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Commissioned Research Report

Exploring the Meaning of Recovery from Recurrent Suicide Attempts

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Executive Summary

A Psychosocial-Psychoeducational Intervention for Suicidal Young Adults: A Pilot Project, is a qualitative study undertaken to develop a grounded theory of successful transition from higher to lower risk of suicidal behaviour for young people with recurrent suicidal behaviour and the meaning that this transition held for clients. Participants had completed at least one cycle of the 20 week outpatient group program Psychosocial-Psychoeducational Intervention for People with Recurrent Suicide Attempts (PISA) and were between the ages of 18 yrs and 25 years at the time of their participation. .

A qualitative Grounded Theory approach was used to investigate the transition away from recurrent suicide attempts. We used a criterion convenience sampling strategy (Patton, 1992). Qualitative interviews were face to face and transcribed word for word. Quantitative interviews provided an overview of symptom severity in the areas of identified deficits for people with recurrent suicide attempts. Ethics approval was obtained through St. Michael's Hospital Research Ethics Board.

Sixteen young people participated in the qualitative interviews and 15 completed the quantitative measures. Participants showed improvements in all areas of previously identified deficits when compared to baseline measures completed while they were in the group. Significant changes were attained in the areas of alexithymia, depression, hopelessness, satisfaction with life, and impulsivity. A secondary analysis of the quantitative measures examining childhood maltreatment and the relationship to suicidal behaviour was completed by Hayley Eisenberg, a Master in Science candidate. Her study showed that increasing frequency of moderate to severe abuse identified by clients correlated with an earlier onset of suicidal behaviour and a greater frequency of suicidal behaviours.

Transitioning from higher to lower risk of suicidal behaviour is a difficult task. Clients identified that the phenomenon of recurrent suicide attempts carries a core relationship with death that cannot be ignored. Transitioning from this relationship to developing a relationship with life/living often requires experiencing ambivalence and turning/tipping points. These seem to provide opportunities for awareness in a number of areas that the client must act on for the transition to lower of risk suicidal behaviour to occur.

The transition to lower risk of suicidal behaviours is possible and it is not a linear path. Experiences of childhood maltreatment can significantly impact the pathway to safer behaviour. Our model of the transition process offers a way to understand where a client might be in the process and possible intervention points where clinicians can intervene. Each client's understanding of death is unique. It is necessary to understand what death means for the individual client. Limbo or existence is an ambivalent place for the client where they are unable to know or commit to either living or dying. Awareness comes through a variety of experiences

and “turning points” and helps the client move away from limbo. Clinicians are well placed to take advantage of moments of awareness and to help them become turning points in the recovery process. It cannot be assumed that clients know what their choices are or how to access or enact them to live life more safely. Clients may require assistance to learn to identify and articulate their subjective experiences. They may also require assistance learning what choosing life or living means and what are realistic expectations and goals for living. Transitioning requires growth, change, and awareness in the areas of emotion, cognition, behaviour, and self awareness.

Background

In 2004, 480 suicides were recorded among Canadian youth aged 15-24 years (Statistics Canada: http://www40.statcan.ca/l01/cst01/hlth66a.htm, retrieved June 26, 2007). Persons with a history of parasuicidal behaviour are believed to be at 23 times more at risk death by suicide (Schaffer,1998) and this risk persists over many years (Jenkins et al. 2002). U.S figures report that there are between 8-25 suicide attempts to one completion (Moscicki, 2001), thus a potential of 3,840 to 120,000 youth may attempt suicide, in Canada, in one year. U.S figures estimate that for every suicide death there are 5 hospitalizations and 22 Emergency Department visits for suicidal behaviors. (http://mentalhealth.samhsa.gov/publications/allpubs/SMA01-3517/ch7.asp). This suggests a large financial burden on the healthcare system alongside the emotional worry to individuals, families and friends. Suicide attempts are much more common than death by suicide in youth. However, no surveillance system for suicidal behavior exists (CASP Blueprint, 2004). Psychosocial interventions targeting suicide attempters, although increasing in the past number of years, have not yet become well established. Research evidence identified a few interventions as likely having some efficacy (MacGowan, 2004); however, Skarbø, Rosenvinge and Holte (2004) suggested that adolescent life events seem to have an impact on young adult mental health despite having received early acute treatment for a suicide attempt. Furthermore, little is known about how young people experience healing from recurrent suicide attempts and what they find helpful in that process.

