

Lessons for Life

**The experiences of people who attempt suicide:
A qualitative research report**

A SANE Australia and University of New England
research partnership study



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Executive summary



Executive summary

Suicide is a serious worldwide health concern and is the fifteenth highest cause of death across all countries (WHO, 2014). The Australian Bureau of Statistics has recently reported the highest suicide rate in the past decade, with 2,535 Australian lives lost to suicide in 2012 (ABS, 2014). For every person who dies by suicide, it is estimated that 20 more people attempt to take their life. Attempted suicide is the single biggest risk factor associated with death by suicide (WHO, 2014). It is crucial that we better understand what helps or hinders people who attempt suicide in order to reduce the suicide rate. Although the field of suicidology is expanding, research and suicide prevention initiatives to date have focused predominantly on expert opinion (academic and clinical) and rely heavily on quantitative studies or data from other countries. There is a gap in the current literature regarding the exploration of the lived experience of Australians who attempt suicide.

The current study

The aim of this research was to identify what can help or hinder people who attempt suicide. Participants had to be over 18 years of age and have attempted suicide more than six months ago. A total of 31 telephone interviews were completed with 7 male and 24 female participants located throughout Australia. A risk assessment was conducted with each participant prior to the semi-structured interview. Of our sample, 23% had attempted suicide on one occasion, 32% 2-3 times, 39% 3 or more times, and 6% did not specify. The time since their last suicide attempt ranged from 6 months to 40 years.

Findings

Historical risk factors

Adverse events from people's past that may have placed the participants at greater risk of attempting suicide included: childhood abuse and/or neglect, trauma (unspecified), suicide bereavement, the death of a parent in early life, bullying, and grief and loss associated with Aboriginal cultural identity.

Triggering influences at the time of the suicide attempt

Participants identified a number of psychosocial factors that were influential at the time of the attempt including: the impact of mental illness, suicide bereavement, lack of professional support, interpersonal relationship problems, pressures of work, drug and alcohol misuse, experiencing abuse or sexual assault, and being in year 12 or starting university. Mental illness and suicide bereavement were very prevalent within our sample with 87% and 58% of participants reporting these respectively. The narrative style of this research captured how, for many of the participants, it was the interaction of a range of these psychosocial factors that led to the suicide attempt.

Emotional state at the time of the attempt

Individuals described a range of intense emotions leading up to and after their suicide attempt. The interviews clearly documented the intense emotional pain, disconnect and hopelessness that many felt. Participants also mentioned feeling overwhelmed, depressed, and trapped with no other option; some experienced constant intrusive thoughts of suicide. When reflecting on surviving their attempt, participants reported feeling confused, angry, ashamed, and regretful, although, several participants also reported feeling grateful at having survived.

When reading this report, be mindful that the topics discussed may cause distressing emotions or memories to surface. If thinking about these issues has caused you distress, or you have been thinking about suicide, please call:

- Lifeline 13 11 14 www.lifeline.org.au
- Suicide Call Back Service 1300 659 467 www.suicidecallbackservice.org.au
- SANE Helpline 1800 18 7263 www.sane.org

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Barriers to communication

Within our sample, 67% did not communicate their thoughts or feelings of suicide prior to their attempt. Common themes revolved around a fear of rejection or negative reactions from others, feeling that they were unworthy or could not be helped, feeling unable to open up or not knowing what to say, or not wanting to worry others.

Talking to family and friends after the suicide attempt was a difficult issue for many of the participants. Some found that family or friends did not want to engage in conversation about it, were judgemental, or found it difficult to understand. However one-third of participants described positive instances where they were well supported. Support and understanding from family and friends was considered as important as professional support to their ongoing recovery.

Professional support

Difficulty accessing effective treatment and/or support from professionals was the most commonly reported barrier to an individual's recovery journey. Of our sample, 25 people talked about their experience of hospital and the majority (80%) described negative experiences, although 50% also reported positive interactions. The most commonly reported problem with hospital was being discharged too early or having difficulty being admitted in the first place. Others described hospital as traumatic, stressful, or distressing; nearly one-third of people felt that they were not taken seriously or were misunderstood. Many participants also talked about being negatively affected by other patients who were severely unwell, or by staff whom they felt were judgemental or disrespectful.

Participants also sought help from health professionals such as GPs, psychologists, psychiatrists, and counsellors in the community. People described a huge amount of variation in terms of their helpfulness and success in treatment, with some describing unhelpful or stigmatising attitudes. Although finding appropriate professional support was sometimes convoluted and frustrating, developing a positive and empathetic relationship with a health professional was a key factor in their recovery.

Stigma and judgemental attitudes

Misunderstanding, stigma, and judgemental attitudes came from professionals and non-professionals alike. This was the second biggest barrier to recovery that was highlighted by the participants. Of particular concern was the assumption that suicide is selfish or attention-seeking. Stigma and judgemental attitudes are pervasive and severely undermine people's willingness to talk about their suicidal thoughts and feelings. It also hampers their willingness to seek and engage with professionals, especially when they have had negative or unhelpful experiences in the past.

Factors that promote recovery

Professional support, access to effective and affordable treatments, and support from family and friends were mentioned the most frequently in terms of what helped participants. People also talked of learning better coping mechanisms and insight, having people understand and not judge them, and having others check in to make sure that they were OK.

Over three-quarters of the participants (77%) felt that they were more resilient and capable of getting through adversity and difficult situations since being suicidal. Just over one-third talked about having learnt to communicate more clearly about their feelings and to access their support network when they begin to struggle.

Important messages from the participants

Spontaneously, half of the participants made a point of highlighting a particular message that they wanted to get across. Of these, the most commonly mentioned was to remove the stigma around suicide particularly in relation to the assumption that suicide is selfish or attention-seeking. Others thought that the most important message was that services need to improve and become more accessible, responsive, and genuinely caring of the suicidal people who present to their door.

Conclusions and future opportunities

The results of this study highlight the complexity of factors that lead people to suicide, and the intense pain, hopelessness, and burdensomeness that people often feel around this time. Having supportive and positive interactions with health services and professionals is crucial to recovery, as is being understood and accepted by family and friends. A resounding message is that people who attempt suicide can recover, and they often possess a great deal of strength and determination having been through such turmoil. Based on these findings we can see a number of opportunities to improve suicide prevention initiatives and to better support people who have attempted suicide and their families.

Reduce the stigma of suicide and mental illness

- Opportunity 1: Education campaigns aimed at both the general public and health professionals to increase understanding about what leads people to suicide and to reduce judgemental attitudes particularly in regards to the assumption that suicidal behaviours are attention-seeking and selfish, and that suicide and mental illness do not discriminate – anyone can be affected.
- Opportunity 2: An education campaign aimed at people at risk of suicide, encouraging them to communicate their feelings with a trusted person and access supports – with clear information about where to go to find help and positive messages about the support that they can reasonably expect to receive.

Improve professional services

- Opportunity 3: Undertake a more comprehensive analysis on the pathways to care that suicidal people take with particular focus on the barriers to accessing services, best-practice treatments, and follow-up care.
- Opportunity 4: Work with hospitals to improve their admission and discharge procedures for people experiencing suicidal thoughts or behaviours so that they feel listened to and validated, and are given adequate and appropriate care.
- Opportunity 5: Work to educate all health professionals about the importance of supporting people who have attempted suicide with a focus on providing ongoing best-practice support (such as psychological therapies as well as medications), and practical coping and problem-solving skills.

Provide supports to families and friends

- Opportunity 6: Review existing supports for families and friends with emphasis on how current resources can reach those who need them and how other types of programs, such as support groups, skills-based education workshops or respite programs may be developed and implemented.
- Opportunity 7: Review the process by which family and friends are involved in the professional treatment and follow-up of people struggling with suicidal thoughts and behaviours with specific emphasis on the communication and assistance offered to them in support of the unwell individual.

Continue qualitative research in this area

- Opportunity 8: Continue expanding narrative-based research into the historical and contextual factors that influence a person's decision to end their life, with particular interest to how resilience helps to protect them from suicide.
- Opportunity 9: Conduct research investigating the barriers that prevent people communicating about their suicidal thoughts and feelings.
- Opportunity 10: Continue to examine the pathways to recovery, including how people increase connectedness, insight, and problem-solving skills.

Structure of the report

This report is intended as a summary and overall exploration of the main findings of the research. We anticipate a wide audience who may be interested in these results and have attempted to write in plain accessible language. We do include a literature review and refer back to previous studies in the discussion, as this gives the findings context and meaning. However, it is not a purely empirical report. In order to keep this report to a manageable length, topics are discussed broadly but we do not explore each issue in depth. However, the researchers will use this data to publish several journal articles that more thoroughly explore the following issues: the relationship between suicide and mental illness; how the results fit with Thomas Joiner's interpersonal theory of suicide; how the results fit with Edwin Shneidman's theory of Psychache; the participants' experiences of help-seeking; and, finding a voice to express suicidal intentions. Details regarding the publication of these research articles will be listed on the SANE Australia website at www.sane.org/projects/suicide-prevention



Introduction

Suicide is a serious worldwide health concern and is the fifteenth highest cause of death across all countries (WHO, 2014). The Australian Bureau of Statistics has recently reported the highest suicide rate in Australia in ten years, with 2535 lives being lost to suicide in 2012 (ABS, 2014). For every person who dies by suicide it can be estimated that 20 more people attempt to take their life but do not die (WHO, 2014). So far in Australia, much of the research into suicide and suicide prevention has focused on expert opinion, quantitative studies, or data from other countries. There is a gap in the literature regarding the exploration of the stories of Australians who attempt suicide and how such lived experience can inform improvements to our suicide prevention efforts.

SANE Australia, together with researchers from the University of New England, examined the experiences of people who have attempted suicide in Australia. This research is important because it gives voice to an often stigmatised and overlooked group of people, many of whom are eager to share their stories in order to try and help others who may be in a similar situation. Qualitative research such as this aims to add depth to our understanding and helps us to examine the complexity of factors that can help or hinder suicidal individuals. Attempted suicide is the single biggest risk factor to eventually dying by suicide, so by understanding how we can help and support people both before and after attempted suicide, we can work towards making a significant reduction in the suicide rate in Australia.



