highlight negative thinking patterns including thinking the future is hopeless, and that one cannot cope (Beck, 1999), and that one cannot escape the aversive environment (Williams, 2005).

Behavioural approaches consider suicidal people to have learnt to inhibit outward expressions of aggression; this aggression is then turned inward on oneself (Leenaars, 2004).

Personality traits such as rigid and pessimistic thinking, increased impulsivity, an external locus of control, perfectionism, and rumination have also been argued as related to suicide (O'Connor & Sheehy, 2000).

Schneidman (1996) considers suicide to stem from *psyche-ache* (intense psychological pain), dissatisfaction arising from blocked or frustrated psychological needs, and a desire to escape.

1.1.1.3 Spiritual theories

These focus on internal, existential crises. Baechler (cited by Schneidman, 1996) considered suicide to be a disease of the soul and a crisis of the self and selfhood. Webb (2010) describes suicide as a loss of an internal innate, spiritual force.

1.1.2 Inter-personal approaches.

Inter-personal approaches are relationally-mediated, viewing suicide as a socially interactive phenomenon. Aldridge (1998) sees suicidality as a communicative act, stemming from a combination of intra-personal and inter-personal conflicts. Joiner's interpersonal-psychological theory (2005) argues that suicidal thoughts emerge when people feel alienated or consider themselves to be a burden to others.

1.1.3 Socio-cultural approaches.

Socio-cultural approaches consider the wider context of society and culture.

1.1.3.1 Moral Understandings

Moral understandings refer to ethical values underpinning societal beliefs. A modernist position argues that suicide is an insult to God; suicide prevention is a moral duty (Leenaars, 2004). A libertarian position suggests that suicide is an individual right and

choice; suicide prevention may be overly paternalistic (Leenaars). A relativist position considers suicide as morally acceptable dependant on the situation and culture (Leenaars).

1.1.3.2 Public perspectives

Suicide is stigmatised and considered taboo in Western society (Schneidman, 2001). Public ideas contributing to this include that suicidal people are weak or ill, and that suicide is always irrational (Gordon, 2009). The media is both influenced by and continues to shape public perceptions around suicide (Links, 2001).

1.1.3.3 Sociological theories

Sociological theories propose that suicide is explicable with reference to social structures and functions. Durkheim (2002) argued that the social processes of integration and regulation mediate individual connectedness and social change; suicidality is caused by extreme imbalances in either of these. Different types of suicide (egoistic, altruistic, anomic, and fatalistic) occur according to the particular imbalance present.

1.1.3.4 Social-materialist theories

Social-materialist theories consider risk factors for suicide to include poverty and economic difficulties. Gunnell et al (1999) highlight significant associations between suicide and unemployment in both males and females. The more recent economic recession and subsequent loss of employment was deemed to increase suicides in England significantly in men, though not women (Barr, Taylor-Robinson, Scott-Samuel, McKee & Stuckler, 2012; Coope et al, 2014). In response, Department of Health (DoH, 2015) highlight the importance for public health staff to “know the options for someone at risk of suicide because of economic difficulties” (pg 12).

1.2 Dominant Narratives of Suicidality

Whilst a variety of approaches are available, dominant narratives may restrict which approaches people draw on. Dominant narratives are those most often told within a culture, and which most affect the values and identities of people in that culture (Mankowski & Rappaport, 2000).

1.2.1 The dominance of the biomedical model.

In contemporary Western culture, suicide is largely constructed through the biomedical model: the link between illness and suicide is positioned as self-evident (Marsh, 2010). For example, the Mental Health Act (Department of Health [DoH], 2007) places psychiatry at the centre of suicidality as psychiatrists may detain people who are suicidal (Marsh, 2010). Psychiatrists are considered experts on suicidality and given roles as advisors to government policy, and editors of journals or books on suicide (Marsh, 2010).

Similarly, much research into suicidality focuses on determining biological, neurological and genetic causes (Hjelmeland & Knizeck, 2010). Even when economic factors are considered to impact on suicide, the focus is on mental illness (DoH, 2015). Marsh (2010) further notes that biomedical perspectives are disseminated as truths within non-professional arenas such as the media and government reports. For example, media guidelines suggest suicide should not be described as normal or understandable and stress the link between depression and suicidality (World Health Organisation, 2008). Accordingly, the biomedical model is the current dominant narrative. A number of possible problems follow from this, which are discussed below.

1.2.2 The problematic effects of a dominant biomedical narrative

How we understand suicide has consequences for how we respond to suicidality (Marsh, 2010). Suicide has largely been considered a “tame” problem (White, 2012, pg.42):

complicated, but easily-defined with a self-evident solution developed from similar, previous experiences. When suicide is understood within a narrow framework, people may become fixed in their thinking and wedded to a single approach, leading to more simplistic and less creative responses (Wilson, personal communication, 2015).

A biomedical construction of suicide considers it as a problem which requires a solution, and is solvable. However, Michel et al (2002) argue that this neglects peoples' lived experiences. Marsh (2010) suggests it could restrict the resources those affected by suicidality draw on to make sense of their experiences. Meanwhile, a primary focus on an individualised approach neglects the impact of relationality, culture and society; the individual may remain the target for change despite alternative potential influences. Similarly, Marsh argues that by constructing suicidal persons as patients, professionals may be perceived as the only ones who can help: attempt survivors may feel disempowered; portraying professionals as solely responsible for patients, places pressure on staff.

Accordingly, such reductionist approaches may be unhelpful. However, survivor perspectives may highlight alternative ways of understanding suicidality.

1.3 Attempt Survivor Perspectives

1.3.1 The value of service user and survivor perspectives.

Service user and survivor movements have been a driving force in promoting alternative perspectives to dominant illness models of mental health. For example, the Hearing Voices Network challenged the idea that voices are a symptom of mental illness, leading to innovative practice (Romme, Noorthoorn, & Escher, 1992). Similarly, research exploring the perspectives of people who self-harm led to self-harm being viewed as a maladaptive way of coping, rather than a symptom of illness and influenced practice (Harrison

& Sharman, 2005). Consequently, understanding service users' perspectives and experiences can helpfully elucidate alternative ways of understanding and responding to distress.

1.3.2 Towards attempt survivor perspectives in suicidology.

Despite the dominant biomedical focus of research into suicidality, since the turn of the century there has been a growing focus on attempt survivors' lived experiences (Lakeman & Fitzgerald, 2008). The attempt survivor movement has also grown: projects and blogs detailing attempt survivor experiences are available online (Anna, 2013; Stage, 2014). This movement is gaining publicity and influence: The American Association of Suicidology recently approved a membership division for attempt survivors who contribute to research and policy-making (National Action Alliance for Suicide Prevention, 2014).

Whilst attempt survivors' accounts cannot necessarily be viewed as more authoritative than others (see below), focusing on them enables inclusion of previously neglected perspectives within suicidology, empowering attempt survivors by reinstating the value of the personal. It can therefore helpfully broaden our understanding of suicidality and the range of available responses.

1.3.3 Difficulties with attempt survivor perspectives.

Whilst including the voices of attempt survivors is valuable, their accounts do not in and of themselves hold more authority than others' accounts: professionals' and academics' perspectives are constrained by the narratives available within their culture and society, but so are attempt survivors' (Shapiro, 2011). Moreover, stories which are more in line with culturally dominant understandings may be privileged. Therefore, whilst exploring attempt survivor perspectives has the potential to transform understandings of suicidality, they may also reproduce and reinforce dominant cultural constructions. It would be useful to elucidate the cultural resources that survivors are drawing on in describing their

experiences. A narrative analysis offers this potential whilst still empowering survivor voices.

1.4 Narrative Analysis

1.4.1 The use of narrative.

Narrative psychology is interested in stories people tell to describe and organise their experiences (Willig, 2001). Through telling stories, people create meaning from difficult experiences allowing for reconciliation and growth (Reissman, 2008). Story-telling is also performative: people tell stories with audiences in mind, positioning themselves in desirable ways (Reissman, 2003).

Narrative psychology also explores the cultural and societal resources people draw on in telling stories including the extent to which story-tellers may internalise and reproduce dominant narratives (Mankowski & Rappaport, 2000). At the same time, narrative is concerned with giving voice to the subject: it allows subjugated perspectives to emerge (Ewick & Silby, 1995). Accordingly, narrative analysis retains connections to personal meanings, whilst also exploring the dominant and subjugated narratives drawn on (Mankowski & Rappaport, 2000).

1.4.2 Narrative Analyses of Suicidality

Fitzpatrick (2014) used narrative analysis to explore how attempt survivors' talk reflected social, cultural and institutional discourses. He focused particularly on moral understandings: participants' narratives demonstrated organised, linear, and coherent explanations, reflecting conventional stories of cause and effect; participants largely

reproduced cultural norms, understanding suicidality as primarily individual, internal and pathological; some limited moves towards alternative constructions were noted.

1.5 Rationale and Aims

This study attempts to build on, rather than replicate Fitzpatrick's (2014) study. In particular, the current study drew on a different pool of participants. Fitzpatrick's participants had all recently attempted suicide and were accessing mental health services. By contrast, the current study recruited participants within the community who considered themselves to have recovered from suicidality. People's understandings of their experiences change over time as they engage in dialogue with themselves and others in different contexts, and the current study aimed to access a wider range of narratives than Fitzpatrick's.

The current study has two main aims: first, to add to the literature redressing the balance of previously neglected perspectives by exploring attempt survivors' stories; second, to elucidate which cultural resources they draw on in telling their stories.

1.6 Research Question

The main research question was: what stories do attempt survivors tell about suicidality?

This question was guided by two sub-questions:

- a.) To what extent do attempt survivors draw on dominant cultural constructions of suicide?
- b.) What alternative constructions of suicide do attempt survivors draw on?

2. Methodology

2.1 Positioning the Research

2.1.1 Epistemology.

This study takes a social constructionist perspective: I focus on different narrative constructions of reality, and consider instances of narratives on suicide to be performed and co-constructed within the context of the research conversation.

2.2 The personal context.

I am a 30 year old British and French, White, female Trainee Clinical Psychologist who identifies as an attempt survivor. My experiences sparked my interest in researching attempt survivors' narratives: I did not feel I had a voice at the time, and the biomedical model does not fit with my experiences. Whilst interested in alternative understandings of suicide, my primary motivation for this research is to promote attempt survivors' voices, whatever their understandings.

In order to ensure reflexivity, I kept a research diary (Appendix 3) and undertook three bracketing interviews (Tufford & Newman, 2010) at different points of recruitment: prior to conducting interviews; following five interviews; and, following all interviews but prior to analysis. These were recorded and revisited throughout data collection and analysis.

2.2 Participants

2.2.1 Criteria for participation.

Table 8 summarises inclusion and exclusion criteria.

Table 8

Inclusion and Exclusion Criteria

Inclusion Criteria	Exclusion Criteria	Reason
Self-identified as having attempted suicide. In line with attempt survivors' perspectives (Webb, 2010), attempted suicide was defined as any act or urge to act which might have ended in the person's death.	Self-identified as only self-harming (no urge to end their life), or only bereaved by suicide.	To ensure relevance to the study.
Last suicide attempt between 5 and 15 years ago	Suicide attempt less than 5 years or more than 15 years ago.	At least 5 years ago: To minimise risk to participants and ensure they had time to reflect on their experience. Not more than 15 years ago: To ensure relevance to current practice as professional responses to - and policy on - suicide has changed over time potentially influencing attempt survivors in different ways.
Based in the UK.	Based outside of the UK	To ensure relevance to UK professionals and policies.
Over 18 at time of interview.	Under 18.	To ensure sample were all adults.
Be willing to have interview recorded.	Not want the interview recorded.	To ensure interviews could be transcribed and analysed fully.
Be willing to give health professional contact details.	Not consent to giving health professional contact details	To minimise risk further, should participants feel suicidal following the interview.

2.2.2 Participant demographics.

Eleven participants were interviewed: 2 men and 9 women of working age. Eleven interviews were considered sufficient to provide a variety of voices and narratives, and yet be feasible to study in depth within the time available. Table 9 summarises participant demographics; all names are pseudonyms.

Table 9

Participant Demographics

Pseudonym	Gender	Age	Last attempt
Matt	Male	44	n/k
Fiona	Female	28	11 years
Abby	Female	31	8 years
Clare	Female	59	11 years
Alex	Female	26	8 years
Anna	Female	n/k	7 years
Charlie	Female	38	15 years
Emily	Female	34	11 years
Sam	Female	39	5 years
Jess	Female	48	9 years
Jack	Male	52	7 years

2.3 Method

2.3.1 Recruitment.

After consultation with service users, including attempt survivors it was decided to advertise through social media: third sector organisations and individuals interested in the topic of suicide were targeted.

Social media posts summarised the study, gave my contact details and highlighted a website giving further information (www.survivorstoriesofsuicide.com). The website was created in consultation with members of the public including attempt survivors (Appendix 4). People interested in participating contacted me via email or telephone.

2.3.2 Procedure.

Following confirmation that participants met selection criteria, an initial phone conversation was setup to encourage engagement, ensure understanding of the study, and organise a means of conducting the interview. Where possible, interviews were conducted in person, but failing this, via Skype.

Interviews were semi-structured: Eight open-ended questions with prompts (Appendix 5). This guided participants to narrate experiences and understandings of suicidality. However, they narrated as they chose to, and I responded naturally within the conversation to create our own context within the interaction. Interviews lasted between 45 and 77 minutes.

All interviews were recorded using a digital audio recorder; during interviews, I made notes of my feelings and thoughts. To debrief, I asked participants how they found the interview and tried engaging participants in everyday conversation.

2.4 Ethical Considerations

Full ethical approval was granted by Salomons Centre for Psychology (Canterbury Christ Church University) Research and Ethics board (Appendix 6).