Within our community, as elsewhere, gaps exist in the provision of service for youth with recurrent suicide attempts. Practitioners working with these people can feel overwhelmed, anxious and frustrated. This can lead to the potential stigmatization of this population (Malone, 1996). The population of persons with recurrent suicide attempts warrants further attention as it has been suggested that multiple attempters have several factors that are attributed to an increase in risk for dying by suicide. Those factors include: a greater number of DSM-IV axis I diagnoses with an earlier onset of psychiatric disorders; elevated levels of suicidal ideation, depression, hopelessness, perceived stress; poorer social problem-solving skills; a history of childhood maltreatment; families histories of suicide attempts and psychiatric illness; and

alcohol and substance abuse issues (Rudd, Joiner, and Rajab, 1996; Forman, Berk, Henriques et al .2004; Rosenberg, Jankowski, Sengupta et al 2005). Despite a number of identified demographic variables and psychiatric categories as risk factors for suicide, the ability to predict individual suicides remains elusive. Risk assessments allow care providers to "place the person along a putative risk continuum, to appreciate the bases of suicidality, and to allow for a more informed intervention" (Jacobs and Brewer, 2004, p.4) How young adults understand their suicidality and what is required to help them move beyond the risk of suicide remains relatively unknown.

Suicide attempts, for the purpose of this discussion include behaviours where the clients report an intention to end their lives. Self injury in this discussion, refers the deliberate physical harm that was not with the intent of ending their lives.

Purpose of the Study

The purpose of this study was to develop an understanding, using a grounded theory method, of successful transition from higher to lower risk of suicidal behaviour for young people with recurrent suicidal attempts and the meaning that this transition held for clients.

Participants were young adults initially assessed for admission to "A Psychosocial/ Psychoeducational Intervention for People with Recurrent Suicide Attempts (PISA)" when they were between the ages of 18-25 years. The PISA intervention incorporates a multimodal approach which includes support and education in the areas of personal safety, emotional literacy, interpersonal relationships, and problem solving. The goal of the group is for clients to learn the skills necessary to decrease duration, frequency and intensity of crisis episodes involving suicidal and self injurious behaviours. Principles of the intervention include: validation of the struggle, hope, the client as "expert", solution talk, and realistic expectations (Bergmans & Links, 2002). Learning skills, discussion, support and the experience of "not being alone" with their problems appeared to be most meaningful for PISA group members at the midpoint of the intervention. Clients may have a different concept of efficacy than that of providers (Franklin, 2003).

Overall we believe that the resulting account of transitions by young people with recurrent suicide attempts will inform future treatment approaches.

Methods

Eligibility criteria for participation in the study included completion of at least one 20-week cycle of the PISA program, age at initial assessment was 25 years or younger, and the individual reported a lifetime history of two or more suicide attempts.

Of thirty-three young adults who were eligible to participate, five had moved out of province, two had died by suicide, six did not respond to attempted contact or could not be located. One individual with a serious drug addiction was removed from the selection list because the person was judged too impaired to be interviewed. The remaining 19 clients were contacted through their previously identified preferred means of contact: 10 by letter through regular post, 7 through e-mail, and 2 by telephone. Each participant received a follow up telephone call with a thorough description of the study and an invitation to participate. Interviews were arranged based on the availability of the client. One client cancelled the interview and was subsequently unable to be contacted. Two refused and 16 who had graduated from the intervention from 6 years to 6 months prior to their interview agreed to participate in this study. Prior to the qualitative interview, the study and consent were explained in a face to face meeting with our research co-ordinator. Consent was signed if agreement to participate was obtained. Ethics approval was granted by the St. Michael's Hospital Research Ethics Review Board.