Literature review



Chapter 1: Literature review

According to The Australian Bureau of Statistics' latest figures on causes of death in Australia, 2,535 people died by suicide in 2012 – the highest number of suicides in the past decade (ABS, 2014). Suicide was ranked as the fourteenth leading cause of death across all ages. For every person who dies by suicide, there are many more individuals who attempt to take their life. Calculating the exact figures for attempted suicide is problematic as many people who attempt suicide do not seek medical attention or tell a close contact. Even when people do present to a doctor or an emergency department for medical treatment, there is no uniform method for collecting data about suicide attempts across Australia. The World Health Organisation's 2014 report, *Preventing Suicide: A global imperative*, estimates that for every person who dies by suicide there are likely to be 20 more who made one or multiple suicide attempts. Understanding those who attempt suicide is crucial in our suicide prevention efforts as a prior suicide attempt is the single biggest predictor of death by suicide in the general population (WHO, 2014).

There is much research on suicide with a specific focus on prevention. Numerous interventions and resources have been developed that identify risk factors and provide information or strategies that are aimed to divert individuals away from the suicidal path. Unfortunately, there is a significant limitation to the current suicidology literature – the voice of suicide survivors has often been neglected. Between 2005-2007 over 95% of studies published in peer-reviewed journals were quantitative studies. Hjelmeland and Knizek (2010) propose that this is driven by a fundamental emphasis on highlighting correlations

and causes. They suggest that more qualitative research is needed to understand suicide from an individual perspective. In particular, individuals who have survived suicide are potentially best able to inform current intervention programs (Webb, 2010). For the purpose of this review, the term 'suicide survivor' refers to an individual who has survived one or more suicide attempts, not those who are bereaved by suicide.

Despite the significant lack of qualitative research, some studies and theories shed light on the personal experience of suicide and on factors that may assist recovery. In 2008, Lakeman and Fitzgerald conducted a qualitative review looking at 12 studies that explored how individuals cope with suicidal thoughts and feelings. Most studies reported a significant experience of suffering, intense emotional and unbearable pain and feelings of hopelessness (Lakeman & Fitzgerald, 2008). Such descriptions are similar to what is meant by 'Psychache' a term coined by Edwin Shneidman, referring to the intense emotional pain and anguish of emotions such as guilt, shame, embarrassment and fear. Shneidman postulated that suicide is caused by psychache when an individual is overwhelmed and unable to withstand the intense pain of emotions any longer (Shneidman, 1993).

Joiner's seminal work to unify a theory of suicidality led to the development of the Interpersonal Theory of Suicide (IPT) (Joiner, 2005). According to IPT, suicidality occurs when three core facets are present: a sense of thwarted belongingness, perceived burdensomeness, and the capability for suicide. Thwarted belongingness occurs when a person's innate desire to connect with people and both care and be cared for is

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continuously unmet, or disrupted. This can lead to feelings of isolation, disconnection and lack of support. (Van Orden, et al. 2010). Perceived burdensomeness is the second integral factor, including the feeling of being a burden to loved ones, friends, work, and even the wider community, (e.g. being unworthy and a drain on valuable resources) combined with a sense of self-hate, unworthiness or uselessness. It is postulated that individuals must also have an acquired capability for suicide, whereby there is a decrease in the fear of death, an elevation in a person's capacity to tolerate physical pain and access to means (Van Orden et al. 2010). IPT provides a useful frame of reference to help understand why an individual may attempt suicide.

In addition to psychache, Lakeman and Fitzgerald's (2008) research also provides evidence to support the notion of thwarted belongingness. Participants reported that they felt isolated, lonely, and disconnected from people in society or from their spiritual or religious belief system. Communicating and connecting with others, gaining support and acceptance and seeking help were considered important factors to the recovery process and overcoming the suicidal experience. Participants also commonly identified a 'turning point' that aided their struggle with suicide, a pivotal moment or event that changed their thinking patterns (Lakeman & Fitzgerald, 2008).

However, it is important to note that this change is not necessarily immediate and that not everyone regrets their decision or is grateful that they survived. In their research, Chesley and Loring-McNulty (2003) found that only 10 of the 50 suicide survivors interviewed reported experiencing any positive emotions (happiness or relief) following their attempt, with 88% of the study reporting negative or ambivalent emotions. Over 60% of the sample reported feeling either 'sad, depressed, disappointed, empty, angry, embarrassed or ashamed'. These findings identify that negative emotions are highly prevalent after an attempt and failure to address or validate the individuals' suicidal experience may have a vital impact on the treatment process.

This impact is demonstrated well in the work of David Webb (2010). Webb discusses his own experience of suicidality. After surviving several suicide attempts, some very well planned, he expressed a great deal of anger and disappointment at waking up and reported feeling hopeless and helpless 'There is no sense of failure quite like failing at suicide' (Webb, 2010, p. 9). In addition to these strong emotions, many individuals must also come to terms with physical impairment or disfigurement due to their attempt. Webb (2010) has emphasised that one of the

most important aspects of treatment is to feel listened to and validated, enabling the individual the opportunity to share their experience in their own words, without rejection, denial or avoidance of the subject.

When Chesley and Loring-McNulty (2003) asked their participants why they do not attempt suicide now, the most common reasons identified were: being linked in with a professional, a sense of self-empowerment, current life success (personal or professional), and a new outlook on life. Common coping strategies that were utilized by the suicide survivors heavily revolved around communication and connection. It appears that no unique factor is prevalent or superior to others, with evidence indicating that a combination of multiple factors is most helpful in aiding recovery. When questioned about their suicide attempt, 55% of participants reported that they now felt glad or grateful that they survived, while 16% felt hopeful. This emphasises that recovery is possible and connecting and seeking help are key components to aiding individuals after an attempt.

This can have important ramifications, particularly for in-patients receiving care. A Swedish study interviewed 18 individuals about their experience of psychiatric care while they were hospitalised following a suicide attempt (Samuelsson et al. 2000). Shame was again a prevalent theme for most participants. Many were concerned that staff would be disappointed in them because they had been readmitted after a further suicide attempt. Having caring, friendly, and respectful staff helped to minimise the feelings of discomfort and shame in-patients felt. Positive interactions with staff also helped some individuals to recognise the seriousness of the situation and that hospitalisation had been necessary. Some reported feelings of relief at being an in-patient because they recognised they were so overwhelmed and could not cope by themselves.

Feeling respected, safe and secure, and validated by treating staff was incredibly important. When participants felt that staff did not empathise, or were not interested in hearing the client's perspective, it was detrimental to the treatment process. Participants often felt pressure, stress or like a burden, leading them to exit treatment early; one participant made another attempt as an in-patient. In contrast, individuals with positive experiences often talked about hospital staff who were highly accessible and who encouraged discharged patients to contact the ward if need be. This promoted a great sense of security knowing they were welcome to come back and could access help (Samuelsson et al. 2000).

Evidence from Canada documents how shame, fear, stigma and discrimination regarding suicide can impede people from seeking help. Individuals who are having thoughts of suicide may be reluctant to discuss them, which can deter individuals from seeking medical assistance or support if they survive an attempt. Some also fear the reactions of close family members and friends, while some have negative thinking patterns or low self-esteem and do not believe they are worth saving or that anyone would care if they died. Individuals are also scared to seek help because of the ramifications – many fear being taken to hospital against their will if they discuss their thoughts or plans (SIEC, 2009).

In the Australian context, De Leo and colleagues (2005) investigated the lifetime prevalence of suicidal ideation and attempts within a Queensland sample of 11,572 respondents. Approximately 4% had attempted suicide in their lifetime, while just over 20% had thought at some point that life was not worth living. Of these two groups, less than half sought some form of professional help (37% and 42% respectively). Many participants did not perceive a need for support (21%), or their attempt did not require medical care (60%), while some did not want to bother others with the burden of care or support. Of particular concern was that 12% did not have confidence in the help available, while 6% thought that there would be a lack of understanding from hospital staff and 20% did not seek help because they were worried what people would think of them (De Leo et al. 2005).

Another Australian study specifically investigated the help-seeking behaviours of adolescents prior to their suicide attempt (Gair & Camilleri, 2003). Contrary to common belief, it was found that young people did seek help from family and friends or counsellors and community services in the month prior to their attempt. The findings from this study emphasised that many individuals contemplating suicide may reach out to informal networks for help. Providing education and support to these groups can potentially aid suicide prevention initiatives if informal networks have the tools to identify and react appropriately before it gets to a critical stage (Gair & Camilleri, 2003).

A study by Ghio et al (2011) involving suicide survivors found a similar emphasis on the importance of non-professional support. Participants who had been hospitalised highlighted the extremely vulnerable and tumultuous period that occurs immediately after the suicide attempt and the months following discharge. Support from family and friends and understanding and empathy were categorised as important protective and preventative factors for further suicide attempts (Ghio et al. 2011).

The events leading up to suicide attempts are often defined by extreme psychological distress and a perceived inability to cope, coupled with feelings of helplessness, hopelessness, and a disconnection from society. This time can be an intense struggle of inner turmoil and pessimistic thoughts, as individuals weigh the pros and cons of life and death. Many do not wish to die; they simply want the unbearable pain and emotions to end.

Surviving suicide leaves individuals with a wide array of emotions – sadness, disappointment, anger, frustration, shame, and embarrassment. Psychological treatment, feeling connected and communicating with others are benefits that are frequently reported to aid recovery and prevent future attempts. Suicide survivors who feel respected and validated have more positive outcomes and lower rates of repeated suicide attempts. Family members and friends also play a vital role in the recovery process, providing affection, support, and understanding. Evidence highlights the role that communication and social connectivity play in recovery, yet suicide survivors often feel isolated and stigmatised. It is important to minimise and reduce negative attitudes that blame, shame, and persecute the suicide survivor.

While research demonstrates that there are commonalities, the suicide experience is unique to every individual and it is important that we attempt to understand and listen to their perspective. Further research is needed to better understand the experience of suicide attempts in an Australian context. Providing suicide survivors with a voice to narrate their own experience may provide insight into what factors help or hinder their pathway to recovery. This current research aims to help fill the gap in our understanding by speaking with Australians who have attempted suicide and make recommendations about how we might best support this vulnerable group.

Aim, methodology, and limitations



Chapter 2: Aim, methodology, and limitations

Aim

To gain insight into the experience of Australians who attempt suicide and to investigate what factors may assist or interfere with an individual's recovery after a suicide attempt.