2.4.1 Risk.

Inclusion and exclusion criteria minimised risk of participants becoming suicidal or distressed during interviews, and no participant became distressed after interview. To minimise threat to myself, phone conversations occurred before meeting participants, and face-to-face meetings occurred in public spaces where participants felt comfortable to talk.

2.4.2 Informed consent.

Participants were emailed the information sheet and consent form prior to interview or given a physical copy at interview (Appendix 7); all signed consent forms. All were informed of their right to withdraw, and given time to consider participation between initial contact, first conversation and interview.

2.4.3. Data protection and confidentiality.

Recorded interviews were transferred to a password protected computer and deleted from the audio recorder. One Excel file with contact numbers, demographics and anonymisation data was kept on this computer.

2.5 Analysis

2.5.1 Narrative Analytic Approach.

This study employed an integrative narrative approach based on thematic, performative and dialogical Narrative Analysis. The analysis was influenced by Bakhtinian thinking which considers stories to be polyphonic (containing many, sometimes conflicting, voices), and considers the history of language used (Frank, 2010). The analysis was further influenced by rhizomic thinking. This suggests that narratives are not fixed, always approached from specific starting points or necessarily complete, but have multiple entryways, and are unfinalised: participants alter their perspectives in the interview, and in subsequent narrations (Sermijn, Devlieger, and Loots, 2008). The aim was to provide a platform for “wild” understandings of suicidality as “associated with high levels of instability, unpredictability, uncertainty and complexity” (White, 2012, pg. 42).

2.5.2 Method.

Interviews were anonymised and transcribed verbatim to ensure the context of the conversation was included (see Appendix 8 for sample).

I used the Listening Guide Method (Brown, 1997) to guide analysis. This provides a methodical way of exploring narratives whilst maintaining the complexity and polyphony of voices. Each transcript was read separately and multiple times; at each time, a different focus was fore-grounded. First, I made notes on the overall plot of the dialogue and attended to the research relationship, integrating my notes from interview. The second read foregrounded participants’ first person voices: I-poems (Brown, 1997) were constructed to consider how participants spoke for and about themselves and their experiences. The third reading focused on analysing key moments that participants dramatized: how they staged these experiences and characterised themselves and others.

At this stage, I constructed a table pulling together information gathered from the first three readings and, considered any emerging voices. Voices were considered in relation to each other and similar voices grouped together: current understandings of suicidality guided groupings but the main focus was on allowing participants' voices to speak. This focused the fourth reading which considered the words narrators used: what meanings were invoked, words' histories, and what might be accomplished by using these.

2.5.3 Quality Assurance

In order to ensure quality of analysis and interpretation, two trainees familiar with Narrative Analysis inspected and discussed one participant's transcript before inspecting my analysis; they agreed that my reading fitted with the transcription. Appendix 9 provides samples of each analytic stage for one participant to provide an analytic audit-trail.

2.5.4. Feedback.

At the conclusion of the study, a link to my website containing a summary of the findings (Appendix 10) was advertised through Twitter and given to participants and involved organisations. Salomons Ethics Committee were sent the same feedback.

3. Results

Participants did not always provide clear, temporally linear narratives of experiences, and the voices which surfaced were not always clear-cut or compatible. Participants may change or develop their stories in subsequent narrations, and many readings are possible. Therefore, the results presented here are not intended to be finalized, generalisable understandings of suicidality, and only provide one reading: examples of how participants construct experiences of suicidality. For context, a summary of stories is provided in Appendix 11.

All participants used several voices, drawing on multiple cultural resources. However, the extent to which they drew on biomedical, psychological, spiritual, interpersonal, social and moral constructions differed in some. Appendix 12 provides tables of the main approaches drawn on across participants.

It is not possible to explore each narration here. The following sections highlight 6 of the stories to exemplify the variety of constructions participants used in their narrations and the interplay of these.

3.1. A Biomedical Construction: Alex – A Struggle to be Taken Seriously

3.1.1 Context

Alex identifies as a bisexual woman. Though born in Scotland she moved to Ireland when her dad moved there during the Troubles for work. She comes from a religious Protestant family and is religious herself. Alex also noted having lived in England for a while.

3.1.2 Results

Alex believes suicidality stems from mental illness. When asked to share her experiences, she responds:

The first time I felt suicidal was when I was 13, so that was when I knew I was ill because before then I'd felt sort of completely normal and I just woke up and sort of wanted to die and I was like, 'Well, this is a bit weird.' [Laughs]

She draws on common ideas of environmental causes of suicidality to highlight her illness: "I was happy, you know, I didn't get abused or anything, I was from a middle class home."

Alex narrates times she felt suicidal and, "Went properly sort of mental." The word "mental" carries a history of acting irrationally and abnormally. She uses action-focused language when describing attempts, but tends towards passive language to understand

these: “My brain would rearrange the dots into words saying kill yourself.” This suggests a lack of control over suicidal urges, positioning the illness as responsible.

Alex positions herself as a good, but helpless patient: “I was trying to do all of the things I could to try and stay well, and I was taking medication and that, but it was just really difficult.” Following attempts, she seeks help but encounters negative reactions. These include public understandings of suicidality as selfish, unpleasant and attention-seeking. Alex is frustrated at the double-bind: “Every time you have a mental illness you are always told to seek help but then when you do seek help you are called attention-seeking! Like, they can’t have it both ways!”

Viewing attempts as attention-seeking links to dominant societal expectations of women as weaker and as motivated to seek help and support (Owens & Lambert, 2012). Alex describes the disempowering effect of hearing her experiences constructed in this way: in hospital she hears a doctor talk to his trainees outside the curtains around her bed:

He was just like, ‘Well, you know, this girl came in last night with an overdose but obviously you know she didn’t really mean to do it and you know she’s quite glad we saved her life.’ I was like, ‘What the fuck did you do, when you’ve never even talked to me?’

Growing up in a Catholic country and with a minister as a father, Alex notes that church-goers drew on a dichotomy of evil and good to explain her suicidality: they said she was being tested by God or had sinned and was being punished. At the time, Alex thought she was possessed by a demon; she was exorcised:

[The exorcist] prayed with me sort of very violently and shoutily, pushed me back into my chair and I was completely freaked out. And then he declared that the demon had gone and then we all had communion and it was like, ‘Hooray!’

Similar to the biomedical model, understanding suicidality as demonic possession suggests diminished responsibility. Only after her youth leaders continue exorcising her and repeatedly fail to listen to her, does she consider alternative explanations: “I was like, ‘Well, crap, we tried to exorcise this before and it hasn’t helped,’ you know, like ‘I must be really ill.’”

In response to people in power imposing particular explanations, Alex appropriates the biomedical model – with its historical power – to legitimise suicidality, silence critics and cast blame elsewhere. Regarding professionals she says: “They feel like it’s your fault that you’re suicidal and that you have chosen...to ruin their day by... having an illness.” In relation to religion she suggests: “It’s not a sin...it’s just an illness.” Helpful services were those which, “Just accepted [suicidality] as part of your illness.”

Alex draws on interpersonal perspectives to describe how she overcame suicidal behaviour: “The only thing I could think about you know every time I felt suicidal was like well my dad’s dying...like I’ve got to not let myself do this.” However, suicide is still an unwanted possibility: describing hearing someone talk about a suicide method, she notes, “I’m going to remember this when I’m suicidal.” Given her participation in the study, this indicates a dual position that talking about suicide might be both helpful and harmful.

3.2 Biomedical, Psychological and Inter-personal Constructions: Fiona – A Story of Burden

3.2.1 Context

Fiona lives with her boyfriend in a small town; she describes “not knowing what she would do without the boy” and feels he has “saved her”. She holds adores her pet reptiles. She described studying and teaching languages, and, as well as her languages, rock music seems to play a very important in her life.

3.2.2 Results

Fiona draws on the biomedical model throughout her story, referring to illness: “I was too ill to do anything basically.” She describes how mental illness runs in her family: “My cousin’s got schizophrenia. My other cousin’s got depression, or he’s got bipolar. So it’s been in our family. So it’s kind of natural, go down that route as well.”

Fiona describes the situation leading up to her first attempt: “I was okay throughout summer; then we got to winter and I just lost it.” Here she draws on a dichotomy of rationality when feeling well and irrationality when suicidal. Yet, she also relates to having some choice to end her life: “But the fact that I could choose if I wanted to kill myself or not was some kind of control.” Therefore, she positions herself as being both in and out of control.

Fiona notes thinking that suicidality is “more nature.” However, she acknowledges the impact of the environment on some illnesses: “Nature-nurture, I guess. I mean with stuff like schizophrenia you can’t really help it but with bulimia it’s like [my children are] going to see me freaking out over food.”

Fiona specifies environmental factors leading to her feeling suicidal: having been “sexually abused twice”, being in a family who “just push everything down”, and when “a guy kind of jumped on me and started touching me inappropriately.” The latter event “triggered everything”, but it is unclear what she feels it triggered – whether an underlying biological vulnerability to mental illness or something else.

Fiona uses psychological language in describing how she felt when suicidal: she appropriates psychodynamic terms when saying, “I’d repressed the abuse, like completely repressed it”; and draws on ideas from cognitive psychology with thoughts around, “Not

coping” and things, “Looking progressively bleaker”. Again, it is unclear if she is drawing separately on psychological approaches or considering these to be symptoms of the biomedical model.

Fiona uses spatial metaphors denoting a worsening situation: “I didn’t know that I was slipping until I had slipped.” The image is of being unable to stop what had been triggered, lacking control and being unaware of what was happening. Rather than casting blame on others, for example, her abuser, she focuses on her individual response and difficulty managing the situation. Accordingly, Fiona struggles, taking the responsibility of her actions on herself.

Fiona describes the burden of suicidality. First, a burden of isolation: “I didn’t have any friends, it was just my mum. Like complete isolation.” Second, a burden of wanting to do something which others consider selfish: “I went through this massive struggle about not wanting to appear selfish but also really, really wanting to be dead.” Third, she cites, “An incredible burden as well...the fact that I’d tried to kill myself and no one knew about it.” Last, she notes: “With the amount of pain I was causing (my mum), with the amount of worry that I was causing her, if I wasn’t there, then she didn’t have to worry.” The individual burden she feels is due to individual, inter-personal and societal factors.

Fiona says her current relationship helped her overcome suicidality though she still struggles with depression and an eating disorder. She expresses positivity about her past suicidal experiences: “I’m glad it happened. Because I wouldn’t be who I am today without them and I think going through all that stuff and still coming out the other side is pretty awesome.” She appropriates an optimistic narrative of living in the best possible world which in itself serves to make sense of and rationalize painful events, and provide an individualized stepping-stone for future hope.

3.3 Biomedical, Psychological and Moral Constructions: Jess – From Surviving to Living

3.3.1 Context

Jess lives in a small city; she is well-educated, having attended a prestigious university and previously worked in a highly demanding professional role. Jess noted still struggling sometimes with some aspects of her mental health, but feeling overall in a good place, currently living with her girlfriend. She described being in the process of writing a book about her experiences and currently volunteering to support the community.

3.3.2 Results

Jess draws on the biomedical model in causing suicidality: “I truly just think it's a chemical imbalance.” She describes herself as, “Still quite barking mad” following her attempt; using language around insanity conveys irrationality and lack of control. However, she also considers her childhood: “I classify myself as ill, and at times not ill, because it helps me understand my behaviour. But in fact...I believe that my illness is purely through an abusive childhood.” Therefore, she considers a biomedical model as leading her to suicidality, but this stems from early experiences.

Jess struggles with complete acceptance of the biomedical model: she jokes about her diagnosis changing over the years and questions diagnostic terms: “Do we - once you've given some-one a diagnosis - do they start living out that diagnosis?”

Jess draws on inter-personal understandings, describing loneliness precipitating each attempt: “It was mostly this huge chunk of loneliness. Um, not being able to talk to anyone properly about how lonely I was feeling.” Similarly, she draws on psychological approaches, highlighting:

The mental pain! You know that mental agony that you feel that is almost physical? And you wonder how you can be in so much pain and still live? It doesn't seem possible! To think if you were in that much pain and it was a physical illness, you would collapse in a heap; you wouldn't be able to walk. And that's how it feels.

Here, Jess uses rhetorical devices such as repetition and pathos. She conveys her agony to the reader to persuade them that under such circumstances, suicide is, "A perfectly reasonable thing for people to do."

Jess draws on moral understandings describing wanting to, "Die like a Roman," characterizing this as a, "Noble ending, exsanguinating in the bath." The nobility of suicide is also, "Like the general shooting his, shooting his brains out before he gets arrested." Here, she appeals to historical contexts where suicide was considered appropriate, thereby giving historical countenance and authority to her assertion that suicide is permissible.

Jess also draws on literary concepts of suicide as freeing, referring to a Sylvia Plath poem:

As you live through life you get all these bits of plaster, like Paris, plaster of Paris, sticking to you until you can't move properly and you're walking through sand and you, you can't do much because you're so disabled by this coating. So what she does, is she tries to kill herself, which shoves her down into the abyss of death, deep, deep, deep down, and then she's brought back to life by, by being saved...and you're yanked up so fast by the...like a piece of elastic, like a bungee jump, that all the plaster falls off

you. So you're reborn naked and new-ling, glistening in your new skin and it feels clean, and it feels like you've left the shit behind.

Again, she uses rhetorical devices of metaphor and repetition to characterize suicide as morally acceptable and helpful.

Jess describes her own attempt as a turning point: after, “[She] felt able to start again and look at things differently.” Currently she sees herself as having moved, “From surviving to living.” Jess argues that death by suicide may be better than death from physical causes:

I kind of don't see it as tragic. As say, my friend, who I was in a relationship with for six years who dropped dead of a stroke one Sunday when I was at work. You know, that I'll never get over. Other friends of mine who have committed suicide I kind of felt there's a reason behind it.