Quantitative

The quantitative measures included: a.) The Structured Clinical Interview for DSM-IV (SCID I and II; Spitzer et al., 1995); b.) The Parasuicide History Interview (PHI; Linehan, 1996); c.) Beck Depression Inventory (BDI; Beck et al., 1961). d.) Beck Hopelessness Scale (BHS; Beck et al., 1974); e.) Barratt's Impulsivity Scale (BIS-11; Barratt et al., 1997); f.) The Toronto Alexithymia Scale (TAS-20; Bagby et al., 1994; Taylor et al., 1990); g.) Problem-solving Inventory (PSI; Heppner, 1988; Heppner and Peterson, 1982); h.) The Childhood Trauma Questionnaire (CTQ; Bernstein & Fink, 1998). Assessments were given by a trained research co-ordinator. Quantitative data was stored and analyzed using in SPSS 15. Despcriptive and paired sample t-tests were used to analyze data in this study using the SPSS 15 software.

Qualitative

This study employed a qualitative Grounded Theory approach to investigate a complex social process (Lee, 1999). Grounded theory is the most appropriate methodology for data that is conceptually dense and involves social processes (Strauss and Corbin, 1992; Glaser, 1992).

Sixteen interviews were conducted by the Principal Investigator (PI) (YB). Participants were informed in the invitation, consent process, and initial interview that the primary goal of this study was to learn from the "experts." Hence their role of "client as expert" was consistent with Lofland and Lofland's (1995) recommendation that the interviewer's role was exclusively as "learner" and with the approach used when they participated in the intervention. Interviews were held in the office of the PI (YB) and lasted 45 minutes to 2 hours. Initially, interviews followed a loose guide based on the interviewer's experience with this population and the recovery literature. The interview focused on the predetermined theme of recovery through a conversational style and participants led the discussion into the areas they identified as important (Patton 2002). A general statement asking participants to reflect on how they remember themselves prior to beginning the PISA intervention, where they see themselves at this point and what contributed to their getting to where they are today was how the interview began. All participants were asked what they took away from their experience of the PISA intervention whether it was good or bad.

After several interviews had been transcribed verbatim, the research team (a social work clinician, bioethicist, two psychiatrists, a PhD candidate research coordinator, a PhD candidate in medical anthropology fellow, and master's student) met to discuss emerging concepts, lines of further exploration in future interviews, and compared the most recent interview(s) from the ones previous. These discussions assisted in the modification of the interview guide to pursue emerging lines of inquiry. The analytic approach in Grounded Theory begins with data collection and continues after all the data are collected. The approach involves 3 main steps: (i) open coding, the process of breaking down, examining, comparing, conceptualizing, and categorizing data; ii) axial coding, the process of re-assembling data into groupings or categories based on relationships discovered in the data; and (iii) selective coding, the process of identifying and developing the central phenomenon as indicated by the data. Each "step" involves constant comparisons of new data with existing data (Rosenfield P.L, 1992). This comparison was done by individual readers followed by team discussions to compare and challenge concepts, codes and points of view.

Several variations of a model began to emerge. Once there was a structure to the models, subsequent participants were invited, at the end of their interview, to identify if the draft models matched their experiences. Elaboration or changing the concepts or aspects of the model was encouraged. Saturation was reached when all readers identified they were learning nothing new from interviews and participants were not identifying any changes in the models. This suggested that data collection could stop as categories in the models seemed dense and complex enough to capture all of the variations in participants' experiences (Fassinger, 2005). However, Strauss and Corbin (1998) caution that saturation is a matter of degree and, if the

data were to be mined further, the potential of finding more dimensions and properties to investigate does exist.

After the participant feedback was integrated into the model, the Community Advisory Panel (CAP) members were invited to share their feedback, expertise, questions, and offer suggestions regarding the next phase of the analysis. The 5 CAP members included careproviders from local shelters and former PISA clients above the age of 25 years. This approach helped to enhance the trustworthiness by ensuring that the findings were appropriately grounded in the study data and that no single perspective monopolized the conceptualization and interpretation of the data.