Methodology

The researchers undertook a qualitative methodology, carrying out 31 semi-structured interviews over the telephone with people from around Australia. The sample was a convenience one, and participants were recruited through advertisements using SANE Australia and the University of New England's online communication networks, Facebook, email, and newsletters, plus two radio interviews aired in NSW and QLD.

Approximately 70 people responded to the call-out for participants, resulting in 31 completed interviews taking between 30-60 minutes. The sample comprised of 7 men and 24 women. Participants were over 18 years old (range 19-72 years) and their most recent suicide attempt had to be more than six months ago (range 6 months-40 years). The criteria for inclusion in the research are detailed in Appendix 1. This study received ethics approval through the UNE Human Research Ethics Committee (No. HE13-245).

Given that recruitment was via media interest in the project and is not representative, not all States in Australia are represented. The majority came from NSW (12) and Victoria (11), with the others coming from QLD (3) SA (3) and WA (2). Eight of the participants were from regional or remote areas with all others coming from metropolitan areas.

Each person who made contact with the researchers was sent participant information, consent forms and resources from SANE Australia including referrals and crisis numbers. Of the 70 people who contacted researchers, 35 people chose to participate. Before the interview began, a screening and crisis assessment was undertaken to ensure that the individual met inclusion criteria and was not at immediate risk of suicidal thinking or behaviours (see Appendix 1). This process resulted in one person being screened out because their most recent suicide attempt was less than six months ago. Three participants were not available at the time of the interview and did not take part in the study. No one was screened out because they were currently experiencing a suicidal crisis and all participants said that they were happy to talk about their suicide attempt/s and had appropriate supports in place.

Interview questions were semi-structured and covered four main topic areas:

- What led the person to attempt to take their own life
- What professional supports the person accessed before and after the attempt/s
- Talking to family and friends about the attempt
- How things have improved, and strengths uncovered.

(See Appendix 2 for full interview questions.)

Questions that were addressed to the participants during both the screening interview and the main interview informed us about their suicide attempts and general mental health. The following two charts provide an overview of the participant's suicide history.

Figure 1. Number of suicide attempts

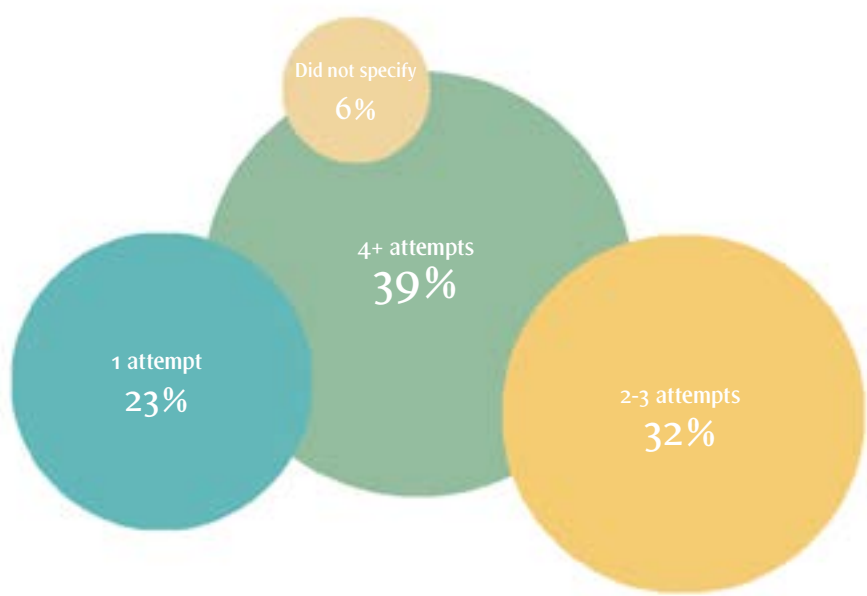
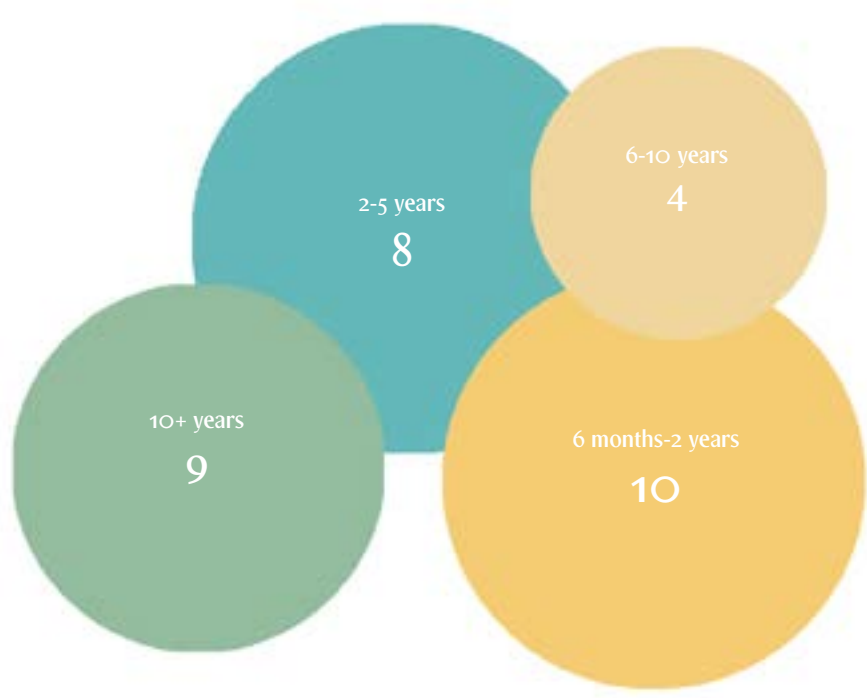


Figure 2: Time since last attempt



Participants were telephoned after the interview by a SANE Helpline Advisor to offer further support, and to check that they had not been adversely affected by their involvement in the research. Although some participants talked of minor discomfort because of the interview, there were no reports of major upheaval or a triggered crisis. It appears that many of the interviewees found the experience cathartic and appreciated the opportunity to share their experience with the hope that it might help others who may be in a similar situation.

Participants were offered the option of reviewing their transcribed interview before the data was analysed. Five participants chose to review the transcript, and, where changes were made, they were minor grammatical changes.

The data was analysed thematically, with each of four researchers reading and coding half of the interviews and then crosschecking with each other to increase reliability and validity and to highlight any themes that were missed. Key themes were agreed on. The data was then analysed for the number of times particular themes occurred, and sorted into the most commonly occurring.

Finally quotes were chosen to represent particular issues and showcase the diversity of views. Quotes are an essential way to present data in qualitative research as they offer us a detailed voice from people with lived experience. It should be noted that there were many insightful quotes that could not be included in this report due to lack of space.

Limitations

As with any research there are limitations as to how far we can extrapolate results to a wider population. As this is a qualitative report with a relatively small sample size, extra caution should be used when making generalisations about the findings. Furthermore, the sample is one of convenience, and is not representative. For example, many of the participants were recruited through a mental health charity (SANE Australia) and affiliated organisations, therefore the number of people with mental illness may be greater in the current research pool than is typical of those who attempt suicide.

Despite these limitations, qualitative studies such as these provide an important opportunity to add detail and depth of understanding to issues such as attempted suicide. When we view the results in context with other qualitative and quantitative studies, we can start to build up a picture of what helps and hinders those who attempt suicide and how we can help this vulnerable population.

Results and discussion



Chapter 3: Results and discussion

This chapter examines eight main themes that emerged from the interviews. These are:

- historical risk factors
- psychosocial influences at the time of the attempt
- emotional states at the time of the attempt
- barriers to communication
- professional support
- stigma and judgemental attitudes
- factors that promote recovery
- important messages from the participants.

Where particular issues are mentioned, the number of participants who expressed this is provided in brackets. All participants are referred to by a pseudonym and their listed age is as at the time of the interview. As an overview of the results, the following tables summarise the top five issues that were most often mentioned as helping or hindering the participants at the time of their suicide attempt.

Table 1. What helped participants at the time of their suicide attempt

Helped	No.	%
Access to effective treatment and medication	17	55%
Support from friends & family	17	55%
Ongoing professional support	16	52%
Better personal coping & problem solving skills	11	35%
Non-judgemental, understanding attitudes from others	5	16%

Table 2. What hindered participants at the time of their suicide attempt

Hindered	No.	%
Difficulty accessing treatment and/or appropriate professional support	20	65%
Stigmatising, judgemental attitudes from others	13	42%
Lack of understanding from family and friends	10	32%
Difficulty communicating about suicide (from them and others)	9	29%
Not being taken seriously or listened to	7	23%

I think my life's been leading up to it, to some extent. I'm not blaming her (my mother) at all really. It's just something – it's an accumulation of many years probably starting when I was, before I was six I think, because I was brought up by a war widow. My father was killed in the war and there were moments there that weren't . . . It wasn't a very affectionate family relationship . . . I think my childhood was a bit empty of emotion and I think that I've been a bit like that myself.

Barry (72)

These findings are consistent with research by Dube et al (2001) showing a powerful graded relationship between adverse childhood experiences and risk of attempted suicide. Each adverse childhood event increased the risk of a suicide attempt by 2-5 fold. Dube et al reported that misuse of alcohol and drugs partially mediated this effect, so that when alcohol and drug misuse was controlled for, adverse life events were less strongly correlated with attempted suicide. However, the researchers conclude that tackling adverse childhood events could be an effective suicide prevention strategy. Although the current research only touches on this issue, it is an area that warrants further investigation.

Historical risk factors

As a starting point to understand the issue of attempted suicide, it is important to have a sense of the historical factors that lead a person to the point of attempting to take their life. It should be noted that the interview questions did not directly ask people about their histories or childhood, so not all people talked about their experience within this context. Those who did mentioned issues such as being bereaved by suicide (5), experiencing childhood abuse (6), the death of a parent in early life (3), bullying (1), trauma (unspecified) (6), and grief around loss of culture (1).

I went through amazing amounts of bullying right from primary school. So right from very, very early – seven, eight, nine years old and that led to really poor self-esteem. There were some incidences of abuse from peers, sexually and physically in primary school and that sort of just led to a really shitty start to high school.