Yet, she is cautious in how seeing suicide as acceptable comes across: “I don't want you to worry, in case I'm going to start reliving it all and falling apart, because I'm not.” Here, Jess may have been influenced by the requirements for GP contact details prior to participation in the study; it could also be interpreted as an awareness of a societal aversion to suicidality being perceived positively.

3.4 Biomedical, Social, Psychological and Interpersonal Constructions: Jack – A Story of Perceived Inadequacy

3.4.1 Context

Jack has a degree in English and at the time of interview spends time writing about films and concerts. He described having been employed in many capacities, but noted having recently done some work with fellow service users. He described himself as quite prone to negative thinking but also quite jokey. He currently lives with his girlfriend.

3.4.2 Results

Jack refers to feeling depressed leading up to his attempt: "I'd got depressed and had some antidepressants." Yet, he argues against diagnostic criteria and biomedical approaches:

"Mental illness...Which I don't really believe in ... I mean the whole, you know: which comes first? High dopamine levels cause, um, high mood or because your mood is going high your body produces dopamine?"

However, Jack believes that biology played a part in his experiences. First, he feels medication may have led to feeling more depressed: "I happened to decide to look at a patient information leaflet... recently, and they're acknowledging that it can cause depression." Second, he describes that sudden withdrawal from lithium could have led him to attempt suicide. Last, Jack describes taking lithium to be helpful: "I started back on [lithium] and I did... It has helped me not feel the way that I did." He acknowledges the duality of voices in response to medication: "I'm quite in two minds sometimes about medications." Therefore, whilst being critical of the biomedical model, he positions his experience to some extent within it.

Jack also draws on social, psychological and interpersonal understandings of suicidality. He notes situational issues leading him to consider suicide: "Because I was at work, like I... It was a stupid, pointless job, it was a non-job." He describes a succession of inter-personal interactions prior to his attempt, including being attracted to a woman at friends' dinner party, but feeling rejected and hurt by her "scornful" reaction to the food he made. He also draws on cognitive, psychological approaches when describing recurring thoughts of inadequacy: "There was a lot going on but what happened on the actual day, if

you want to that, is, um, uh, a similar sort of feeling of inadequacy.”

Whilst Jack refers to situational and interpersonal factors, these seem to trigger feeling inadequate. The sense is of being put upon by others and situations, which lead him to feel inadequate: “I knew I hadn’t done [something at work] and I felt really bad about it. It was... It was like another failing.” Similarly, “The experience of being with, uh, (my friends) and how the interaction went reinforced the negativity.” Accordingly, whilst feeling inadequate, Jack has trouble negotiating responsibility for this.

Jack notes the influence of films on his chosen attempt method: he is surprised when the reality contradicts the cinematic depiction, and when his life does not end, he thinks, “Oh you can’t even do that.” This highlights the strength of his feelings of inadequacy.

Jack refers to socio-public understandings of suicidality when he argues against suicide prevention policies explaining, “I’m ambivalent about...it’s a Stop Suicide campaign.” In light of this, he states, “I knew that they would try to stop me if they had an inkling, so I’m pretending nothing was wrong.” He argues that, “A campaign that goes around saying, ‘You’ve got to stop this,’ um, [is] likely to make people even more secretive about their plans.”

Jack says he would not currently attempt suicide but describes praying to God asking God to end his life:

I’m sort of giving him permission to end my life but I’m not doing anything myself and I’m...and equally, it’s a sort of way of saying, ‘And if you don’t then I’ll know it’s not going to be like this forever, and two or three days and I actually feel better and you’ll help me through it’.

Again, he appears to negotiate responsibility for living or dying; this has the effect of renewing Jack's hope for the future, and in the purposefulness of life.

Despite current wishes to die, he sees past suicidal actions as positive since he can better support others: "I like to be able to share some insights into how I've...I see the mental health system."

3.5 Biomedical, Situational and Inter-personal Constructions: Charlie – An Ordinary Response to Extra-Ordinary Circumstances

3.5.1 Context

Charlie described herself as being in the process of writing a book; living with her girlfriend. She noted having an affinity with birds. She described being fascinated by biology, and studying at University. She also described being creative as well as being naturally interested in life and death matters. She came across as a very humorous and independent person.

3.5.2 Results

Charlie focuses on situational and inter-personal factors which led her to suicidality. She relates very early experiences of her parents attempting suicide: "I think that's the point where it probably started for me, the interest in suicide and death." Charlie further describes how child sexual abuse led to her wanting to end her life:

I already in the back of my mind thought any purpose in life was as somebody's sexual plaything and by the time I got to the age of 12 I thought, 'God, I don't really, I can't, the thought of a whole life of that, no, no thank you.'

Her suicide attempts are considered natural consequences of situations she was in: "I actually think it's quite a natural response, um, to huge stressors."

Charlie acknowledges that mental illness exists, in others or other parts of her life but

actively differentiates her “panic years” from her suicidal experiences:

At that point, suicide suddenly became not an option because I’d become phobic of being sick...I was not a well bunny at all and actually it’s the only time in my life when I considered that I was ill.

Charlie notes elements of both rationality and irrationality within experiences of suicidality:

I mean I’ve seen friends where they’ve been suicidal and you can kind of see that at that point they’re not calm, they’re not, their thought processes are not rational as such. They’re not entirely irrational but um... and at that point I would be concerned for them.

When asked specifically about her language in relation to suicidality, Charlie acknowledges that: “Actually to be honest I think the choice of word breakdown in leading me into the psych unit is probably a bad choice of word because I don’t actually see it as a breakdown really, if I’m honest.” When asked what influenced her to use this word, she says, “Because that’s the terminology that is generally used, that, that if you end up in a psych unit it’s usually people will say you’ve probably had a breakdown.” Accordingly, she ventriloquates dominant biomedical language (Brown, 1997). In considering her language, Charlie then appeals to everyday occurrences: “I mean it’s not like I was just like driving along and my car suddenly broke down. I was still going somewhere; it may just have been skidding a bit downhill.”

Despite other characters being present in Charlie’s narration, an individualistic sense pervades. This is notable when describing recovering from suicidality: she introduces no other

characters but focuses on herself. What helps recovery stems from inside her: her struggle through life, learning from experience and instances of self-awareness.

Charlie describes seeing suicide as a positive: “I just don’t see suicide as a negative thing. I think, um, yeah, don’t get me wrong, life is a precious thing but sometimes it’s just too much.” She uses a metaphor of having an exit strategy should she experience a panic attack: “I will hang around but the reason I’m able to hang around is because I know that I can leave at any time, and I find that really comforting.” She differentiates her thinking from others’ when noting societal taboos and risk-aversion to suicide: “No, no, it’s a really, it’s a dirty word. And then when it is mentioned people can be, can get things quite out of perspective, I think.” To counter others’ perspectives, she draws on her knowledge of biology to argue that suicidality should not be considered in moral terms:

I have known animals to effectively commit suicide at times of stress so to me it doesn’t seem wrong or weak. I really don’t like the strength and weakness thing but it, even now, it seems to me quite natural.

3.6 A Spiritual Construction: Matt – A Spiritual Journey

3.6.1 Context

Matt lives in a big city. He described himself as being in a very good place and was moving in with his girlfriend. He is very well read, and noted being inspired by the works of specific psychologists which have both helped him, and which he uses to try to help and support others, for example giving talks and leading groups. Following a spiritual path by listening to his true self was very important to Matt. He also described being in the process of writing a book about his experiences.

3.6.2 Results

Matt's story centred on his personal, spiritual journey to seeking enlightenment. This spiritual path involved: "Receiving guidance from my true self...or erm, that part of myself that is completely at one with whatever word you want to call it: God, Universe, Source, Spirit." The cultural resources he draws on seem to be more Eastern understandings of spirituality when he talks about his spiritual path, seeking enlightenment and following enlightened mentors to spiritual places. However, with a large focus on himself and how he worked to attain spiritual enlightenment, he seems to draw still on relatively individualized conceptions.

He is the only participant who does not use the word suicide, instead choosing to refer to the act of "jumping". He actively disassociates his experiences from the idea of suicide: "There was no sort of – I'm planning this...or I'm going to attempt suicide. That word didn't even ever come into my mind." However, his decision to take part in a study on suicide suggests that he acknowledges others may consider his jump to be an attempt.

Rather than his jump being seen as a result of a crisis, it is a positive turning point towards this goal of oneness of being: "So even though I've had lots of surgery, everything – the whole thing has been the biggest gift ever." Moreover, he seems to indicate feeling that the jump itself was what led him to spiritual enlightenment: "I think if I didn't jump, I still could be lost in the ego." Rejecting the term suicide - which holds a history of negative connotations linked to evil, criminality, and insanity – might allow him to view his experiences as positive.

Whilst using potentially medicalised labels, he positions himself as being creator of his experiences (rather than the illness having created his experiences): "I created this whole thing. I created the psychosis...You know. Nobody did this to me. It was what I was doing." This suggests he holds himself responsible for his actions. Yet, the responsibility of having

acted in a way which is typically perceived by society in a negative light is not a burden to Matt because he believes so strongly in the positive impact the jump has had on his life; he sees himself as being empowered and so, accepts his experiences.

Matt describes the lead-up to his jump as stemming from him thinking he was on the right spiritual path, but actually not being on this path. He notes biological, psychological and interpersonal factors, describing lack of sleep, emotional pain and self-isolation. However, these are seen as a result of following the wrong spiritual path rather as causes of the jump per se. Matt acknowledges that others might have different understandings of his experiences and suicidality in general: “[The psychiatrist] was seeing me through the medical model. What was it? ‘Command hallucinations, delusional beliefs’. You know, ‘Here is the medication to keep you well.’” Matt seems to accept that others hold different perspectives, but states that the medical model was not what helped him. He reframes the medical model’s notion of a chemical imbalance as him having created the imbalance:

I mean the medical model is just delusional beliefs, command hallucinations, all of this stuff. It’s a chemical change in your brain, the medication is to change the chemicals in your brain so that it can work normally... But I created those chemical changes. You know? By not sleeping, not talking, not eating, not drinking. The stuff I was doing in my mind. I created that. So, you know everybody is a creator.

They’re not little puppets.

Therefore, whilst accepting that others may believe in the medical model and mental illness as a way of understanding suicidality, Matt challenges it as an appropriate model for his experiences:

It may be a starting point to help people... OK the medication is sort of rebalancing my brain....Fine. But don't end there. Go much further into: OK let's really work out what caused them in the first place and how to get yourself better afterwards.

4. Discussion

4.1 Summary of Results

The current research highlights attempt survivors' narratives of suicidality and the cultural constructions drawn on to understand these. Consistent with Fitzpatrick (2014), the culturally dominant biomedical model featured in all participants' narratives. However, in contrast with Fitzpatrick, not all participants used canonical forms to narrate experiences. Moreover, many did not construct their experiences primarily from a biomedical model. All participants referred to alternative understandings of suicidality including psychological, religious, inter-personal, moral and public understandings.

All participants drew on cultural resources to legitimise suicidal acts: whether trying to persuade the reader that they were not to blame (Alex and Jack), that their actions were understandable (Jess and Charlie), or meaningful (Fiona and Matt). This indicates that attempt survivors may make sense of their suicidal behaviours in many ways. However, as all sought to justify their behaviour, this could indicate how stigmatised perceptions of suicidality are and the effects of this on attempt survivors.

Many participants highlighted positive features of attempted or completed suicide. This is in contrast with approaches outlined in the introduction and, with Fitzpatrick (2014). A person's context influences how they are heard but also how they present themselves (Georgaca, 2004); locating interviews in non-medicalised environments, when people may

have considered alternative perspectives could influence conversations towards more subjugated voices. Indeed, Matt completely rejected the biomedical model and developed his understanding through interactions with a spiritual community. How a person interprets their experiences depends on how others - particularly those in authority, such as clinicians or religious leaders - label these experiences (Scheff, 1966).

A positive construction of suicidality echoes literature into psychosis suggesting that a crisis may be a transformative experience (Jackson, 2008). A positive construction of suicidality may also link to Frank's (2010) typologies of illness narratives. Frank argues that chaos narratives – where people still struggle with illness – are more transgressive and unheard in comparison to quest and restitution narratives – where people feel better. In particular, quest narratives centre on personal journeys towards wellness and appear more concerned with neoliberal approaches to healthcare. Certainly some positive voices of suicidality (Fiona, Charlie, Jess and Matt) might be akin to quest narratives. Yet, Fiona, Charlie and Jess also describe current or potential future struggles with suicidality suggesting overlap with a chaos typology. Accordingly, Frank's typologies may be only somewhat relevant to attempt survivors' constructions of suicide. Moreover, given professional theories of suicidality as negative, a quest narrative may be a subjugated narrative of suicidality (Shapiro, 2011).

4.2 Practice Implications

Attempt survivors drew on a plurality of voices and approaches in narrating experiences of suicidality. This is consistent with suicidality as a “wild problem” (White, 2012, pg.42) requiring various approaches and practices: at individual, relational and social levels.

This suggests that professionals need to draw on a variety of approaches when working with those who are suicidal or attempt survivors. Psychologists - given their breadth of training - may find this easier than some professions. Yet, working with suicidality is a multi-disciplinary endeavour; training could be offered to ensure a range of professionals feel confident in working across multiple levels.