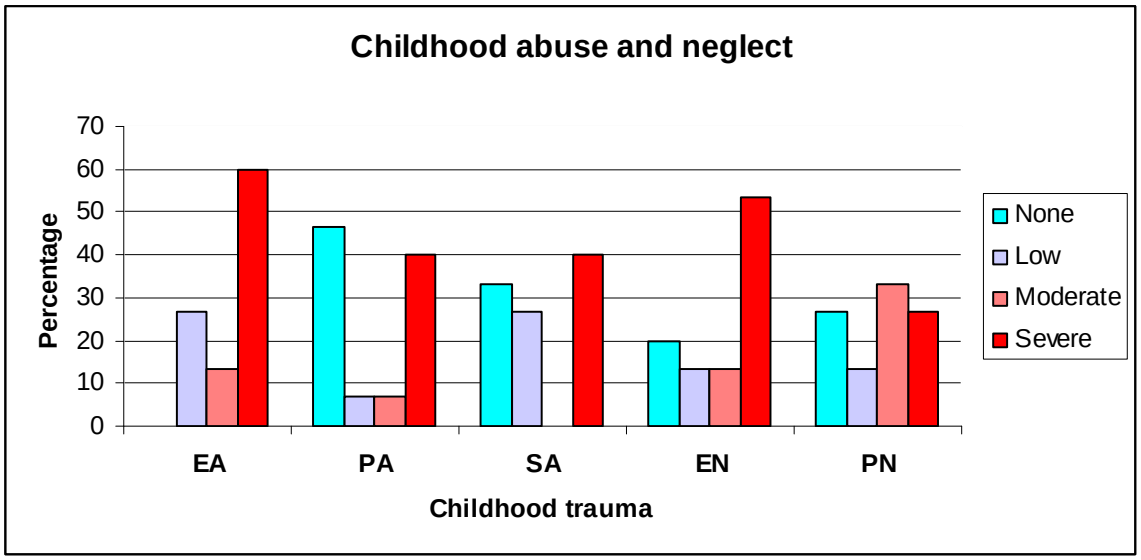
The writing of the narrative of the research included all team and CAP members participating to further the analytic process. Data was managed in the qualitative research software NVivo7.

Results

Quantitative

Two men (12.5%) and 14 women (87.5%) participated in the interviews. One person did not return to complete the quantitative interviews. This discussion will focus on the 15 who completed the measures. The mean age of the 15 participants was 25.75 years (SD=3.31) and their age range from 20 years to 33 years of age at the time of the interview. When initially interviewed for acceptance into the PISA groups, the participants ranged in age from 18 to 25 years with the mean age at that time being 22.31 years (SD=2.35) (see table 1for distibutions).

Nearly all participants (93.3%) are not married and 20% (3) live on their own, with 33.3% (5) living with a family member or partner. Another 33.3 % (5) live in subsidized, shelter, supportive housing environment. Three (18.8%) of the participants completed high school, 25% (4) had some university or college education, 3 (18.8%) had a university or college degree and 33.3% (5) completed grade school. Currently five (31.25%) participants are in school either full or part time. Nine (60%) receive financial support via disability benefits or income assistance and 73.3 % (11) are currently unemployed.



A secondary analysis was completed by Hayley Eisenberg as her Master in Science Degree thesis of the quantitative measures examining childhood maltreatment and the relationship to suicidal behaviour. Her study identified that a significant positive relationship was found between the number of forms of abuse and the number of suicide attempts reported ($r = .651$, $p < .05$). In addition, there was a statistically significant negative relationship between the number of forms of abuse and the age of onset of attempts ($r = -.555$, $p < .05$). This suggests that the increased number of forms of abuse results in an earlier age of onset of attempts, perhaps increasing the number of attempts made. A series of Pearson correlations were performed to investigate the relationship between suicide attempts and a history of childhood trauma. There was a statistically significant relationship between the number of suicide attempts and the severity of emotional abuse ($r = .667$, $p < .01$) and physical abuse ($r = .598$, $p < .05$), as well as a positive linear trend with emotional ($r = .495$) and physical neglect ($r = .531$). There was no statistically significant relationship found between the number of suicide attempts and the severity of sexual abuse ($r = .421$).