Vicky (29)

I had a lot of issues with my father. He's very – not so much physically abusive or in no way sexually abusive but just verbal abuse . . . He was fairly atrocious. But I don't speak to him anymore. I don't have anything to do with him for the last ten years . . . I have a problem with – even with my partner now, with not being able to feel that I'm good enough, sort of thing, and it was very hard growing up with him'.

Chloe (32)

Psychosocial influences at the time of the suicide attempt

Participants described many psychosocial factors that led to their suicide attempt. The most commonly reported issue was the presence of symptoms of mental illness (58%). Next was the lack of professional support (35%), although the issue of accessing professional support will be addressed later (see p. 23). There were also a number of other serious life stressors that participants highlighted were present around the time of their suicide attempt, such as being recently bereaved by suicide (4), pressures of work (5), drug and alcohol misuse (6), interpersonal relationship problems (9), experiencing abuse or sexual assault (5), being in year 12 or starting university (5), negative effects of medication (4) caring for a sick family member (3), and physical health problems (3). First, we will look at how the experience of mental illness affected people at the time of the attempt and then how the combination of other life-stressors led to a build up that undermined their ability to cope.

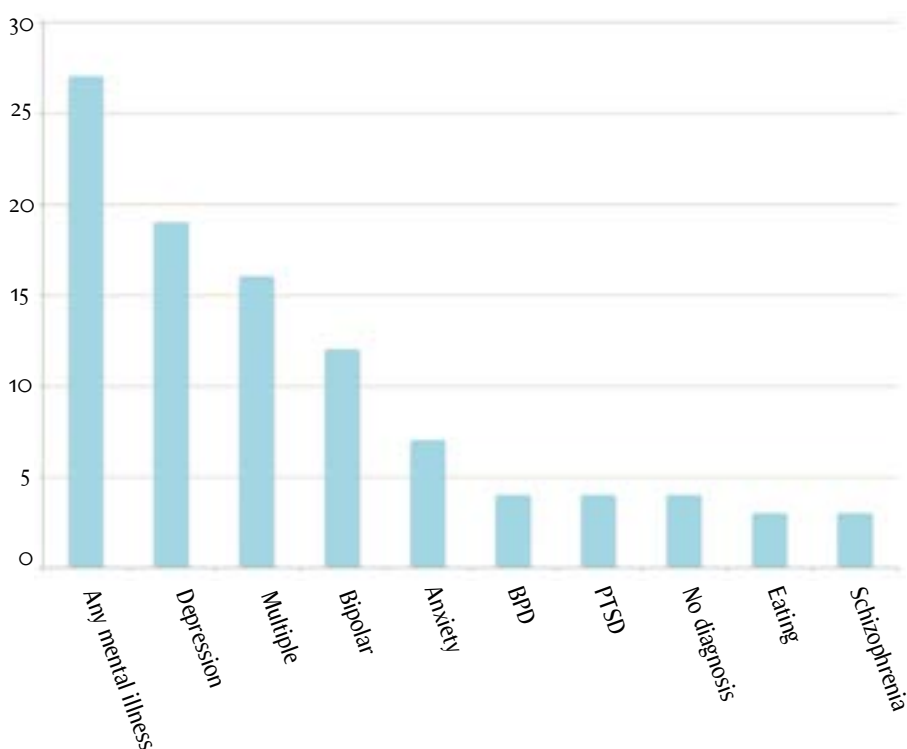
Figure 3. Word cloud of most commonly-mentioned issues impacting on the participants at the time of the suicide attempt.



The impact of mental illness

In screening for eligibility for the study, participants were asked, 'Have you been diagnosed with a mental illness?' Table 3 below outlines the result of this question:

Table 3: Number of participants with a diagnosis of mental illness



Lessons for Life: The experiences of people who attempt suicide

Twenty-seven of the participants (87%) reported having been diagnosed with at least one mental illness. This finding is consistent with research that indicates up to 90% of people who die by suicide have a mental health problem (Cavanagh et al. 2003). More than half of our sample (52%) reported two or more mental health diagnoses. Mood disorders were the most prevalent with 61% reporting a diagnosis of depression and 39% reporting bipolar disorder. These results were similar to the figures of mental illness reported in an Australian sample of suicide attempt survivors (De Leo et al. 2005). Of their sample 67% reported the presence of mental illness during their time of crisis and depression and anxiety disorders were again the prevalent mental illnesses reported (46%, and 27% respectively).

A recent meta-analysis conducted by Chesney, Goodwin and Fazel (2014) indicates that borderline personality disorder, anorexia nervosa, depression, and bipolar disorder have the highest suicide risk amongst people with mental illness. Prior research by SANE also indicates the lifetime risk of suicide for bipolar disorder is 15% (SANE. 2003), and an estimated 70% of people with schizophrenia experience suicidality (SANE. 2002). It is important to note that mental illness is not always the cause of suicidality and many people with mental illness do not struggle with suicidal thoughts: however, it was a significant factor in the lives of people interviewed for this research. Nearly everyone who talked about the impact of their mental ill health spoke of the severity of their symptoms and the difficulties in managing them:

I guess it was predominantly for me around my Post Traumatic Stress Disorder and increasing symptoms with that and not coping I guess . . . and I was just really depressed and in this sort of cycle. So that was – that wasn't sort of an event that would lead up to it. That was more of just my own mental health I guess.

Jessica (36)

In hindsight, I was – yeah, very depressed at that time. And I did seek help. I think my mum actually came with me the first time ever. I just needed to know how to manage it. I just couldn't work anymore. I was just lost. I was having, the week that (the suicide attempt) happened, extreme panic attacks which I've never really experienced that strongly, like I had a heart attack – I was concerned that's why I went to check my heart.

Ed (40)

I'd been diagnosed in 1980 with schizophrenia and I had a lot of awful voices, you know, in those days of course made me feel very suicidal and then I developed panic disorder. But I didn't know what it was and it was so overwhelming that I just couldn't stand it anymore. It was enough hearing the voices taunting me, but then I felt this panic, and it swept me up with it, it was just so confusing.

Kate (58)

A number of participants (33%) felt that the symptoms of mental illness directly led to their suicidal feelings. In this way the decision to take their life was not a choice or something they felt that they had control over.

I think the reason I get suicidal is because I have a mental illness . . . with bipolar I get depressed and when I get depressed I can get suicidal, so a lot of it, it's not something I choose to do. It's not like, you know, one day you sort of think you know life's too hard, I'm going to kill myself . . . It's I've got this depression and I'm sick of feeling miserable and I feel that my life is futile and, you know, I want to end it.

Martina (42)

I think that, suffering from PTSD as well also . . . worsened the depression . . . one of the things that I would like to say would be that when I became suicidal there weren't sort of thoughts of me deciding that I didn't want to actually be here. It was the depression controlling me . . . if that makes any sense.

Margaret (42)

All they did was just keep me drugged up, but it didn't stop the paranoia and that's where most of the suicide attempts have come from . . . to get away from that paranoia.

Josh (33)

One participant discussed the impact of his own lack of understanding about mental illness as leading to his suicide attempt. Tim's story highlights the misunderstandings that can occur when we assume mental health issues only affect those who have experienced adverse life events. This suggests that there may be positive benefits to teaching mental health literacy in the wider community and particularly within schools, so that developing adolescents and their parents know the signs to look for and what to do if such signs occur:

I didn't think I had a problem or a condition. I didn't think I was depressed or had social anxiety or anything like that. I thought my life and my circumstances were bad. And I think a big part of that was just my ignorance towards depression and anxiety as a condition. I thought at the time, that depression could only come about in real circumstances and it had to be triggered by something obvious like your family dies or your house burns down, something like that, 'cause mine just sprang up really randomly. I thought maybe it's nothing.

Tim (21)

Bereaved by suicide

Eighteen of the 31 participants had been bereaved by suicide (58%). Four people had lost a parent to suicide, three people a sibling, five people another close relative (such as grandparent, cousin or aunt), nine people had lost a friend, and five people had lost more than one person to suicide. Research indicates that individuals who have known someone who has attempted suicide or died by suicide are significantly more likely to experience suicidal ideation or attempt suicide in their lifetime (De Leo et al. 2005). A recent review of the literature by Pitman et al (2014) examining data from 57 studies looking at the impact of suicide bereavement, shows that exposure to suicide of a family member is associated with several negative health and social outcomes, including suicidality. These effects include an increased risk of suicide in partners bereaved by suicide, increased risk of required admission to psychiatric care for parents bereaved by the suicide of offspring, increased risk of suicide in mothers bereaved by an adult child's suicide, and increased risk of depression in people bereaved by the suicide of a parent. Reviewing the literature on non-kin relationships, Maple et al (under review) also found increased suicide risk among those exposed to suicide of other close contacts.

Nine of the people who were bereaved spoke of the negative impact that that had on their lives and, for some, how it heightened their own risk of suicide. For example:

I honestly do believe, if I had not been around so many suicidal people, or actual suicides in my life, I probably wouldn't have done it or tried to do it as many times as I did.

Interviewer: Do you think that showed you a possible option?

Yup! One hundred percent. This is an acceptable option. When you feel that you can't do it anymore, it's okay to do this.

Maria (35)

However, even though suicide bereavement can be a traumatic and extremely unsettling event, in some cases exposure to suicide can be a deterrent from engaging in future suicidal behaviour. Eight people who were bereaved talked about how their exposure to another's suicide lent a protective element to their own thoughts, enabling them to recognise the impact that their own death would have on others:

I guess in terms of my recovery . . . it was probably the best thing that could happen out of the situation. Like so not that she took her life but that it was the turning point in my life . . . you kind of you saw the effect that it had on everybody and you felt the emotions that you experience and you kind of know, like when you think about suicide - you think it is an end measure but that concept isn't fully grasped and when my mum took her own life you do realize, well, she's not coming back.

Kelly (26-44)

'I think it's probably what saved me, because she (my mother) took pills. And, I was sitting there with a tray of pills, I was about to take it all . . . and I had this flash, about . . . looking at what we went through when mum passed away, and, you know, I couldn't do it again . . . You know, you get it in your head that you're doing everybody else a favour, and I don't know, just at that moment, I thought, 'well, no, no . . . I'm not, because dad's going to have to go through it all again, my brother's going to have to go through it all again.'