Professionals should be aware of the struggle that suicidal persons might face in trying to make sense of their attempts, but also consider how local and societal contexts might affect these understandings. Given clinicians' potential power to influence how attempt survivors might label their experiences, clinicians should remain open-minded and give clients space and support to come to their own understandings; this is similar to recommendations outlined in *Understanding Psychosis and Schizophrenia* (British Psychological Society, 2014). In particular, clinicians need to accept that some survivors might view their attempts positively, and perhaps create space for positive learning from suicidal crises. However, clinicians would also need to consider how to do this whilst not appearing to promote suicide.

Given some of participants' moral arguments, a goal of preventing suicide – and certainly preventing it at all costs - is not universally supported by attempt survivors. This is in marked contrast to government policy (DoH, 2015) which focuses on the need to prevent attempted suicide and death by suicide. This poses an issue for government policies and professional practice which need to take into consideration the perspectives of the people they serve, lest an already silenced group feels further alienated. Accordingly, policy makers should consult attempt survivors.

4.2 Limitations and Future Research

One difficulty of attempting to capture a wild problem is that it is hard to do justice to complexity whilst maintaining both clarity and sufficient brevity. Accordingly, the current reading is only one amongst many and other aspects of participants' stories could be explored. For example, recovery was a feature in most participants' stories and could be explored further, as could attempt survivors' identity before, during and after their period of suicidality.

Within a dialogic approach, readers are inherently part of the interpretative process, bringing their positions, identities and cultural filters to interpretation (Reissman, 2008). Accordingly, a different reader may not have developed the same analysis; this might be considered a limitation. Nevertheless, to ensure a plausible reading has been presented here, it has been explicitly linked to features in the text with quotes (Reissman, 2008), and a sample of analysis was verified by two fellow narrative analytic researchers.

Moreover, the research diary and bracketing interviews helped me consider how my own narratives might have impacted on interviewing or analysis, and supported me to honour participants' stories, rather than my own. For example, in the second bracketing interview, I discussed with the interviewer my worries about having come across as doubting Alex's assertion that her suicidality was caused by illness; we considered what questions or frameworks might help to curiously stand alongside someone's story and facilitate future interviews. This helped me to feel more confident in being open to others' stories in future interviews, and analysis.

In line with a dialogic approach, the results are not intended to be generalisable (Reissman, 2008). Rather, the stories collected are examples of stories of suicidality within a

given context. However, the very procedures for trying to access a potentially difficult to reach sample may have made it more or less likely that particular attempt survivors would participate. For example, the exclusion on ethical grounds of people who did not consent to provide healthcare professionals' details could have put off some people.

The current research is the first to highlight positive narratives regarding suicidality. Further research might elucidate how common this is, as well as what might facilitate or impede this understanding. Talking about suicide attempts has been viewed as positive and enriching (e.g. Anna, 2014), and as morally problematic and encouraging copycat attempts (e.g. Williams, 2011). Given this, it could also be useful to explore how others – professionals and members of the public – view the potential for suicidality to have positive aspects or to be a transformational crisis.

6. Conclusion

This study aimed to add to the literature redressing the balance of previously neglected perspectives by exploring attempt survivors' stories, and to explore what cultural resources their stories drew on. The findings suggest that the 11 attempt survivors interviewed drew on, but were not restricted to, the current dominant biomedical narrative of suicide. They also drew on multiple cultural constructions across individual, relational and socio-cultural levels to narrate and make sense of past suicidal behaviour. These included psychological, spiritual, situational, interpersonal, moral, and public understandings; the extent to which these were drawn on varied between participants. This contrasts with Fitzpatrick's (2014) findings suggesting that suicidal persons tended to reproduce biomedical understandings of suicidality; this may be understood in terms of the different contexts and samples of each study.

Participants within this study also seemed to use various constructions of suicide to justify

their experiences. One previously unexplored voice to emerge was of suicidality as having been a positive experience. Findings suggest that suicidality cannot be understood from only one perspective, whether this is the dominant narrative or not: clinicians and policy makers need to remain open-minded about how attempt survivors might view their experiences.

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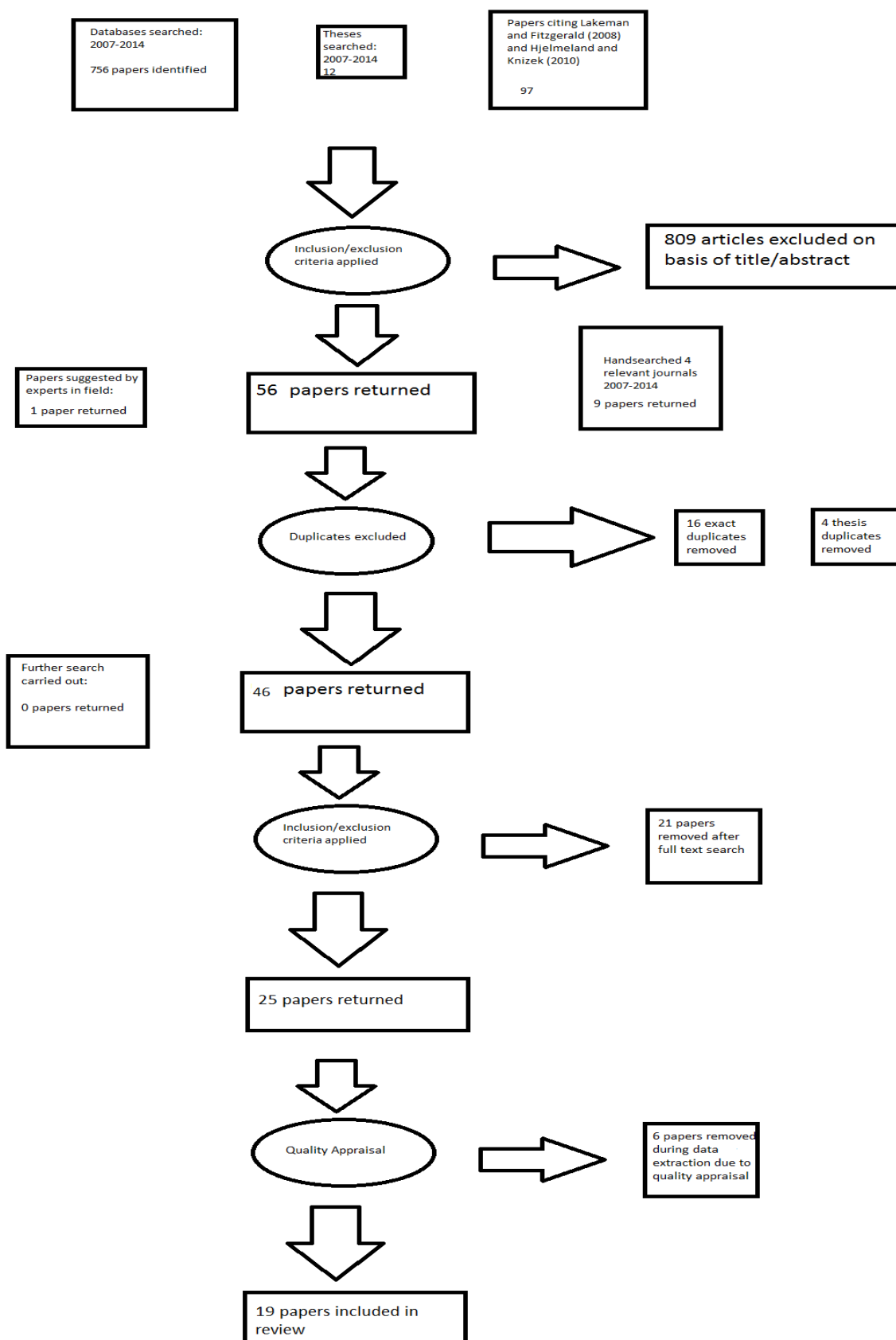
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Section C

Appendices of Supporting Materials

Appendix 1: PRISMA Flow Chart



Appendix 2: Main Focus and Concepts of Papers

Reference	Early life	Leading to attempt	Suicidal experience	Recovery
Biddle et al (2010)			Nature and accessibility of method constrains decisions of how to or whether to end life	
Biddle et al (2012)			Media and lay knowledge affects choices make around how to end life	
Bergmans, Langley and Lavery (2009)	All participants reported a history of child maltreatment.		'Living to die': choice of death appears easier than choice of life	'Ambivalence/turning points': moments of questioning whether want to live or die Pockets of recovery: taking small steps towards not ending life

Biong and Ravndal (2009)	Insecurity and difficult circumstances Feel different and radical choice to manage context	Not manage new or old/new culture Emotions and shame	Defeated and wanting to die	Turning point as specific events which make person question their desire to end life
Bonnewyn et al (2014)		Life disrupted by loss Loneliness Loss of control	Feeling unable to continue	
Cleary (2012)	High levels of emotional pain through life	Difficulties identifying symptoms/disclose distress Coping mechanisms – drugs/alcohol Dominant masculine narratives prevent talking about distress	Over time people's options narrow and suicide is perceived as way out	

Fitzpatrick (2014)		Internal psychic processes (pressure, job and stressors, despair)	Responsibility directed outwardly. Suicidal behaviour viewed as individual, internal and pathological by attempt survivors;	Need to get “better” Control emotions and improve self
Ghio et al (2011)		Family conflict as trigger Existence of psychiatric disorder important but not sufficient alone to cause suicidality Decision, isolated and exclusive; not communicate	Helplessness/hopelessness akin to psychache Liberation and solution to unbearable pain Anger, pain, suffering; suicide as freedom Risky moments after for retrying Feeling impotent and hopeless about recovery	Need staff to understand and empathise and be monitored after; need to share experience with peers

Gordon, Cutcliffe and Stevenson (2011)			<p>Conflict over living or dying means isolate selves from others.</p> <p>Unable to communicate ambivalence of life and death with others.</p> <p>Belief of worthlessness – have nothing to share with the world.</p>	<p>Negotiating dialectic of destiny involves working out one's relationship with living/dying; push and pull and place in world; negotiate turning points which is facilitated by inner and outer dialogue.</p> <p>Revitalising worthiness involves confronting a crisis of destiny and earning a life</p>
Holm and Severinsson (2011)	Difficult lives as children and adolescents	Guilt for difficult life and desire to punish self.		<p>Desire to recover by searching for strength and taking responsibility</p> <p>Struggle to be understood as the person you are</p>

				<p>Recovering by refusing to be violated</p> <p>Recovering by being able to feel safe and trusted</p>
Jordon et al (2012)		<p>Expectations of what it is to be a successful man</p> <p>Not talk to others</p>	<p>Disconnect with humanity</p> <p>Suicide as unspoken</p> <p>Suicide as atypical</p>	<p>Inter-personal connection with professionals is helpful</p> <p>Find new meanings in recovery</p> <p>Value of belonging and mixing with others in situation as suicide can be stigmatised</p>

Lees, Proctor, Fassett (2013)		Multifactorial inter and intra-personal reasons including difficult life events;		Therapeutic engagement essential to reducing isolation, loss of control and distress. Quality of genuineness, compassion, trust and unconditional positive regard in professionals vital
McAndrew and Warne (2010)	Unacceptability of being gay as growing up leading to intrapsychic defences.	Loneliness of being outsider in wider culture leads to wanting to hurt self, destroy 'bad' part of self and punish 'crime' of being gay.		
Olliffe et al (2014)		Circumstances leading to despair. Hopelessness made	Suicidal behaviour mobilises internal and external stigma with possibility for external	

		worse by estrangement from others as self-management strategy; loss of masculine signifiers. Alcohol and drugs.	social control and censure to further ostracise men and amplified despair. Perception that after a man makes a decision to suicide, then little can be done to save him; lethal suicide perceived as masculine.	
Orri et al (2014)		Devalued self and not felt that dominant feelings are accepted; Shame, guilt, loneliness and loss of meaning; hopelessness. Perceived impasse in or loss of interpersonal relationships.	Suicidal act as a way of freeing oneself from an intolerable condition. Acting on body as offering control of life. Anger at failure to end life. Suicide as communicative act of and means to getting another to listen. Suicidal act as revenge towards others.	

<p>SkogmanPavulans, Bolmsjo, Edberg and Ojehagen (2012)</p>		<p>Loss of control in relation to life situation: felt chaos and spiralling out of control; unsolvable problems. Inner debate over taking life or not: weighing up pros and cons, justifying suicide and passing point of no return.</p>	<p>Being suicidal involves being in want of control but unable to regulate thoughts, control emotions or actions. Suicide attempt seen as trying to escape vicious circle, the only way out of endless suffering and being exhausted.</p>	<p>Wish to take control Possible life-lines included getting adequate help.</p>
<p>Vatne and Naden (2011)</p>	<p>Difficult events contributing to attitudes formed of self and life in general.</p>	<p>Feeling alone in the darkness and losing touch with the world. Inter-relational problems and specific</p>	<p>Relief experienced in suicidal act. Anger at having not succeeded. Suicide as having an option available: having no options leads to unbearable feeling.</p>	

		<p>events impact until it becomes too much.</p> <p>Struggling for death and life.</p>	<p>After suicide attempt, feeling shame and guilt due to responsibilities for others; talking about suicide as a taboo.</p>	
Vatne and Naden (2014)		<p>Struggled for a long time and tried to cope with various problems on own.</p>		<p>Helpful professional responses: Experiencing sensitivity, trust and openness. Creating space for a dialogue.</p> <p>Addressing the matter with direct questions.</p> <p>Being met on equal terms.</p>
Zayas (2010)		<p>Ranges of intent to kill self: from wanting to uncertainty</p>	<p>Emotional despair; Powerless and angry leading to redirect emotions to the body</p> <p>Regret after attempt</p>	

		Escalating tensions and triggers including abuse, family and peer conflicts	Worries about social stigma of suicidal behaviour	
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Appendix 3: Sample of Research Diary

March 2014: Two other trainees researching suicide and I did a small presentation at an event for qualitative research on suicide. It was a little nerve-wracking as I was aware that I hadn't even started recruitment and wasn't sure how the audience might react, but they were very positive and encouraging. Overall the message is that getting participants should not be a problem, which is reassuring. I met an old colleague there also who encouraged me to get in touch with the charity we worked for and see if they could Tweet or publicise the study; this would be really helpful so going to get in touch as soon as possible; still trying to get my head around making this website.

April 2014: I've started trying out a few different software for website making which are also free: a few are far easier to manage than others. I've asked a few friends for suggestions as well which has been good. Initial feedback from people is to not do classic pictures of people crying or holding their heads in their hands. I had actually thought about doing this! Glad to have asked around, as those kind of pictures are often used around mental health but then aren't really helping to combat stigma. On discussion, some more nature focused pictures seemed to go down well.

May 2014: I'm really frustrated with how slowly the website has been going! It's getting in the way of me recruiting but I don't feel able to start recruiting until it looks relatively professional and I have no idea how to do this! Why do I always seem to find myself needing a degree in graphic design to complete assignments for this doctorate!?

June 2014: I dropped focusing on the website for a while as I was going a bit stir-crazy with it. Have decided to focus a bit more on Section A before coming back to

it; there seems to be so much out there that I'm quite overwhelmed. There seems to be quite a bit on attempt survivors when I look at it; worried that my study will come up as having been done recently!!

Reading for Section A has helped me think a bit about Section B; I think I'm a bit too close to the material to be doing a more distant discourse analysis... from what I've read, more of a narrative analytic approach might suit what I'm trying to do.

July 2014: Hooray! The website is finally done; I've had some really positive comments about it from various people. In particular, it was really useful to ask a few attempt survivors. They suggested changing a couple of language bits, like taking out the words "kill yourself" and replacing them with "wanting to die". This feels right as it is a bit less about the violence of an attempt. I'm going to try to get my head around Twitter as well to be able to promote it now.

Promoting of the website online has gone down quite well and I've already got three people lined up from the first 'recruitment drive'. Others have re-posted links to help out with publicity and I'm quite surprised and chuffed with how it's gone so far. Have decided to opt for a narrative analysis instead of discourse analysis: I am wanting to focus on empowering and bringing out the personal in suicide, which is definitely suits more of the former than the latter!

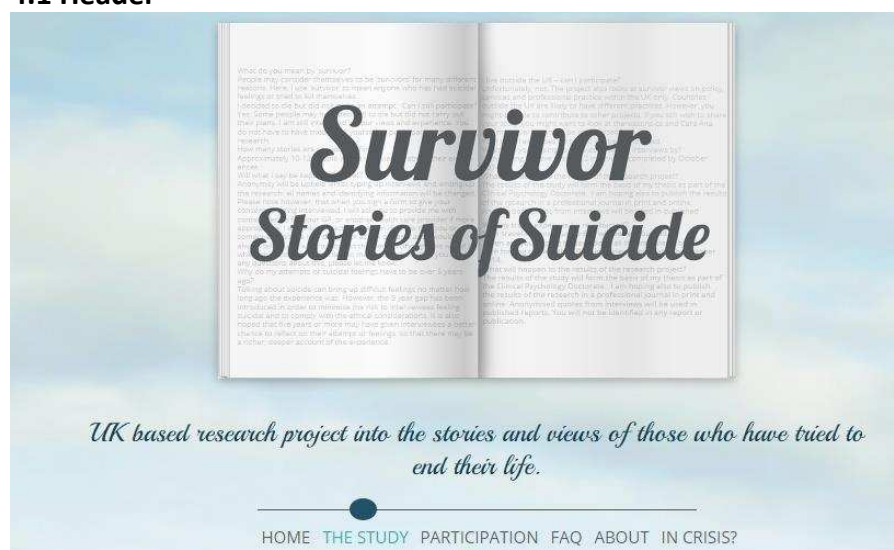
August 2014: Interviews so far have been really good: touching and poignant. I was initially worried that I might have difficulty encouraging them with what to say or making sure they stayed on track but I realise actually that it isn't about a track: they bring their narratives and that is what is important; they also bring a lot! There is so much in the stories and I really have not needed to do much prompting at all!

Interesting, that all three so far said how they were glad that the suicide attempt

happened: two said it made them who they were today. That really struck me when it was said as in doing the section A bits, I've not really come across this perspective. I was going to launch the second recruitment drive tomorrow but heard about Robin Williams' death today. Quite shocked and saddened but also annoyed with the media once again flouting explanations and jumping to conclusions, spreading myths of suicide. Makes it feel all the more important to do this project and the stories I have been given justice.

Appendix 4: Website Information

4.1 Header



4.2 Study Information



I am really interested in talking to people with first hand experiences of having tried to end their lives.

I am doing this research project, 'Survivor Stories of Suicide', to explore first-hand accounts about suicide and surviving an attempt to end one's life. The project hopes to better understand how survivors in the UK view their suicidal feelings and attempts, including views on professional responses and policy.

The information from [this study](#) will hopefully help both professionals and survivors better understand attempt survivor perspectives. This might then influence how professionals and services respond to people who feel suicidal.

Would you be willing to be interviewed about your experiences?
Do you know of someone who might be willing to be interviewed about their experiences?

4.3. Participation Information

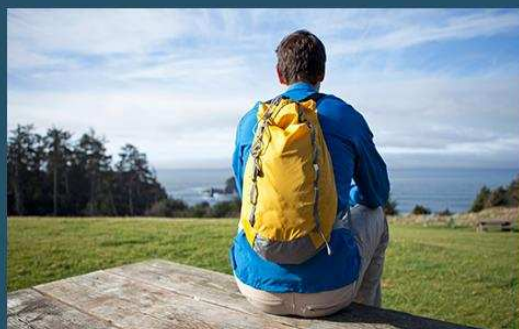
Want to participate?

For the purposes of this study, all interviewees must:

- Be over 18 years old.
- Have last attempted suicide at least 5 years ago.
- Be willing to have the interview recorded.

If you are unsure of whether or not this applies to you, please do [get in touch with me](#).

Please note that if you are based in the London or South East of England, I will happily travel to meet you to conduct the interview. If you are anywhere else in the UK, the interview would need to be conducted on the phone or via Skype.



If you want to participate, get in touch!

We will arrange an initial phone conversation where we will briefly discuss what the study involves and any further questions you might have about the research. Should you decide to continue, we would arrange a convenient time and place to hold the interview, either in person, by phone or on Skype. The interview will, as far as possible, be like a conversation about your experience of feeling suicidal, your views on suicide in general and what might have helped shape your thoughts on this. This would last for up to one hour.

4.4 FAQs

Frequently Asked Questions

What do you mean by 'survivor'?

People may consider themselves to be 'survivors' for many different reasons. Here, I use 'survivor' to mean anyone who has had suicidal feelings or tried to try to take their own life.

I decided to die but did not make an attempt. Can I still participate?

Yes. Some people may have decided to die but did not carry out their plans. I am still interested in your views and experience. You do not have to have tried to kill yourself to participate in this research.

How many stories are you looking for?

Approximately 10-12 people will be interviewed about their experiences.

Will what I say be kept confidential?

Anonymity will be upheld whilst typing up interviews and writing-up the research: all names and identifying information will be changed. Please note however, that when you sign a form to give your consent to being interviewed, I will ask you to provide me with contact details for your GP, or another health care provider if more appropriate. I will only contact this person if I think that you or someone else's life is in danger or at risk of harm and I would always tell you if I were to contact this person (though this would be whether or not you consented to me making the call). If you have any questions about this, please let me know.

Why do my attempts or suicidal feelings have to be over 5 years ago?

Talking about suicide can bring up difficult feelings no matter how long ago the experience was. However, the 5 year gap has been introduced in order to minimise the risk to interviewees feeling suicidal and to comply with the ethical considerations. It is also hoped that five years or more may have given interviewees a better chance to reflect on their attempt or feelings, so that there may be a richer, deeper account of the experience.

Can you travel to meet me?

I am happy travel to meet you for a face to face interview within London and the South East of England. If you live further afield in the UK, we could arrange a recorded phone or Skype interview instead.

I live outside the UK – can I participate?

Unfortunately, not. The project also looks at survivor views on policy, services and professional practice within the UK only. Countries outside the UK are likely to have different practices.

However, you might be able to contribute to other projects: if you still wish to share your story, you might want to look at thereasons.ca and Cara Anna.

Will my travel expenses be reimbursed?

Your travel expenses up to £10 will be reimbursed.

When are you hoping to have done all the interviews by?

I am hoping to have the 10-12 interviews completed by October 2014.

What will happen to the results of the research project?

The results of the study will form the basis of my thesis as part of the Clinical Psychology Doctorate. I am hoping also to publish the results of the research in a professional journal in print and online. Anonymised quotes from interviews will be used in published reports. You will not be identified in any report or publication.

For more in-depth information about the study, please download the [complete information sheet](#).

Alternatively, if you still have questions, please contact me by [email](#) or call me during office hours on 07756 190 308.



4.5 About the Researcher

About Celine Redfern

My name is Celine Redfern and I am a Trainee Clinical Psychologist at Salomons Centre for Applied Psychology, Canterbury Christ Church University. This research project is being conducted in partial fulfilment of this Doctorate. I am employed to train by Surrey and Borders Trust University. My supervisors are Ms Anne Cooke and Dr Ian Marsh.

I chose to do this research because I've seen lots of articles and statements around the statistics of suicide but very few actually asking those who have tried to end their lives about their own opinions and experiences. When I was younger, there were times when I wanted to die. I know it can be hard to talk about and I am thankful for those willing to share their story with me.

It's great to see a number of suicide attempt survivors being more open about their experiences; I'm hoping to contribute to this movement through this research.



4.6 In crisis?

Feeling distressed or in crisis?

If you are feeling distressed or want to end your life, please take steps to find the help you need. In particular, there are services available to support you.

In the UK:

- Your GP
- The Samaritans: 24 hour confidential telephone, email and text message service, www.samaritans.org, call 08457 90 90 90 or email jo@samaritans.co.uk
- NHS Direct: 24 hour national helpline offering health advice and information 111 free call from landline or mobile.
- Saneline: Telephone helpline 6pm-11pm 0845 767 8000
- Scotland specific: www.suicide-prevention.org.uk
- Childline: 24 hour national helpline for children and adolescents (under 18) 0800 11 11
- Nightline: confidential listening line for students run by students: nightline.ac.uk

In the US:

- suicideinfo.ca



Appendix 5 – Interview Schedule and Prompts

Initial question: Maybe you can start by telling me a bit about yourself?

Prompt: Anything that you might like to say or share about you.

Questions/themes to cover:

Could you say a bit about the circumstances that led up to your suicide attempt?

Prompt: What was going on for you in the run-up to the attempt?

Would you tell me about the suicide attempt?

Prompt: Anything that you would like to share.

How did you attempt to kill yourself?

What was going through your mind at the time?

How did you understand your attempt at the time?

Prompt: What did it mean to you at the time?

What might have helped shape that meaning?

Was there any way that anyone talked **to you** or about the attempt that you found helpful?

Was there any way that anyone talked **to you** or about the attempt that you found unhelpful?

What happened after?

Prompt: Did you seek professional help? What was the reaction? How did you feel about that?

Did you seek informal help? What was reaction? How did you feel about this? If not, what do you think stopped you from seeking help?

What is your current understanding/interpretation of your suicide attempt?

Prompt: What does it mean to you now?

What might have helped shape that meaning?

Was there any way that anyone talked **to you or** about the attempt that you found helpful?

Was there any way that anyone talked **to you or** about the attempt that you found unhelpful?

How did you get to this point of understanding?

Prompt: Was your understanding affected by anyone you discussed it with?

How might professional reactions have influenced this?

Were you in touch with other survivors? How might they have influenced your perspective?

Friends or family members' perspectives?

Were you aware of any policies around suicide? How might these have influenced your perspective?

Is there anything else you would like to say about your experience?

Appendix 6 – Ethical Approval

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Appendix 7 – Information Sheet and Consent Form

7.1 Information Sheet

Information about the research

‘Survivor Stories of Suicide’

Hello. My name is Celine Redfern and I am a Trainee Clinical Psychologist at Salomons Centre for Applied Psychology, Canterbury Christ Church University. I would like to invite you to take part in a research study. Before you decide it is important that you understand why the research is being done and what it would involve for you.

Talk to others about the study if you wish.

Part 1 tells you the purpose of this study and what will happen to you if you take part.

Part 2 gives you more detailed information about the conduct of the study.

People may consider themselves to be ‘survivors’ for many different reasons. In this information sheet (and the study as a whole), ‘survivors’ refers to anyone who has had suicidal feelings or tried to kill themselves.

Some people may have decided to die but did not carry out their plans. I am still interested in your views and experience. You do not have to have tried to kill yourself to participate in this research.

Part 1

What is the purpose of the study?

The study hopes to better understand how survivors view their suicidal feelings and attempts, including views on professional responses and policy.

It is being conducted in partial fulfilment of the Doctorate in Clinical Psychology at Salomons Centre for Applied Psychology, Canterbury Christ Church University. My supervisors are Ms Anne Cooke and Dr Ian Marsh.

The information from this study will hopefully help both professionals and survivors better understand survivor perspectives. This might then influence how professionals and services respond to people who feel suicidal.

Why have I been invited?

You have been invited to be interviewed because you have identified yourself as having wanted to kill yourself in the past (between 5-15 years ago). Approximately 10-12 people will be interviewed about their experiences.

Do I have to take part?

It is up to you to decide to take part in the study. If you agree to take part, I will then ask you to sign a consent form. You are free to withdraw at any time, without giving a reason. This would not affect any care you are receiving.