Michelle (29)

Other life stressors

As well as the impacts of mental illness and being bereaved by suicide, there were many other environmental and social factors that contributed to people's state of mind and eventual suicide attempt. The narrative style of the interview highlighted how for many it was a combination of a number of adverse events that eventually undermined their ability to cope:

I think it was a build up of everything that had happened since my mum had passed away. I had a breakdown in a relationship. I had changed jobs, changed areas, I was taking heaps of drugs, drinking, I had a pregnancy that, in that time, before I had a fabulous pregnancy, I ended up miscarrying. Anyway, all those things just led up, and I just lost it.

Michelle (29)

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I'd taken a job in Sydney in the public sector and I progressed from middle management to senior quickly, within three months, and I did struggle with the transition. And I slipped again into depression and then I went to a GP and took three months leave and travelled overseas to get away from it. I came back and I was okay for a bit, and then started to slide again, and then back into the restructure whirlpool . . . and that just kicked me over the edge. The job I had was very difficult, highly paid, very difficult staff, difficult clients, rarely were there any positives in it.

Matt (46)

Tessa's story is a poignant illustration of how a number of adverse life events can lead to attempted suicide:

Case Study: Tessa (25)

My attempt in 2012, my cousin committed suicide in September that same year, and it was a really bad week. We found out that my mum had cancer in her colon. And five days later on the Sunday, we got a phone call that they found my cousin hanging in the park . . . so he had passed away on the Sunday and my mum had to be operated on on the Monday. And because no one else in my family has a valid licence I had to be responsible to take her and pick her up. And I was running back and forth between family, because one was in hospital and the other side was grieving.

And my boyfriend and I were having issues 'cause he couldn't really handle me being back in that state. Like he was supportive, everyone was supportive to an extent, but I felt like nobody was really listening. And then on the eve of my cousin's birthday, which was not even like three months after he had passed, I woke up I had to go to work and I literally had like no energy to do anything. And then that morning I just – the whole idea of doing anything else just seemed so . . . ridiculous – I just couldn't do it. I really just couldn't. So I didn't go to work, I was home alone because mum was in hospital . . . I just thought, I really just felt like OK I'm done. Like I'm just too tired. I'm just way too tired with my feelings and everything, so I started to look for ways to do it.

Internal states at the time of the suicide attempt

As well as the numerous external factors that contributed to people's feelings of suicide, the participants talked about their internal emotional state around the time of the attempt. Many felt hopeless (13), overwhelmed (12), depressed (10), and trapped with no other option or way out (10). A number of people described the constant intrusive thoughts of suicide (9) the extreme mental pain that they were trying to escape (8), and the quick escalation leading to the decision to take their life (8). A further finding was that many people felt that they were a burden and described thinking that others would be better off without them (7). Many discussed how difficult these internal feeling made it for them when trying to communicate their suicidal thoughts to others. The findings of this study around internal states are consistent with a number of prior studies discussed in the literature review. Certainly themes of hopelessness, disconnectedness and burdensomeness as outlined in Joiner's IPT of suicide are evident in the responses from the participants here. So too is the dominance of intense psychological pain, as highlighted in Shneidman's theory of psychache:

The sadness and the darkness was just something that no one could comprehend, unless you've been in that darkness and that for me . . . it was the darkness that was drawing me and the darkness wouldn't allow any light to come through, any love, anything uplifting. [It was] really really traumatic . . . painful and when people talk about pain they think physical pain but when you are in that much mental anguish . . . you are just in so much mental pain you just want to end it and that's what was driving me.

Margaret (42)

Just feeling like it – it's just hopelessness, just that you don't want to be a burden to other people, because I know it's an ongoing problem that I've got, and that I feel like I'm a problem for other people . . . and that it would actually be better for other people as well as myself. It would just put me out of my own pain, but better for other people as well.

Cherie (43)

I just remember these absolute feelings of despair and I remember it being extreme. I didn't feel worthy. I didn't feel wanted. I didn't feel cared for. I didn't feel loved. I didn't think anybody wanted me around.

Monique (37)

When I was in the place where I was with my last attempt, it wasn't selfish. For me, it was the most selfless thing I could do. Remove myself from the equation and prevent damage to the people I cared about. It wasn't for me about ending my life and making it stop. It was about protecting other people which now, I can look back and go, 'What?' But at the time, it made perfect sense. Everyone would be better off without me.

Maria (35)

However, when I'm suicidal, it's the knowledge that I am going to constantly be subjected to this time and time again. It's the knowledge that my family are going to be subjected to this time and time again. The lethargy, the lack of drive and motivation, the loss of self esteem, self-confidence, the overwhelming sadness and the – and when I'm in the depths of it, that inability to see a way out – a way forward. When you're still sort of in some form of – you still have partial control of it, you can tell yourself, 'This too will pass,' or, 'This will get better,' or, 'This won't be like this forever'. But then when you get to the real depths of it, there's just no light at the end of the tunnel. It is like being at the bottom of that well with a lid on the well and no way out.

Shellie (47)

I actually felt surprised and happy. Yeah, I woke up in the morning and went, oh ok, and just went on with things . . . In a way I guess the emotion was spent. I had gone through what I thought was a suicide and, and then that emotion was spent when I woke up in the morning. I felt more relaxed and calm and I guess happy that I didn't die.

Steve (45-64)

I had a psychologist, who's the psychologist I still see, and a psychiatrist. I had all, you know, good, good family support and friends and all that sort of stuff, but that just didn't scratch the surface and actually just made me feel guilty that I had all of this wonderful support and still wanted to do it [die by suicide].

Jessica (36)

I didn't ever think I'd get to that point, and I did. And, yeah, it just felt stupid, I think. You know, seeing what – with mum, and all the attempts that she'd had that we'd been able to stop, and then, I didn't have the – I was going, 'You idiot, what are you doing?' I felt really dumb, really empty, really just lost – I was lost – and then, I think from that point I was in a bit of a haze until they took me to hospital.

Michelle (29)

Emotions after the attempt

As well as describing a range of distressing emotions prior to the suicide attempt, some participants also described how they felt in the immediate aftermath. They most frequently talked about feeling confused (7), angry (5), ashamed and regretful (5). Alternatively, some participants described feeling relief and happiness that they didn't die (6).

Others reflected on the impact the suicide attempt would have on family and friends (3) and some were given cause to reflect on how they ended up in that situation particularly in light of the supports around them (3):

I was angry, disappointed, and then probably hot on the heels of that ashamed and embarrassed, above all, that I hurt people. 'Cause at that point, previous to that attempt, the only person who was really aware of . . . the depths of what I'd been through and everything was my partner and my doctor. But at that point, my partner had to disclose to everyone. He needed support and everything else.

Maria (35)

These findings are consistent with previous research by David Webb (2010) and Chelsey and Loring-McNulty (2003) where negative emotions were common immediately after a suicide attempt. Such findings give insight into the vulnerable state that people can be in after a suicide attempt, and the need for sensitive and non-judgemental interactions with others that will help to reduce these feelings of guilt and shame rather than reinforce them.

Barriers to communication

This section examines whether or not people talked about their suicidal feelings or behaviours either before or after the attempt. Two-thirds of people (67%) did not tell anyone of their suicidal feelings prior to the attempt. A major barrier to people communicating was their fear of the reaction they might encounter from others (9). Several people talked about not feeling worthy of help (3), not knowing how to talk about their feelings (3), or not wanting to worry others about their problems (2). Four participants talked about being very good at hiding their feelings from others. There were also cultural

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barriers to talking about suicide and mental health issues that were highlighted by an Aboriginal participant. Many people talked about the importance of overcoming such barriers to communication as being an integral part of their recovery process:

I think the worse I start to feel, the more withdrawn I become, the more super-sensitive I become to people's comments and even though I want to reach out for help, it's been like – I don't know how to ask for help and I have this tremendous fear and I'm super-sensitive to the fear of rejection. I mean the thing that comes to my mind most of the time is, 'Nobody hears a silent cry for help.' And that's what it is. I don't know how to reach out for help. I don't know how to pick up the phone and make that call and convey how bad I'm feeling.

Grace (58)

But I think with suicide . . . a lot of people don't really talk about it and I think it's perhaps because there's a shame factor that you often feel . . . because people think suicide is a very selfish act and . . . I think depression is more understood but I still think suicide is a bit of a taboo area because people think it is a very selfish thing to do, and so if you have felt suicidal or if you have an attempt and were unsuccessful you almost sort of feel a sense of shame . . . for feeling that way.

Martina (42)

I looked my dad in the eye and said, 'I'm going for a walk.' And had already swallowed, I don't know how many pills. And I looked at him and said, 'I'm going for a walk.' And I knew full well that my intention was that I'd never see him again, because I was hoping that the walking would speed up the absorption of all the drugs . . . I was really good at hiding everything . . . I have amazing parents that were just always there for me and I had a great upbringing and a great life and I felt – I don't know. I think I wanted to protect them.

Vicky (29)

I think that a lot of the suffering comes from not feeling like you're worthy enough to even discuss it with someone else. You know what I mean? That no one would want to hear what you've got to say, and I don't know how you could change that in someone . . . just to sort of encourage more people to talk somehow, especially guys, I think, too because it's such a huge thing of being strong and not speaking and the hardest thing is speaking when you're overwhelmed with emotion. It's almost as though your brain doesn't allow you to connect to your words, but that's exactly what you have to do, to be able to express what you're feeling and to not commit suicide.

Tracey (42)

A lot of Aboriginal people and especially men are very, sort of . . . they keep a lot of stuff in. We don't talk about that kind of stuff. We say things are okay and yeah. I just sort of...I didn't do anything. I just sort of kept it all to myself . . . Like I've said to you now, in my life, I think, especially that I'm Aboriginal – when I talk about mental health, it's a pretty – a sort of taboo thing.

David (37)

I was able to put on such a good face because that's what I had learned, but it could be the person sitting down next to you laughing to you telling a joke that they could be in a really stressed place. That was the stumbling block for me because I didn't show the depths of barrenness that I was carrying within myself and my thoughts.

Zoe (52)

These findings are consistent with research that indicates less than half the people who experience suicidal ideation or attempt suicide seek help. Our findings mirror those of De Leo et al (2005) where people often reported not seeking help because they were concerned about the reaction of others, or did not feel they needed or were worthy of support.

Reactions from family and friends

One-third of participants did tell someone close to them about their suicidal thoughts prior to the attempt and most received helpful responses, although in four instances people did not. One participant talked of how she begged repeatedly for help but that those around her thought she was attention-seeking.

I actually kept begging for help. I remember doing that a lot. I would stand in front of my family and teachers, and I'd just be like, 'I need someone to fix me. I don't know what's wrong with me'. And, no one knew what was wrong with me. They just assumed I was an attention-seeker. Even up until four years ago, people assumed I was just attention-seeking. And, it was completely . . . it was a moot point. It was, no matter what I said, they – the more I tried to say I needed help, they didn't care. It was like, 'No, you're just wanting attention. We're going to ignore you'.

Olivia (29)

Communicating with family and friends after the attempt was an ongoing issue for many people. Some found that family or friends completely ignored the attempt or did not want to engage in conversation about it (5). Other family members and friends were judgemental or found it difficult to understand or support them (12). Lack of understanding from family and friends was the third biggest hindrance to recovery for the participants:

Results and discussion

They [family] sort of told me they were glad I was still around and then moved on and everyone was a bit scared of talking about it I suppose, and I was quite glad of that. I didn't want to talk about it either.

Emma (26)

I found my father not very supportive . . . there was just a letter at home . . . mentioning that it was selfish of me to do it, and that's all I really remember in the letter, so I remember feeling very hurt by that.

Imogen (26)

When I told my brother, he didn't know until I went down to see him a couple of months later. He was shocked. He's still trying to come to terms with it. He . . . wants to understand it, I think, but he doesn't understand it at all. He can't understand the fact that his brother tried to commit suicide . . . he finds it really difficult to get into his brain.

Barry (72)

I think they [family] . . . couldn't understand why this was happening after I'd reached such a high spot, you know . . . my whole life I'd been quite successful and driven and confident. Yeah, so I think my ex-wife was probably the most angriest at me, and that was difficult.

Ed (40)

Eleven people talked about the help and support they had received from friends and family and how important this was to their recovery. Five people talked about the importance of trying to increase understanding of suicide in the community by writing about their experience in social media – via online blogs, Facebook, or other forums.

I have some friends who were fantastic through that time and who actually had also experienced being suicidal – not at the same time as me – but who were very helpful because they could just kind of cope with just hanging out and . . . knowing that I felt like absolute shit but would kind of cope with that. So that was, yes, great.

Jessica (36)

And he [Dad] has been really supportive and I do talk to him about it. And he still, even though his current wife doesn't like it, he'll still talk to us about mum . . . when we're on our own, we'll talk about the attempt, and the actual suicide, and it's been more so lately because Dad's best friend's son just committed suicide a week ago.

Michelle (29)

Well basically, after it happened and everyone had been told, I basically wrote a big blog post about the experience and about how it had felt and what had happened and just kind of explaining to everyone . . . it was after that that I got a lot of messages from people just saying that they didn't know and a lot of other people saying they've been through similar things that have never told anyone about it.

Maria (35)

Professional support

The participants in this study talked about many different occasions when they sought professional help both prior to and after their attempt. This professional help included visiting doctors, psychologists or counsellors, psychiatrists, calling helplines, presenting at emergency departments, being hospitalised, or attending community-based mental health services. There was a huge amount of variation in their experiences ranging from life-saving to dismissive. Most people experienced a variety of both helpful and unhelpful interactions with professionals, and many described a long and complicated path before finding appropriate support. Difficulty accessing appropriate professional support was reported by two-thirds of people as the biggest hindrance to their recovery. Conversely, having access to good professional support and treatments was the most helpful factor. This section will first describe the experiences of people when in hospital, (emergency departments, intensive care or psychiatric hospitals), and will then examine the support they received via community-based services such as General Practitioners (GPs), psychologists, psychiatrists, and counsellors.

The experience of hospitalisation

Twenty-five of the participants talked about the experience of being hospitalised around the time of their suicide attempt. For some, this occurred as a direct result of needing immediate medical care and for others the hospitalisation happened leading up to or soon after the attempt.

Most participants who talked about hospitalisation described negative experiences (80%), although approximately half (13) also described some positive experiences. The most frequent complaint was about being discharged too early when they were still unwell or having difficulty being admitted in the first place – sometimes leading to an escalation of the crisis. Ten people described the experience of being in hospital as traumatic, stressful or distressing, and nearly one-third of people felt that they were not taken seriously or were misunderstood. Many participants also talked about being negatively affected by other patients who were severely unwell (7), or by staff who they felt were judgemental or disrespectful (6). Nearly one-third of people highlighted that there was very little follow-up after they left hospital and few (if any) referrals provided. Five people made the point that their experience in the private sector was much better than the public hospital system:

To be honest, they treated me like I was completely anonymous . . . like I was a ghost or something. It was like, [you're] put in a room, and just stay there. And the doctor was like, 'Did you mean to do this?' And I was so young, and I just, I was so scared, and I didn't say a word. And then they said, 'No, she's fine. Fix her up and send her home.'

Olivia (29)

I stayed about three days in the acute unit, mainly because it was the weekend. And the psychiatrist that released me is my current one . . . and I was just talking to her the other day and said 'You know, it's funny how even as late as 2006, I was released without any money, without any shoes, without any follow-up plan' and she said, 'Oh my God! Did I do that?' I'm like, 'Well actually you did', and she goes, 'Oh, I was new. I didn't know what I was doing.'

Matthew (46)

Well actually they let me out two days later, saying they needed the bed. Yeah, that really crushed me you know? I said to the doctors 'but I just tried to kill myself' . . . and they said 'oh, but we need the bed.'

Josh (33)

I think for me the hardest thing about attempting suicide was probably with the medical staff and just that sense of, I mean, I felt like a failure anyway but to have contact with medical staff who didn't – couldn't – cope with that or couldn't understand or told you, you know, you're wasting their resources . . . I've had some really horrible interactions with medical staff that I think back to now, I think I should've made a point but I wasn't in the space to do it.

Jessica (36)

I had a five-day wait to get in which was extremely difficult, extremely difficult. By the time I got into the hospital on a Tuesday – it was the following Tuesday so a week had gone by – by this time. I was just, I was in all this turmoil of, 'What the hell happened? I didn't see this coming'. And I really needed to talk and unfortunately, I had a very long wait to see a psychologist, but the day after I was admitted, I just went down in an absolute heap.

Grace (58)

These findings are consistent with work by Samuelsson et al (2000) showing the negative impact that in-patient care can have on suicidal people if their experience is not validated and they are not treated respectfully. It is essential that services work to reduce stigma amongst staff and make the experience of hospital and emergency services more positive and accessible.

When experiences were positive, people mentioned being taken seriously, listened to and feeling that the hospital was a safe haven (7). Three people talked about specific examples of where staff had been compassionate and two of the younger participants talked about good experiences on a youth-specific ward. This data again replicates the findings of Samuelsson et al (2000) and the importance of providing empathetic care that empowers and respects attempt survivors and minimises the potentially traumatising impacts of hospitalisation:

It was a lot less confronting than it might have been being in an adult psychiatric ward for the first time. So it was actually, I think, a good experience, and I was always very scared of going to hospital . . . I think one of the important things I learned was that hospital is always an option and they will take you seriously. That was one of my real fears. I thought they'd go, 'No. You're fine. Go home'.

Meghan (19)

From what I remember, the staff were absolutely magnificent, very supportive. They asked me very early in the piece if it was okay if my husband was involved with my treatment . . . which was fantastic because in a lot of instances, I wasn't mentally capable of making decisions. So he was in any and all discussions regarding my treatment was involved, and that was invaluable.

Shellie (47)

Hospital staff did some things that no one in my whole life had ever done. This young girl, she was a mental health nurse, and she put her arm around me, and I just cried. And she didn't try and make it better, she didn't try and give me advice, she just sat there and put her arm around me and just let me cry until I stopped.

Interviewer: And you found that very helpful?

Yeah! Definitely! Because it's not someone saying, 'Okay, enough crying. Buck up. Here's what you need to do.' It's someone just saying, 'It's okay to feel how you feel.'

Olivia (29)

Professional support in the community

As well as support in hospital, many people talked about seeking professional support for their mental health and suicidal feelings in other settings. Participants sought help from numerous professional people including GPs, psychologists, psychiatrists, mental health case managers, mental health nurses, counsellors, and telephone helplines. Most people described a huge amount of variation with these professionals in terms of their helpfulness and success in treatment. At least one-half of the participants talked about having developed a positive and helpful relationship with at least one health professional at some point, and several talked about occasions where a health professional directly intervened to save them from a suicide attempt. Access to professional support was one of the three most helpful factors in recovering from a suicide attempt:

I've been to a lot of different [psychologists], and the one I've got at the moment is extremely effective. She's helped me deal with a lot of different things that have been going on from childhood and things like that, so I feel like I've been resolving different things.

Cherie (43)

I've got a fantastic psychiatrist and she is just really supportive and she's taught me a lot of self-compassion, and because she's not pathologising – which I had had a fair bit of in the past particularly from the first psychiatrist I saw, but then, and I mean in a lot of ways, he was quite good, so there's that.

Alison (50)

[My GP] heard about my suicide attempt, and she actually tried to find me through the system because she was absolutely gorgeous and she couldn't believe what she heard . . . I was very embarrassed when I went back to see her, but I thought I had to do that and she was absolutely gorgeous about it so in that way, I talk about it very openly to her.

Barry (72)

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She [my psychologist] basically freaked out and I ended up in a hospital that night . . . because I rang her and left a voicemail when I left home that night after putting the kids to bed and I intended to go kill myself. And I left her a voice mail – perfectly calm and cheery voice mail just saying, ‘I’m gonna have to cancel my appointment on Wednesday, I’m afraid. Something’s come up. I just wanted to say thanks for everything you’ve done and I’ll see you again soon.’ And that was kind of it. And she heard that voicemail then rang me.

Maria (35)

He [the psychiatrist] gave me my diagnosis for borderline personality disorder. I was at university at the time and he told me to go the university library. He wrote me a prescription for medication, told me to go to the university library and get the DSM IV and look up borderline personality disorder and read it because that’s what – that’s who I was . . . It wasn’t great. That experience was so . . . It basically put me off of seeing a mental health professional for the next what, 15 years. And that triggered the attempt because I read it and I recognised a lot of myself in it and I felt very trapped by the diagnosis, I suppose.