What will happen to me if I take part?

If you choose to take part, we will arrange an initial phone conversation where we will briefly discuss what the study involves and any further questions you might have about the research. Should you decide to continue, we would arrange a convenient time and place to meet in person for an interview. The interview will, as far as possible, be like a conversation about your experience of feeling suicidal. This would last for a maximum of one hour

Interviews will be audio-recorded.

Will I be paid?

Travel expenses up to £10 will be reimbursed.

What will taking part involve?

If we arrange an interview, we will meet to talk for up to one hour. The focus of the interview will be around your experiences and the particular circumstances around this (what led up to the suicidal feelings or suicide attempt, what happened during, what support you may have tried to get after and, how you may have tried to overcome such feelings after). I will also be asking about your views on suicide in general and what might have helped shape your thoughts on this.

What are the possible disadvantages and risks of taking part?

The interview will include what led up to your suicidal feelings, how you understood this at the time and how you see it now. Talking about distressing experiences may in itself be distressing; some people can feel these experiences again very vividly just by talking about them. This might lead some people to feel further distress and low mood after the interview and for this reason, it would be advisable to consider the effect of taking part carefully before making your decision. You may wish to discuss the decision with someone you trust who knows you. Please note that you have the right to pause the interview for whatever reason should you wish. You also have the right to end your participation at any point and do not have to give any reason for this.

Will it be confidential?

Anonymity will be upheld whilst typing up interviews and writing-up the research: all names and identifying information will be changed. Please note, however, that when you give your consent, I will ask you to provide me with contact details for your GP, or another health care provider if more appropriate. I will only contact this person if I think that you or someone else's life is in danger or at risk of harm and I would always tell you if I were to contact this person (though this would be whether or not you consented to me making the call). If you have any questions about this,

please let me know.

What are the possible benefits of taking part?

Some people may find that talking about their experiences of feeling suicidal may help them understand them better. *However, we cannot promise the study will help you but the information we get from this study will help better understand perspectives of people who feel suicidal.*

What if there is a problem?

Any complaint about the way you have been dealt with during the study or any possible harm you might suffer will be addressed. Detailed information on this is given in Part 2.

Will my taking part in the study be kept confidential?

Yes. We will follow ethical and legal practice and all information about you will be handled in confidence. The details are included in Part 2.

This completes part 1.

If the information in Part 1 has interested you and you are considering participation, please read the additional information in Part 2 before making any decision.

Part 2

What will happen if I don't want to carry on with the study?

Should you wish to withdraw from the study at any point, you are free to do so without having to provide an explanation. If you let me know your intent to withdraw, I will not contact you any further regarding this research.

What if there is a problem?

Complaints

If you have a concern about any aspect of this study, please contact me on my research mobile (*number taken out for thesis*). Please note I will only be able to respond to this during work hours (weekdays between 9am – 5pm) but if you leave a voicemail I will return your call as quickly as I can. If you remain unhappy and wish to complain formally, you can do this by contacting my supervisor, Ms Anne Cooke, Salomons Centre for Applied Psychology, Canterbury Christ Church University on 0333 011 7096 or anne.cooke@canterbury.ac.uk.

Will my taking part in this study be kept confidential?

Yes:

- The data collected will be kept confidential so that all digital recordings will be kept under password protected files and once interviews have been transcribed, you will no longer be identifiable.
- Sometimes when writing up the research it is useful to quote what someone has said. However, should this occur you would remain anonymous.

- According to Data Protection Act, data will be stored securely for 10 years and then destroyed

Should you wish you can also request a copy of your data (including transcripts) to check for accuracy.

What will happen to the results of the research study?

The results of the study will form the basis of my thesis as part of the Clinical Psychology Doctorate. I am hoping also to publish the results of the research in a professional journal in print and online. Anonymised quotes from interviews will be used in published reports.

You will not be identified in any report/publication.

Who is organising and funding the research?

This study is conducted as part of my studies on the Clinical Psychology Doctorate, Salomons Centre for Applied Psychology, Canterbury Christ Church University. I am employed to train by Surrey and Borders Trust University.

Who has reviewed the study?

This study has been reviewed and given favourable opinion by a research panel at Salomons and by Salomons Research Ethics Panel, part of Canterbury Christ Church University. My supervisors Ms Anne Cooke and Dr Ian Marsh have also reviewed and contributed to the study.

Should you wish to participate, you will be given a copy of this information sheet and a signed consent form to keep.

If you would like to participate, please confirm that you have read this information sheet by signing and dating below:

Signature _____

Date: _____

Contact details

If you would like to speak to me and find out more about the study or have questions about it answered, you can contact me on my research mobile (mobile number taken out for thesis). Please note that calls will only be responded to between working hours (9am to 5pm on weekdays); if I am unable to answer, please leave a message and your phone number and I will get back to you. Alternatively, you can leave a message for me on a 24-hour voicemail phone line at 0333 011 7070. Please say that the message is for myself, Celine Redfern, and leave a contact number so that I can get back to you.

7.2 Consent Form

CONSENT FORM

'Survivor Stories of Suicide'

Name of Researcher: Celine Redfern

Please initial box:

1. I confirm that I have read and understand the information sheet dated..... (version 1) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected.

3. I give permission for the interview to be recorded

4. I agree that anonymous quotes from my interview may be used in published reports of the study findings.

5. I understand that, should you think I, or someone else is in danger, you will need to contact my GP/health care provider. I understand that if you feel the need to contact this person, you will let me know. I consent to providing these details:

GP/health provider name: _____

GP/health provider address: _____

GP/health provider phone number: _____

6. I agree to take part in the above study.

Name of Participant _____ Date _____

Signature _____

Name of Person taking consent _____ Date _____

Signature _____

Appendix 8 – Sample Transcription (Charlie)

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Appendix 9 – Sample of Each Analytic Stage (Charlie)

9.1 First Reading: Identifying Plot and Own Reactions

Transcript	What is happening? What stories? When, where, with whom and why PLOT?	Own perceptions
<p>It's just to kind of start off and get a sense of, of, of, how you see yourself and those kinds of things.</p> <p>R: It's strange actually because I am at this point of my life where I kind of feel that, as I'm reaching my</p>	<p>Life as a negative constant previously; a struggle since very early on; now positivity: life beginning (despite suicidality always being around)</p>	<p>Gentle encouragement</p> <p>Reminds me of Gergen and Gergen's narrative forms: life was</p>

<p>forties, um, life is finally beginning which sounds like a real cliché because life has been a real struggle to get to this point. Um, and not meaning to sound cliché but I feel like I'm getting my wings at last. Um... yeah, I mean I... I had my first breakdown when I was 12, so it's quite a long time ago.</p> <p>I: Hm.</p> <p>R: But it actually feels like yesterday and that started as a result of child abuse in that my grandfather started hitting on me. Um... and that in itself almost seems fine, because obviously it's not fine, um, but that triggered a sort of a cascade of unwellness, um, and I became quite withdrawn. I mean at that age you are quite withdrawn anyway but um, I became even more so. Um, and then I started self-harming and um, that was really helpful. I know, um, a lot of people would go, "Oh no, how can that possibly be helpful?" but actually it was. And it wasn't until, um, people knew that I was self-harming and</p>	<p>Life as beginning after struggle; Metaphor of getting wings (bird or angel?) → being able to fly and be free?</p> <p>'Breakdown'</p> <p>Breakdown still seems quite prominent Victim of child abuse and grandfather as perpetrator but then evaluates this in itself as OK (something else needed as well?); qualification of evaluation as being OK perhaps in response to potential audience and narratives around abuse?</p> <p>Circumstances triggered being unwell Social expectation of what teenagers are like.</p> <p>Dramatises others' evaluation of behaviour (not being understood?)</p> <p>Suicide as a response to not being allowed to self-harm; positivity of self-harm; Suicidal thoughts build up → something that happens without control?</p> <p>Lack of freedom encourages suicide;</p>	<p>negatively stable and now progressive story.</p> <p>Inviting me into positivity of now before explaining difficulty of past. Illness narratives coming along?</p> <p>I'm not quite sure why things in themselves are fine; questioned use of unwellness and what this means to her?</p> <p>Constant moving from how it was and sidelining.</p> <p>I feel like I know how self-harm is helpful. Definitely being positioned as a professional here not fellow survivor.</p>
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<p>that it was more difficult for me to self-harm that actually thoughts of suicide really started to build up.</p> <p>I: Hm.</p> <p>R: Um, and I, looking back at it, think actually because I didn't really have the freedom to injure myself to sort of keep things under control, that kind of pushed me more towards suicide. And I've noticed that, that my suicide attempts, albeit the few of them, they have occurred when self-injury has been denied me.</p>	<p>Push towards suicide as not being agent of control; self-harm as keeping control</p> <p>Suicidality as occurring in midst of restricting freedoms (due to risk prevention from others) Character of others as trying to help but not.</p> <p>Lack of power.</p> <p>Others responses of 'protection' make things worse.</p> <p>Lack of control –no option; not responsible.</p>	<p>Reminded by previous participants description of Sylvia Plath's In Plaster.</p>
<p>I: Taken away from you.</p> <p>R: Um, and it just builds and builds and builds. And it, I, um, I wrote a thing recently actually about um, [unclear 0:06:05] and um, self-injury and the relationship between that and um, self-injury and suicide. And um, they do definitely go hand in hand for me. Take that one away, I have no other option then to... but I mean I haven't self-injured in, I don't know, 15 or 20 years, something</p>	<p>Clarifies that not injuring self; changed.</p> <p>At the time not foresee that could be a time when didn't have self-injurious thoughts</p> <p>Picking up on that 'I'm better now' idea and looking for influences; placed Charlie in position of being better.</p>	<p>The contrast of the present and past feelings makes me feel like I'm being reassured in some way; "things get better; I'm OK now; it was awful then."</p>

<p>like that. It's quite a while now but I mean to think that there would ever be a time when I didn't was um, yeah, I couldn't foresee that. But now I don't. I mean occasionally I will get the urge but um...</p> <p>I: So then what do you think kind of actually got you to that point of kind of 15 or so years ago to kind of go, "Oop, no, I'm not going to kind of go through these attempts. I'm not going to self-injure"?</p> <p>R: Do you know what it was? I, um, when I was 18 I, um, I took some magic mushrooms, like you do when you're 18 and a bit wild and you've just been released from the psych unit, you've got no parenting around so you go a bit bonkers, um, and uh, it kind of opened a doorway in my head and the following day I was sitting in a pub and I had this, um, I don't think of it as a panic attack, I think of it as a fear attack. Um, and my life went completely down the toilet at that point. It totally</p>	<p>Engaging me in the question or maybe taking this in herself? Portraying self as natural response to circumstances → not pitying, but portrays what says as everyday occurrences. Giving the background to why stopped suicide: things got worse.</p> <p>Quite matter of fact about things. Differentiating own understandings from others' words.</p> <p>Life was OK when suicidal? Option of suicide as a resource; things worse when not able to: by own reasoning. Anxiety as completely separate from suicide. Anxiety as stopping suicide Looking back at it seems insane.</p> <p>Suicide not option = trapped.</p> <p>Well and illness narrative – illness linked to anxiety? Not suicide? Not a well bunny is dumbing it down? Irony?</p> <p>Still the I character and not others; resourceful? Not sure where this came from?</p> <p>Again reference to other identity as writer as helpful.</p>	<p>At first I wasn't sure she'd understood the question – why are we going on down a route where things are getting worse and not better? Then I feel quite surprised that it seems to be life getting worse that stops the suicide – it's the 'illness' that comes in and takes away option of suicide; I feel even s bit strange to think of this this way</p> <p>I'm struck by the difference in setting the scene as someone not doing well – not victim as such – but not really maybe functioning and then,</p>
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<p>crushed it. Um... and at that point, suicide suddenly became not an option because I'd become phobic of being sick, um, my whole life revolved around vomit, which just sounds insane but it did. And therefore I couldn't attempt suicide because I was so frightened that it would make me sick. And so for the first time in my life I felt really, really trapped. It was just horrendous. I was not a well bunny at all and actually it's the only time in my life when I considered that I was ill. Um, but what I did was I went to, I don't know how I did it, I went to college, um, and I did a biology course. And I'm somebody who really likes detail. If you ever read anything that I write, I like detail. And I found it really, really helpful to understand on a cellular level what was going on when I panicked.</p> <p>I: Hm.</p> <p>R: But by, well not chance because it's biology, but um, there was a whole thing about, um, injury and</p>	<p>The other character as biology → teachings; realisation and exploration.</p> <p>The body as separate from the mind in the way it sends out armies; the body as something which tries to heal itself (versus the mind attacking in suicide?)</p> <p>Body positioned as amazing;</p> <p>Realisation; turning point of being against the body.</p> <p>Something else taking over? Subconscious decision. Taking control as within the self.</p> <p>The decision to cut cast as another character? It lessened its hold; externalised; did make an active choice?</p> <p>The character of self-harming fades out without quite realising in relation to character of Charlie.</p> <p>Charlie as taking charge and making decision not to do that.</p>	<p>uncertainty of what happened but then managing something; achievement. Gergen's plot: not stagnant but worse at first then better.</p> <p>The way that Charlie thinks of the body and the physiology makes me think of her kind of gaining some awareness but also respect for the body. Perhaps some kind of spiritual awakening of nature?</p> <p>I'm struck by the lack of other people in this narrative: voice of self-</p>
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<p>how the body responds to that and all the amazing things that happen if you injure yourself. And I was just totally blown away by that, that the whole, the way that the body responds to it and all the armies of white blood cells and the healing and that just totally engaged me and I thought, “You know what? Actually every time I injure myself I’m causing my body to have to go to this much effort to repair it and you know keep my uninfected.” Um, and though it wasn’t actually a conscious decision, from that point on it just gradually, I, it gradually lessened.</p>		<p>recovery; independence? Others don’t even feature as characters which hold her back or support her; very individualised. Protagonist on own.</p>
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9.2 Second Reading: Creating “I-poems”