Maria (35)

However, there were many instances when people described unhelpful or even stigmatising interactions that hindered their capacity to recover. For example, seven participants felt that the professional who they saw did not take them seriously or were disingenuous, and six felt that the professional made things worse. Another five thought that professionals focused too much on medication and not enough on the underlying causes:

I did see a counsellor at university, but they – not to undermine their role ‘cause they’re great about whatever they normally deal with – but when it came to some of the issues I was facing, . . . I think my counsellor just said I was attention-seeking in terms of wanting to harm myself.

Tim (21)

I was seeing my doctor quite regularly (for depression), and I would tell him honestly how I was feeling, and he would up my medication. At no point can I say that while I was on the medication did I feel relieved of depression . . . which I think is sad that someone can hand out you know such high doses of antidepressants and in my opinion they did nothing for me . . . I think that for me the doctor that I was seeing should have actually paid a bit more attention to my calls for help, I think that instead of increasing medication, I think for me counselling and spending a bit more time talking to me would have benefited me more than upping my medication.

Margaret (42)

It was also highlighted that assumptions about what suicidal people look like, their social status, and their support networks need to be challenged as three of the participants felt that they were dismissed by professionals due to their healthy appearance and the presence of supports around them:

I felt like I’d been told by that counsellor, ‘Well, you just need to have a good cry about it and you know, get over it.’ Compared to the average person in that reception area, who were people probably facing more extreme circumstances than my own . . . I would’ve been well-dressed, I would’ve been well-spoken. I went to a Catholic ladies college. And I think the assumption was that I was a very rich girl having a whinge.

Liz (47)

By this stage, I’d been to all the local doctors where I lived and they – there was only two – and they both told me I was a normal teenager. And yet I was there screaming for help saying, ‘This isn’t right . . . I don’t know what’s wrong, but I don’t – I shouldn’t – have to feel this way all the time.’ And they both told me I was a normal teenager and everyone felt like this. The next time I saw that doctor, I had a gut full of pills.

Vicky (29)

My GP is lovely and I’ve been seeing him since the children were born, so about six years. He was lovely, but mostly inadequately prepared to be able to deal with the suicide attempt and the aftermath of it. Very supportive kind of guy, but just didn’t – or doesn’t have the – I don’t know. Maybe because I don’t fit the stereotype of what people think about mental illness, maybe? He said these things like, ‘Your children are so fabulous and your partner’s so fabulous and you’re so fabulous, I never would’ve picked that you have these issues’.

Maria (35)

Stigma and judgemental attitudes

Misunderstanding, stigma, and judgemental attitudes came from professionals and non-professionals alike. This was the second biggest barrier to recovery that was highlighted by the participants and was talked about by one-third of those interviewed. Of particular concern was the assumption by others that suicide is selfish (5) or attention seeking (7). They discussed how stigma prevented them from opening up about their suicidal feelings (4) and that they would be scared to tell an employer about their problems because they didn't want to be treated differently or lose their job (4).

I think if you were to put a hundred people in a circle and you say to them, 'Who's heard of suicide? Has anyone been affected by it?' You'll have almost every hand raised. People just don't talk about it because it's stigmatised, and so is mental health, tenfold. Mental health is so stigmatised, . . . I found it so bad where I'm working now that I kind of wonder if it was someone that wasn't as strong, whether they'd be able to deal with it. How would they cope?

Monique (37)

Oh, gosh yeah. People saying, 'Oh, it's just attention-seeking. It's, you know, if she was serious, she wouldn't tell anyone about it, she'd just go ahead and do it'.

Olivia (29)

Living in a small town, coming home to the rumours and the gossip and – 'Look out. That's the crazy chick.' Small towns are great for mental health. They really are. They do wonders. It's half the reason I was there in the first place. So that was not helpful. There was no anonymity. There was no-one that didn't know that I had just got out of a psych [ward] and everyone actually knew what that meant.

Vicky (29)

I've watched my family judge other members of my family who were very mentally ill, friends judge members of my family because they are very mentally ill. So I just went, well I'm not even gonna go there because I know what people have said about my mother or my sister or my brother. And I don't need that label as well. I know how nasty people can be.

Emma (26)

Stigma is pervasive and severely undermines people's willingness to talk about their suicidal thoughts and feelings. It lessens the likelihood that people will seek and engage with professional supports, especially when they have had prior negative or unhelpful experiences. It is crucial that we work to break down the stigma associated with suicide and mental illness perpetuated by both professionals and the general public, and to encourage those who are struggling with suicide to discuss their feelings and seek help.

Factors that promote recovery

Professional support (16), access to effective and affordable treatments (17), and support from family and friends (16) were mentioned the most frequently in terms of what helped participants. People also talked of learning better coping mechanisms and insight (11), having people understand and not judge them, having others (5) check in to make sure that they are OK, and better communication and increased connectedness (4). Five of the participants also highlighted that the beginning of a new life stage – in particular the responsibility of having children – helped them on their path to recovery. Being involved in less stressful work or volunteering (4), and becoming aware of the impact that suicide has on others (5), were also cited as reasons for their progression towards better mental health. These results mirror findings by Chelsey and Loring-McNulty (2003) showing that suicide survivors draw on a range of supports in helping them with their suicidal feelings.

Alison talks about the importance of an ongoing relationship with a mental health professional as a way to stay well:

I knew that for me getting ongoing access to either psychological or psychiatric therapy was critical. For me, it's like, you know, going to the gym. So this is what I do to keep myself well mentally, and if I don't do that then sooner or later life happens, enough you know, that there is more going on than I can actually deal with and process. And the more I have to put things in the cupboard without dealing with them, without processing them, then it builds up to a critical level and then I get depressed because the skeletons are rattling and I can't deal with them.

Alison (50)

Lessons for Life: The experiences of people who attempt suicide

Maria illustrates the importance of having active support from family and friends who are well informed and know what to do if she is struggling:

I mean it [my suicidal feelings] still exists, but because family and friends and support networks are aware of it, they make some conscious effort to mitigate that. They check in with me to see how I'm going, in a kind of non-invasive, in a supportive, 'Oh, how are you doing? Is everything OK?' And they legitimately wanna hear the answer and if they think that I'm a bit off-key, they will gently push . . .

My partner is very clear now that if he perceives that I'm in a dangerous place, he knows exactly what numbers to call. And he knows that it's better to maybe have me pissed off at him that he's called up [the crisis team] and they've come out to assess me, than it is to have me dead.

Maria (35)

Shellie talks about the importance of receiving a diagnosis, learning about her mental illness and online peer support as being central to her recovery:

Yes, but the way the doctors go about it leaves a lot to be desired. 'Hello! You've got bipolar.' 'Thank you!' 'Yeah, take this script and go away.' For me, I was very relieved because I've had 21 years – that was 21 years from when I had my first suicidal depression – until I was diagnosed. And so it was like, 'Oh, thank God there's a name for this!' But I was given nothing, no information on what bipolar was. I didn't even know it used to be called manic depression. So I went away and educated myself. I got involved with an online support group, and I learned more in that first year from the people in the online support group than I've learned from any doctor.

Shellie (47)

Tracey and David's comments illustrate the importance of increased connectedness and community involvement as a way to promote recovery:

I've really discovered in the last, probably, two years, that it is quite possible to turn things around and that a really cool part of starting to recover from having a mental illness is to actually face some of your fears and to go out and to make little steps to do things that maybe have made you anxious or scared you in the past, and that tends to actually build up your confidence and to make you feel as though you have a purpose and that you have a reason to be in the world. Like, I started doing volunteer work and that brought an instant feeling that I was actually contributing to the world. And up to that point, I had felt so useless and so pointless that it was really hard to find a reason to actually be alive.

Tracey (42)

I go to a men's group in Sydney and over a hundred men turned up once a week and just talk about their own things. Mainly alcoholics or people who have been through different things in their life and just sort of like they're gathering and talking and yarning and having a cup of tea and a chat.

David (37)

Strengths and positive outcomes

We asked the participants what strengths or lessons they had learnt through their experience of suicide. Over three-quarters (77%) felt that they were more resilient and capable of getting through adversity and difficult situations. Just over one-third talked about having learnt to communicate more clearly about their feelings and to access their support network when they begin to struggle. Half of the participants talked about having more self-awareness, the ability to identify triggers, or better coping skills. These findings are important as they highlight that despite the depths of despair and hopelessness people may experience when suicidal, surviving a suicide attempt can lead to the development of internal strengths, coping skills and a new mind-set that can help them to recover and grow. Half of the participants talked about the importance of research that examines people's lived experiences – they hoped their stories might help others who have been or are suicidal.

I guess the other thing I probably would like to say is that . . . even where I am now, even though I know I'm a lot stronger, it's not that I have any expectation that I'm not going to go through really painful times in my life anymore. In fact I expect that I will. You know, because life does have those times when we are not in control even though we like to think we are. But what I do know is different, is that I know I can survive them and I will survive them. You know that you can actually survive these things and be a stronger, more whole person as a result of surviving.

Alison (50)

I think the biggest thing for me is I'm stronger than what I ever thought I could have been, to have got out of that situation. I think it reinforced to me that it's important that I am honest with telling loved ones you know how I'm feeling. And before it gets to that stage of any thoughts at all of suicide, I think it's important to tell someone that you love.

Margaret (42)

Yeah. I mean, aside of all the usual stuff, I've learned to be more aware of my own emotional state and stuff like that. I've learned about my weaknesses. I'm terrible at communicating which is a real problem. And I can get through a lot, and that just because I feel suicidal, it doesn't mean I have to kill myself.

Meghan (19)

Important messages from the participants

Spontaneously, half (16) of the participants made a point of highlighting a particular message that they wanted to get across. Of these, the most commonly mentioned was to remove the stigma around suicide and mental illness (7) particularly in relation to the assumption that suicide is a selfish act or attention-seeking. Others thought that the most important message was that services need to improve and become more accessible, responsive, affordable and genuinely caring of the people who present to their door. Providing resources and education to families and friends so they know how to best provide support was also raised as an important message.

I guess that it can happen to anybody. I think it doesn't matter if you've had a fantastic upbringing, or if you've got everything in life that you want. It can change in a moment and that anybody can be affected by it.