I poems in different scenes/narrations	Thoughts and ideas
<p>Early experience</p> <p>I’m just thinking about it</p> <p>I mean the thing with me</p> <p>I was... 3 maybe</p> <p>I think, I think that’s the point where it probably started for me</p> <p>I think</p> <p>I don’t really know</p> <p>I think um</p> <p>I’m very much like my dad.</p> <p>I am my father’s daughter</p>	<p>Uncertainty still about it – lots of ‘I think’. Linked to internal world?</p> <p>Link self with dad.</p>

<p>I mean he came back for a few days</p> <p>I think, and tried it again, I didn't really understand it,</p> <p>Suicidal thoughts</p> <p>I, it was definitely as I started to have that breakdown at 11, 12 I really do remember thinking quite clearly about suicide, not that I was going to attempt it I do remember</p> <p>I spent a lot of time drawing coffins</p> <p>I think that's probably an indication of it building up</p> <p>I remember him</p> <p>I mean</p> <p>I look back</p> <p>I think, "My God, what planet were you on"</p> <p>I would maybe he would perhaps have taken me aside and just said, "You know are you alright?"</p> <p>Suicide attempts</p> <p>I mean I had gone quite quickly I just, I really couldn't give a shit, I'd got up that morning</p> <p>I mean I laugh about it</p>	<p>Suicide coming into thoughts; clearer memories:</p> <p>Suicidal thoughts as bubbling up/building up?</p> <p>Thinking concepts → inward style of I?</p> <p>Sudden shift of the now:</p> <p>Disbelief at what happened; The 'I' comes with quotes of other: connection with the other?</p> <p>More action; resolution in the moment of suicidality?</p>
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<p>I can see, not because it's funny I can see the humour in it, I got up that morning</p> <p>I went to the, uh, the cupboard I went in there I found I don't know a handful of junior Disprin I thought that would be enough.</p>	
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9.3 Third Reading: Identifying Dramatisations

Scene	Summary
Prologue	Charlie opens by grounding her narration in the present: what she is doing now, the current context of our surroundings, her current relationship. She reflects on her past attempts, summarising her view that her attempts happened when self-injury was denied to her. She notes that she can see her past attempts in a different light now and almost summarises her current relationship with suicidality whilst pre-empting both what I and the general public might say in response to this.
Early life experience	Charlie describes a succession of difficult – and from my perspective, potentially traumatic - events within her early life in quite a matter of fact way: I got no sense of being or trying to shock, but quite stoic. The events include both parents' foray into mental health services including both of them having made suicide attempts, her dad trying to hurt her mum and then kill himself whilst she and her brother were present, the separation of her parents, and her step-dad being sexually abusive. Many of these events were said to have not been remembered until later. Within the story telling, I didn't get the sense that Charlie saw herself as a victim regarding events relating to her parents; potentially more victimised identity regarding sexual abuse, but overall, her telling remains matter of fact. Despite the presence of

	others in the narrations, there is no real sense of what might be happening for them
Build up	<p>Charlie named the trigger of her grandfather ‘hitting on her’ which led to self-harming (which she found helpful). Again she positions others as being confused by this.</p> <p>She describes suicidal thoughts as building up and narrates a scene where a Maths teacher chastises her for being messy in her work but fails to notice the content of the messiness: drawings of coffins etc. I get the sense of the teacher is portrayed as almost hopeless and completely missing the point; a caricature of a fastidious teacher so fixated on teaching, order, neatness that he misses the emotional connection with a pupil; again Charlie doesn’t quite portray herself as a victim in the way the teacher fails to understand her. I found this event quite astounding, but also rather absurdly comical in the way it was retold.</p>

9.4 Table Bringing First Three Readings Together, and Considering Initial Voices

Scenes	Summary	Voices/roles	Initial ‘Voices’ Summary
Prologue	Charlie opens by grounding her narration in the present: what she is doing now, the current context of our surroundings, her current relationship. She notes that she can see her past attempts in a different light now and almost summarises her current relationship with suicidality whilst pre-empting both what I and the general public might say in response to	<p>Current identity as not suicidal; happy → writer, partner.</p> <p>Suicidality as still important and impactful; always present.</p> <p>Option of suicide as comforting as a possible way out;</p> <p>Suicide as a choice.</p> <p>Suicide as always a possibility.</p> <p>Different perspective to others: others fear or risk-prevention style attitudes towards suicide.</p>	<p>Voice of current positive circumstances</p> <p>Voice of rationality</p> <p>Voice of choice.</p> <p>Voice of suicide as possibility.</p>

	<p>this by highlighting that she does not want to end her life at the moment</p>		<p>Voice of different perspective</p> <p>Voice of risk prevention.</p>
<p>Setting the scene</p>	<p>Charlie locates herself in her current happy life with future possibilities in comparison with past struggles; but then shifts to events leading to suicide attempts: grandfather 'hitting on' her.</p> <p>Self-harm viewed as helpful and allowing her to keep things under control: she summarises that her attempts happened when self-injury was denied to her; she positions others as being confused by this.</p>	<p>Past struggle versus current happiness.</p> <p>Suicidality as response to sense of agency being taken away from her.</p> <p>Self-harm as helpful;</p> <p>Others as not understanding.</p>	<p>Voice of difficult circumstances</p> <p>Voice of suicidality as gaining self-agency</p> <p>Voice of others not understanding</p>
<p>Out of suicidality and into illness</p>	<p>I take the lead in focusing on recovery from self-injury: out of hospital at aged 18, Charlie takes some magic mushrooms which leads to extreme anxiety. It is here (regarding anxiety) that she describes being ill, unwell; it is also here that she describes a turn away from suicidality as she fears being sick so cannot overdose. Not having the option to end her life is</p>	<p>Positions self as ordinary teenager in response to extraordinary circumstances</p> <p>Powerless.</p> <p>Helpless/trapped.</p> <p>Fearful.</p> <p>Out of control.</p>	<p>Voice of difficult circumstances</p> <p>Voice of helplessness</p>

	described as making the situation worse for her.		
Studying	Charlie notes that through this she somehow gets herself into college and studies: she becomes fascinated by the body and biology. There is a distinct absence of others in this scene and the 'I' is very strong in a sense highlighting an internal strength. The spotlight then is on her, and – without realising - the light almost seems to fade on self-injury as a character.	Resourceful Resilient/strong. Learning experience Respecting body. 'I' focus: Independent. Agent of change.	Voice of independence Voice of strength Voice of learning Voice of self-agency
Revelation	Psychological insight gained: prior sexual abuse at home; self-awareness and acknowledgement of this leads to big shift and change	Self-awareness and insight as a turn to recovery from suicidality and self-harm	Voice of difficult circumstances Voice of self-awareness
A forced interval	Charlie first gets distracted by the current context before it starts to rain and we are forced to move elsewhere to conduct the interview further		

Voices highlighted and grouped:

Those most frequently referred to by Charlie (in italics) referenced in write-up

- *Illness/wellness voices: rationality (8); choice; irrationality (3)*
- *Voices of difference: voice of different perspective; Voices of others not understanding; voices of others not seeing; voice of comic absurdity (4); voices of difference; voice of humour; voice of difference/not understanding (2)*
- *Voices of individualism: voice of individualism; voice of independence;*
- *Voices of morality: voice of morality; voice of risk prevention (4); voice of stigma/taboo*
- *Voice of difficult circumstances (4)*
- *Voices of relationality: voice of isolation; voice of suicide as silent; voice of difficult circumstances*
- *Positive voices: Voice of independence; Voice of strength; Voice of learning; Voice of self-awareness (3) Voice of suicidality as gaining self-agency; Voice of self-agency; Voice of gaining insight/realization; voice of expertise; voice of wisdom*
- *Voices of now: current positive circumstances; suicide as possibility (2) voice of managing; Voice of holistic identity*
- *Voice of action in the attempt (3)*
- *Voice of lack of power (2)*
- *Voice of naivety*
- *Voice of determination*
- *Voice of helplessness*
- *Voice of manipulation*
- *Voice of determination*

9.5 Fourth Reading: Exploring Language Used

Some examples of the language considered in Charlie's narration are provided here. In particular, language and words which seemed crucial to Charlie or the context we created through our interview was considered. In particular, I

considered: what meanings were invoked? Words' histories? What might be accomplished by using these?

1.) Charlie relates to her "Crow-sign" – a link or appreciation of this bird, culturally linked with death and the beyond; Charlie sees the crow also as a link to life and creativity; as misunderstood by others perhaps; a bird can fly and has wings and she talks about these too around ideas of flying which conjure up notions of freedom. The crow may be a metaphor for how she perceives herself as naturally linked to death but also that this link is frequently misunderstood by others?

2.) When talking about family relations, following both her parents having attempted suicide when she was very little, and all of them being admitted together to the hospital, she describes it as a "psychiatric holiday". The idea of psychiatry certainly links to the biomedical model but the holiday part is a real juxtaposition: it almost conveys a jovial normality at the circumstance. She would have been too young to remember this herself so who has portrayed it to her in this way to lead her to such a consideration? Telling it in this way, moves focus away from what could be seen as very difficult circumstances when very little, but highlights instead as almost a harmless, parody: the everyday normality of this life is enhanced.

3.) Hospital as a "Victorian asylum" on the horizon; image of horror, institutions and being locked up for good? The assumption might be of others perceiving her as insanity because of suicidality but at the same time Charlie has just narrated a moment where she is clearly rational as she has awareness that her parents do not (that they are going the wrong way and following the wrong signs). A "Victorian asylum" also conjures up ideas of inhumane treatment which might also be linked to her next description of the building as like "Dracula's castle": there is a

definite foreboding and fear of the horror of what might be inside the building.

These words help to convey this fear.

3.) The parrot that pulls his wings out if stressed: brings the image of self-harm or suicidality as completely natural given stressful circumstances; animals “commit suicide” but commit also links to moral features of suicidality as a crime, a sin; being “committed” is linked to insanity; but here she describes how normal and natural it is to “commit suicide”. She is very interested in biology and has already said how this helped her to stop self-harming: perhaps given her knowledge of biology she is appropriating biological constructs as a way to work against moral arguments of suicidality: it is natural; every animal does this. It might counter any judgement from others about suicidality?

Appendix 10 – Feedback

Stories of Suicide: A Narrative Analysis exploring attempt survivors’ cultural constructions of suicidality.

I would first like to thank everyone who helped publicise the study, who enquired about taking part, and those who did take part. I am hoping to write up the results of the study for publication soon. In the meantime, however, please find a summary of the study here:

Suicide affects many people, and remains a challenge for services. Many approaches and theories have already been proposed. These include – but are not limited to – ideas that suicide comes from a mental illness, that suicide is linked to psychological problems, that it is a spiritual problem, or that it stems from inter-personal or relational problems. Many people also think of suicide as a taboo subject whilst there are different moral arguments about whether or not it is

acceptable. Whilst there might be several theories about suicide, our society and culture tends to see suicide in terms of a mental illness or something biologically wrong with someone.

Whilst some people find this a helpful way to understand their experiences, not everyone will. Moreover, focusing overly on one perspective may limit how we respond to suicide. In other areas – like hearing voices – research into service user perspectives have helped to shift professionals towards more holistic understandings and responses. Whilst a suicide attempt survivor movement has already grown over the last few years, it is useful to conduct further research into understanding survivor perspectives and stories, particularly as the focus has previously often been on professional perspectives.

This study aimed to add to the literature redressing the balance of previously neglected perspectives by exploring attempt survivors' stories; and, to understand what approaches and factors they draw on in telling their stories.

Semi-structured interviews were conducted with 11 people who self-identified as suicide attempt survivors. A narrative analysis was conducted. Narrative analysis values people's personal stories and meanings, whilst allowing exploration of some of the frameworks people might use in their stories; it is a suitable method of empowering often silenced groups (like suicide attempt survivors) whilst also exploring any potential new ways of understanding suicidality.

The interviews were very rich and provided a wealth of information on perspectives of suicidality. In particular, participants drew on a wide range of different frameworks and understandings when describing their experiences. In particular, they drew on the current dominant biomedical model of suicidality and

differed in how useful they found this approach. However, they were not limited to this approach, and also drew on multiple approaches across individual, relational and socio-cultural levels to narrate and make sense of past suicidal behaviour. These included psychological, spiritual, situational, interpersonal, moral, and public understandings; the extent to which these were drawn on varied between participants.

Participants within this study further seemed to use various constructions of suicide to make sense of their experiences: whether to say that they were not in control of their actions when feeling suicidal, to say that their experiences were completely understandable given the circumstances, or to say that their experiences had made them who they are now. Some – though not all – participants highlighted that suicidality had been a positive experience for them in some way.

Overall, findings suggest that suicidality cannot be understood from only one perspective, whether this is the dominant narrative or not: clinicians and policy makers need to remain open-minded about and responsive to how attempt survivors might view their experiences; consulting attempt survivors in policy-making would be useful. When working with people who are suicidal, clinicians should also remain open-minded and give clients space and support to come to their own understandings.

Given the incredibly rich stories told, but the limits of this study, it was only possible to focus on one aspect of attempt survivors' stories. However, recovery was a feature in most participants' stories and could be explored further, as could attempt survivors' identity before, during and after their period of suicidality.