Kelly

I think the main thing is just sometimes for some health professionals, particularly like those in emergency and even some psychiatrists, to actually take people seriously, because sometimes it all seems to be that, you know, unless you've actually kind of got the scars to prove that you have done something . . . it's just sometimes they don't seem to understand that . . . even though you can express quite well how you are feeling and what you are going through etc, that you really need help and you really need to be in a safe environment and to be taken seriously.

Martina (42)

I guess like the reason why I had decided to participate in this research is – what I would like to see change – is more follow-up, because the difference between my cousin and I was, I had a lot of good support networks with me at the time. But with my cousin, he didn't want anyone to know. And the follow-ups weren't very frequent, and he left the hospital after like two weeks and he tried to kill himself while he was in there twice, and they still thought that he was OK to go, and from what I got told from my aunt and uncle they only followed up once. And that was only two days after he was let go.

Tessa (25)

I don't know, more of kind of education and understanding, for spouses or family. My partner had no idea that my improvement of mood was due to the fact that I've made a decision that I wanted to die and I was going die. So he didn't know that that was a warning sign . . . so he found that quite challenging at the time, that he didn't feel like there weren't any resources, at least none that he could find, that would give him the tools to be an active participant in my ongoing safety and recovery.

Maria (35)

I think it's watching for signs, if that makes sense, and not for reasons. I think people often think, 'Well nothing's happened for this person, nothing challenging has happened, so they couldn't be in that sort of catastrophic state.' And I think people can be in that catastrophic state even though nothing in particular or of great importance or a significant challenge has happened.

Liz (47)

Conclusion



Conclusion

The results of this study add depth of understanding to the lived experience of having attempted suicide, particularly to what can help or hinder those who attempt. The results mirror themes found in several earlier studies, especially around the complexity of factors that lead people to suicide and the accompanying intense pain and feelings of hopelessness and burdensomeness. They highlight two reasons why health services are so important to people's recovery. First, health professionals can play such a positive role in helping people understand and manage their suicidal thoughts and behaviours. Second, if professionals and services fail to engage with people in a way that validates, supports, and follows them up, such interactions can become a huge barrier to seeking further professional support and can increase people's feelings of worthlessness.

Being understood and accepted by people in the wider community is also crucial. Negative attitudes about mental illness and suicide can prevent people from speaking out about their feelings. However, the care and understanding of family and peers cannot be underestimated. When carers are adequately educated they can play an important role in helping individuals to monitor their mental health and link them with professional supports. A resounding message is that people who attempt suicide can recover and those who have survived an attempt are often stronger and more resilient. As Alison says:



A lot of people think that – people who don't understand or people who are in the midst of it – think that having a mental illness or feeling like committing suicide or even trying to commit suicide, that it's a weakness. And my long-term experience is that it is quite the reverse – that to continue to survive, to continue to live with that much pain, especially if you don't have help, and adequate support – is it takes an enormous amount of strength.



The results highlight the variety of factors that can aid people in their recovery and the need to encourage a multifaceted approach to supporting those who have attempted suicide – one that does not just rely on a medical response, but also includes reducing stigma and isolation, peer support, empowering carers, and helping to improve people's communication about their suicide thoughts and feelings.

Recommendations



Recommendations

It is crucial that we include people's experience of attempted suicide in our research and suicide prevention efforts. Thankfully, there are a number of other such research projects being undertaken in Australia which together will help to give us a clearer picture of why people attempt suicide and what can be done to support them. Although the current research does have a limited sample size, we can still see a number of opportunities that warrant further examination.

Reduce the stigma of suicide and mental illness

An investment in programs that reduce stigma around suicide and mental illness in both the wider community and within health professions will have a strong positive effect on tackling the level of suicide in Australia. This report suggests that the stigma that people experience is one of the biggest barriers to them talking about their suicidal feelings and in engaging with health services. This is supported by findings in the WHO (2014) report that shows stigma to be a significant barrier to seeking help around mental illness and suicide.

- Opportunity 1: Education campaigns aimed at both the general public and health professionals to increase understanding about what leads people to suicide and to reduce judgemental attitudes particularly in regards to the assumption that; suicidal behaviours are attention-seeking and selfish, and that suicide and mental illness do not discriminate – anyone can be affected.

- Opportunity 2: An education campaign aimed at people at risk of suicide encouraging them to communicate their feelings with a trusted person and access supports – with clear information about where to find help and positive messages about the support that they can reasonably expect to receive.

Improve professional services

Lack of appropriate treatment was the single biggest barrier to people recovering after a suicide attempt. Conversely, access to appropriate professional support was the biggest factor that helped the majority of participants. Unfortunately many people experienced a range of difficulties in accessing professional support and there continue to be systemic problems. These include having access to limited options for care in rural areas, being considered too well to be admitted to hospital, experiencing stigma once in hospital, being discharged without follow-up or when still unwell, being exposed to individual professionals who are judgemental or who do not have the skills or capacity to support complex cases of mental ill health and suicidality.

- Opportunity 3: Undertake a comprehensive analysis on the pathways to care that suicidal people take, with particular focus on the barriers to accessing services, best-practice treatments and follow-up care.
- Opportunity 4: Work with hospitals to improve their admission and discharge procedures for people experiencing suicidal thoughts or behaviours so that they feel listened to and validated, and are given adequate and appropriate care.

- Opportunity 5: Work to educate all health professionals about the importance of supporting people who have attempted suicide with a focus on providing ongoing best-practice support (such as psychological therapies as well as medications) and practical coping and problem-solving skills.

Provide supports to families and friends

It is essential that family and friends be recognised for the huge burden of care they carry in support of people who struggle with suicidal thoughts and behaviours. So far in Australia, there are very few resources for the family and friends of people who attempt suicide. Among these are the *Guiding Their Way Back* booklet (Beyondblue, 2014) and the *SANE Guide to Staying Alive* (SANE, 2010). Both of these resources help to educate family and friends about what to expect after a suicide attempt and how to access supports. We need to ensure that this type of resource is easily available to the people who need it, as well as making available a range of other programs and ensuring that professional services adequately consult and involve families in the process of supporting people struggling with suicidal thoughts and behaviours.

- Opportunity 6: Review existing supports for families and friends with an emphasis on how current resources can reach those who need them and how other types of programs, such as support groups, skills based education workshops or respite programs may be developed and implemented.
- Opportunity 7: Review the process by which family and friends are involved in the professional treatment and follow-up of people struggling with suicidal thoughts and behaviours with specific emphasis on the communication and assistance offered to them in support of the unwell individual.

Continue qualitative research in this area

It is essential that we continue to listen to the experiences of those who have attempted suicide in order to more deeply understand their experience and give them voice in our suicide prevention efforts. Although the experiences of people who attempt suicide is slowly gaining more interest from a research perspective, it is important that we continue to examine this area so that we can more clearly define what it is that will help others in a similar situation.

- Opportunity 8: Continue expanding narrative-based research into the historical and contextual factors that influence a person's decision to end their life, with particular interest to how resilience helps to protect them from suicide.
- Opportunity 9: Conduct research investigating the barriers that prevent people communicating about their suicidal thoughts and feelings.
- Opportunity 10: Continue to examine the pathways to recovery, including how people increase connectedness, insight, and problem-solving skills.

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Appendices

Appendix 1: Suicide Attempt Research Screening Tool

Question	Answer	Exclusion/Inclusion
General Screening		
Over the age of 18?	Yes	Included in study
	No	Excluded from study
Have you attempted suicide before?	Yes	Included in study
	No	Excluded from study
How long ago was your most recent suicide attempt?	More than six months ago	Included in study
	Less than six months ago	Excluded from study
Do you feel comfortable talking to me about your experience of suicide?	Yes	Included in study
	No	Excluded from study
Do you have a doctor, psychologist or other health worker who you see for support?	Yes	Included in study
	No	Included in study only if no suicide risk detected
Have you been diagnosed with a mental illness?	Yes	Included in study
	No	Included in study
Suicide Risk Assessment		
In the last 30 days have you experienced any suicidal thoughts or feelings?	Yes	
	No – Finish screening questions	Included in study
Have you thought about a plan for taking your life?	Yes	Excluded from study
	No – Finish screening questions	Included in study
Can you access the means for carrying out this plan?	Yes	Excluded from study
	No	Excluded from study
Do you have a time frame for carrying out this plan?	Yes	Excluded from study
	No	Excluded from study

Appendix 2: Interview Questions

1 How long ago was your most recent suicide attempt?

Was that the first time you had attempted suicide?

- If not, at what time in your life have you experienced suicidal thoughts or actions?
- Have you ever attempted suicide soon after (within 3 months of) being in a hospital or inpatient unit?
- If yes, was there any connection between that suicide attempt and your stay in hospital?

Now thinking about just one suicide attempt:

2 Can you tell me what led you to wanting to end your life?

- Did anyone know about your plans?
- Did you specifically tell anyone about your plans?
- Did you reach out for help from a friend, family member or colleague?
 - ⌚ If yes, how did that go?
 - ⌚ If no, why not?
- Did you get any professional help from a doctor, counsellor or other health professional?
 - ⌚ If yes, how did that go?
 - ⌚ If no, why not?
- Is there anything you think would have stopped you from trying to end your life?
- How high was your expectation that you were going to die?

3 What happened immediately after your attempt?

- Did you get medical assistance?
 - ⌚ If yes, how did that go?
 - ⌚ If no, why not?
- Have you had any psychological help since your suicide attempt, such as therapy or counselling?
 - ⌚ If yes, how did that go?
 - ⌚ If no, why not?
- Is there any person, professional or service that particularly helped you after your suicide attempt?
- Is there anything particular that happened after the suicide attempt that you felt made things worse?
- Is there anything that you think should have happened to support you after your attempt?
- Did this happen?
- Do your close family and friends know about your suicide attempt?
 - ⌚ If yes, how did that go?
 - ⌚ If no, why not?
- Do you think things have improved for you since the attempt?
 - ⌚ If yes, in what way have they improved?
 - ⌚ If not, why do you think things haven't improved?
- Have you had any help in finding supports or have you done that on your own?

4 Is there anything that you have learned about your own strengths from your suicide attempt?

- If you knew someone in the situation that you were in (of contemplating suicide) what would you say to them?
- Is there anything else that you think is important for us to know about suicide attempts from your perspective?

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