Appendix 11 – Summary of Participant Stories

Alex – A story of illness and a struggle to be taken seriously

Alex views her suicidal experiences as stemming solely from mental illness; she describes that she has had no dramatic event in her upbringing or life to explain her feelings and attempts otherwise; she further highlights her close family members' similar emotional and behavioural responses to argue for the illness. Every suicide attempt described starts with feeling depressed/manic, becoming out of control, making suicide attempt, and seeking help (which is then interpreted by others as attention seeking). Her attempts are cast as being very upsetting and worrying to her parents and she almost characterises herself as a burden to them. Alex talks about being religious but not feeling that suicide is a sin. When she was a teenager, Alex went to church youth group, who – because of her feelings and behaviour - believed she had a demon in her and tried to exorcise her. She describes at the time having gone along with it because she did not know what else to do, but now vehemently disagrees with what happened and characterises an abuse of power from the youth leaders.

Alex only briefly touches on a sense of healing or recovery from suicidality stating that what has helped her not act on urges to kill herself includes getting diagnosed (which gave her some insight into what was happening), peer involvement, the death of her father and her mother's wish for her not to try again. She focuses largely on her past experiences, rather than her current or future identity, however, intimates that, whilst not currently suicidal, she will definitely feel low and manic again and, that the urge of suicide will return.

Sam– Enacting a cycle of suicidality and family estrangement.

Sam describes suicide as a selfish act but also recognises that at the time of her attempts, she thought very negatively about herself and felt hopeless at what others could do; she casts mental illness as the cause of her negativity and suicidality. She describes difficult early experiences including being very upset by her parents' and her mum and her being physically abused by mum's partner. Sam notes being given a diagnosis early on. She described several attempts which seem to follow a cycle of suicidality: Sam faces a difficult situation, drinks and takes drugs, gets in a bad mood, is scared of death but has had enough of life, attempts to end her life, survives, and decides not to do it again until she faces another difficult situation. She describes her last attempt was a turning point as she had really scared herself and did not want to hurt lots of people: she noted being happy to be alive. Her story is characterised by lots of disagreements and separation within the family, describing herself as an outcast which upset hers. She notes her family's and professionals' responses to her attempts as thinking she is 'mental'. Sam describes her medication as keeping her suicidality at bay and adds that psychology has also helped.

At the same time of noting that she has difficulty coping with difficult circumstances and not having confidence, she also describes some self-agency and self-reliance in "getting on with things", "taking control of [her] mind" and gaining self-awareness of the ways in which she can help manage her illness. She further describes being able to talk to an employer when she did not feel well. Sam identifies currently as caring for and supporting her mum who is not well and, as

being a partner. She says that it feels odd that she tried to take life but also notes sometimes having continued thoughts of suicide whilst also being generally happy.

Emily – A story of genetic propensity to depression and a quest to be understood by others.

Emily sees her suicidality as a result of her having clinical depression, which itself is viewed as being a result of a genetic propensity to depression, linking both her close families' similar struggles with mental health and that she had had a happy childhood as proof. Despite alluding to some situational difficulties each time, she describes how the illness wrapped her, making her think that her family were better off without her. There is a palpable sense of not being understood by her family.

Emily describes a recurring pattern of feeling low before having realisation. For example, after planning to cut herself with a razor in the bath, she went to see the GP and his blunt questions are said to shock her out of it; at her attempt, she is shocked into realising she does not want to die, and seeking help. The attempt seems to lead to some positive experiences. For example, she had made the choice to live and so, seems more determined; she further describes a shift in her thinking, seemingly taking back control from depression and taking charge in how best to take care for herself. Similarly, whilst her family are angry at first with her, she then feels able to have a conversation with them so that they can try to understand her more. Emily notes taking time to heal as being crucial in her recovery. She further describes how over time, others – including her family – have come to her almost as an expert of illness; she shares knowledge and takes a stand in her convictions towards how mental health should or should not be treated. Emily describes herself at the moment as doing quite well for herself, though still experiencing depression and

being bored with her job. Her future is characterised as open to both positives and negatives but there's a sense of depression always being a possibility.

Fiona – A story of burden

Fiona characterises her choice to kill herself as trying to gain control at a point when she had lost control. Her plans and attempt are described as a response to feeling others would be better off without her but on reflection she feels that nature played more of a role in her attempts than nurture: she refers often to her diagnoses of bulimia and depression. Fiona describes abusive early experiences which were suppressed until a specific event as a teenager triggered her memories. She describes her friends noticing a gradual slope into depression, though she lacked insight. She characterises herself as unwilling, but forced into therapy; here she started to develop awareness of suicidal thoughts though described finding it hard to speak about her experiences overall. Fiona describes being isolated and struggling with suicidality and her diagnoses.

At one point, she portrays herself as determined to end her life through this plan, but burdened by the secret of holding it in; eventually telling her therapist, she ends up in an inpatient ward. She describes the inpatient stay as useful in finding a place of calm in a stable environment and, finding it reassuring that others would not allow her to hurt herself. Whilst on leaving the ward, her bulimia is said to be making her suicidal, she describes a shift in her thinking, rationalising what would likely happen if she attempted suicide again. In narrating her healing, Fiona describes support as being important, but also highlights having learnt about herself and how her illness might affect her. She recites one band's lyrics which expresses what she found so difficult to express. She continues to struggle with depression

and bulimia, but notes feeling supported. Fiona adds that she is glad that the suicidality happened as she would not be the person she is if it had not: citing the band's lyrics, she feels that she is yet to make her mark.

Jess – From surviving to living

Jess describes seeing suicide as an understandable, noble thing, a way of casting off the detritus of life that has clung to her; she describes feeling reborn after her last major attempt. However, she also refers to suicidal thinking as self-absorbed and selfish. Her early experiences are characterised as abusive, very difficult situations. Jess' suicidal experiences are characterised as stemming from intense psychological pain, loneliness, accumulating burden of life but she also refers to diagnostic terms of clinical depression and mania as influencing some of her decisions.

Her father is present as a character to whom she is close and finds comfort in but largely absent from her life except to wield power and change circumstances from afar. Jess's healing is characterised by support from others providing safe, containing, predictable places. Overcoming suicidality is seen as coming from a number of areas: therapy, medication, time and internal mechanisms such as learning, gaining self-understanding and insight. There is also a sense of being more confident, in control and an agent of change as she moves away from suicidality. Her present is characterised by still working on getting better, being in a loving relationship, writing and helping and contributing to society through volunteering. She demonstrates strong beliefs in benefits, and societal responses to suicide. Her future is characterised as a positive, towards living rather than just surviving.

Clare – A foray into the psychiatric system and back again.

Clare describes suicide as wanting to die in response to the extreme psychological pain she was feeling at the time. She describes being relatively older when she first went to the GP and was diagnosed with depression following successive overwhelming environmental demands. She describes that acute depression and possibly medication led her to having thoughts (that seemed to come from nowhere) about hurting herself.

Clare notes that she has no memory of the lead up to her suicide attempt but remembers waking up in bed in hospital alive, and glad that she was alive. At first she has difficulty in believing what is being said about how she was: she characterises herself as becoming out of control, irrational, a danger to herself and a burden to her family who take her to an inpatient ward. The inpatient ward are considered as doing their minimum in taking her and in taking care of her: she attempts suicide whilst sectioned; this is presumed to be as a response to having her freedom taken away. The hospital are further characterised as completely unsupportive in relation to the attempt: it is not talked about and she and her family are seen to be left on their own with it. Clare continues to be involved in the psychiatric system. After some time of struggling with depression and suicidality, Clare happens upon an organisation specifically to support suicidal people. Clare describes that healing largely came from being in a safe space in which to talk to people who were not frightened of suicide and did not invoke an attitude of suicide prevention at all costs. She adds that further proper, good quality therapy helped. She invokes multiple current identities as well as being an attempt survivor. She talks passionately, thoughtfully and knowledgeably about societal taboos and fears

around suicide, the rights of those diagnosed with mental illness, the rights of people to be able to end their life and the legal and moral complexities of suicide.

Jack: A story of perceived inadequacy

Jack characterises suicide as stemming from inadequacy and desperation. He describes suicide as a response to feeling nothing will be better and deciding to cut your losses. Throughout his narration, Jack portrays himself as thinking very negatively but, also as encountering many situations where others are insensitive, unaware or purposefully malicious which makes him feel worse. Jack describes having first diagnosed himself with depression shortly after his marriage broke down and, subsequently getting medication for this. Years later, prior to his attempt, he describes feeling trapped in a relationship. He adds that he had stopped taking medication which he feels might have added to his hopelessness and caused his attempt. He casts himself as being determined to end his life but having failed, adding to his sense of inadequacy.

Following the attempt, he continues with life as before but, when contemplating whether he wanted to end his life again, notes not acting on this, thinking that God wanted him to survive. When feeling low, Jack notes still having suicidal thoughts praying to God to not let him wake up; there is some passivity in this suicidal urge: rather than actively seeking death, there is an idea of gratitude if his life ended. Jack adds that he feels going back on his medication has also helped him to not want to further act on any suicidal urges. He portrays himself currently as knowledgeable on mental health issues, helping and supporting others with problems. He positions himself as an authority on suicide when discussing how others make judgements about suicide.

Charlie: An ordinary response to extra-ordinary circumstances

Charlie characterises her self-harm and suicidality as understandable and normal, particularly given abusive early experiences. In contrast, others' responses to suicidality and the suicidal situation are characterised as strange. Her period of suicidality is talked about as being difficult but it is in marked contrast from her period of anxiety based 'illness' where she felt unable to attempt suicide and so, trapped and helpless. Despite family being sometimes present, an individualistic sense pervades. This is particularly notable when describing recovering from suicidality which appears largely to stem from inside her: her struggle through life, learning from experience and instances of self-awareness and insights. She appears to characterise herself currently as quite knowledgeable about mental health and offers advice to others; her identity is not limited to her past suicidality.

Professionals from the past are characterised as being largely ineffectual but she notes being in connection with good professionals currently; these appear to be ones with who she can engage on the same level. Charlie notes that her future is hopeful and full of possibilities but this also includes the possibility of suicide; for Charlie this possibility is a positive option.

Abby – A story of escape and endurance.

Abby characterises suicide as a potential escape from dark times when she could not cope. She describes a happy childhood but a teenage life where there seemed to be no escape from relentlessly difficult situations, leading to her first attempt. She describes feeling quite lonely and unable to talk to others. After her first attempt, she characterises herself as enduring the difficult situations at home

and school until going to university. Whilst she describes having a breakdown at university, her partner (husband now) cared for her.

After a traumatic birth to their daughter, Abby characterises herself as losing control: planning to end her life believing her family would be better off without her. Through this she seems to have retained some insight and courage, stopping herself from going through with her plan, considering how her child could be kept safe if she were to end her life, and, after two years, Abby decides to tell others about her experiences and seek help. She notes having learnt from therapy but also characterises healing as stemming much from her own determination and sense of agency. Abby casts herself at present as happy, sometimes still anxious but overall managing despite difficult situations. Her past suicidal experiences are viewed in a positive light now: as making her strong and who she is now.

Anna – A tragic witnessing of suicide and the struggle to be heard.

Anna characterises suicide as a deeply selfish act. She describes a difficult upbringing within an abusive family and continuing the cycle of abuse by ending up with abusive partners. When Annabel makes a concerted effort to break this cycle, she chooses a new partner and things seem to be going well. However, she starts realising that he is controlling and abusive and the story spirals downwards: he crashes a car with her inside, causing her injuries of which she still struggles. She then positions herself as craftily creating an escape whilst ensuring that all the children (from both of their different earlier relationships) are safe. Her plan goes wrong when her partner hangs himself in front of her. The pain and trauma of this leads Anna to attempt suicide herself. She is taken to hospital and initially regrets living. She is invited to stay in the inpatient ward, but realises she could not then

take care of her children. She refuses and vows to never try again, deciding instead to live for them.

In her recovery from suicidality, Anna receives therapy and support, but still seems to be struggling for others to understand what it is like to have a partner kill themselves in front of you. Her experiences have made her very scared of what she calls 'mental people' and, whilst caring for her kids, she spends most of the day in bed because of her injuries sustained in the earlier accident.

Matt – A story of a spiritual journey

Matthew actively notes that he does not see his jump as a suicide attempt: rather, he sees it as one of many turning points within his spiritual journey; a gift that he created to come to be on the right spiritual path. In telling his story, Matthew notes that prior to jumping he had thought he was on the right spiritual path, but acknowledges now that this was not the case: the guidance he was receiving is characterised as being from a needy, wanting place, rather than a place of calm and acceptance (as it is now).

He describes being supported by others through the journey but notes that prior to jumping, he had severely. Matthew describes the few months after jumping as being hazy but that spending the time in bed in hospital provided him with time and space to enjoy simple things. Whilst Matthew characterises professionals as being mostly supportive following his jump, he characterises himself as completely responsible for everything that has happened and will happen in his life. He describes currently being in a very good and positive place in life, managing and enjoying every day. He identifies as wanting to help people and engages in peer support.

Appendix 12 – Table of the Main Approaches Drawn on Across Participants

12.1 Individual, internally mediated approaches

Approaches and voices	Alex	Sam	Emily	Fiona	Jess	Clare	Jack	Charlie	Abby	Anna	Matt
<i>Psychological</i>		x	x	x	x	x	x		x	x	x
Not coping				x		x	x		x	x	
Negative thinking		x		x		x	x		x	x	
Inward thinking		x	x		x	x			x	x	x
Emotional pain					x	x	x		x	x	x
<hr/>											
<i>Religious/Spiritual</i>	x						x				x
Testing fate							x				
Spiritual Journey											x
Being possessed	x										
<hr/>											
<i>Positive experiences</i>			x	x	x	x	x	x	x		x
Added to their lives			x	x				x	x		x
Turning Point			x		x			x			x
Learning experience			x					x	x		x