SCID I& II diagnostic results concurred with previous literature suggesting that people with recurrent suicide attempts are likely to have several comorbidities (Rudd, Joiner, and Rajab, 1996). All clients reported between 2-9 diagnoses within their lifetimes and only one participant was found to have no current axis I or II pathology. The most common lifetime axis I diagnosis was depression (86.7%/13) followed by panic disorder (60%/9), alcohol abuse (46.7%/7) and post traumatic stress disorder (PTSD) (46.7%/7). The most common current axis I diagnoses included PTSD (26.7%/4) and social phobia (20%/ 3). The most common axis II diagnosis was

Borderline Personality Disorder (BPD) (73.3%/11) followed by ¬¬¬¬Avoidant Personality Disorder (APD) (46.7%/7) and Antisocial Personality Disorder (ASPD) (20%/3).

Since completion of group, participants identified a change in their behaviours, believing that their behaviours had decreased either in duration, intensity or frequency. Table 2 identifies the distribution of suicidal behaviour as identified at the time of the study interview.

Symptom measures show a continuous decline when comparing time one (time of group participation) scores with those at the time of the study interview. As indicated on Table 3, statistically significant differences are noted when comparing measures of alexithymia (TAS-20) , depression (BDI), hopelessness (BHS), impulsivity (BIS-11), and satisfaction with life (SWLS) prior to attendance of the PISA group intervention program and at the time of the current study.

Table 3
Symptom Measures: Time One (group participation) to Time Two (current study interview) t-test Analysis

	Time 1 Mean score	Standard Deviation Time 1	Time of Study Interview Mean score	Standard Deviation Study interview	Sig (2 tailed)
Toronto Alexithymia Scale (TAS-20)	63.43	11.33	50.84	11.12	.008
Subscales:					
Difficulty Identifying Feelings	24.73	6.50	17.38	5.39	.003
Difficulty Describing Feelings	19.15	5.06	16.15	3.48	.086
Externally-Oriented Thinking	19.53	4.48	17.30	4.81	.198

Problem Solving Inventory (PSI)	116.75	26.18	102.25	23.71	.108
Subscales:					
Problem solving confidence	38.75	9.28	29.33	7.73	.006
Approach –avoidance style	60.60	11.64	52.3	14.04	.049
Personal Control	24.16	3.61	19.66	4.73	.014
Beck Depression Inventory (BDI)	38.76	11.27	5.53	10.93	.000
Beck Hopelessness Scale (BHS)	13.0	4.77	5.3	4.45	.002
Barratt Impulsivity Scale (BIS-11)	75.11	7.26	67.12	11.31	.078
Subscales:					
Non-planning	29.14	5.60	25.55	5.98	.196
Motor impulsivity	25.69	4.21	22.37	4.40	.121
Attentional	18.44	3.00	15.33	4.58	.015

Impulsivity					
Satisfaction with Life Scale (SWLS)	11.5	6.89	19.0	6.64	.015

Qualitative

Clients identified transitioning from recurrent suicide attempts in complex and individualized terms. Through interdisciplinary team discussions, transcript analysis and further team discussion, three "models" emerged from the initial data (see appendix 1). The Community Advisory Panel members advised that model #3 had the most direct clinical utility and model # 1 seemed to describe the variety of paths encompassed in the process in Figure 1. As the narrative analysis process began, this model was transformed to Model #4 which this report will focus on. Our emphasis is on developing theory that gives rise to clinical utility. We are aware that both secondary analysis and future work may alter this initial model to one more specific and detailed.

These participants under the age of 25 struggle with repeated encounters of near death by suicide. The model deals with their movement from "living to die" to "dying to live" (int. 15:712-714). As our respondents reported, "living to die" held many meanings, yet our analysis brought to light four major facets of the process moving from "living to die" to "dying to live." The facets are discussed next: a. suicide/death; b. moving away from death; c. tipping/turning point and d. awareness.

A. Suicide / Death

The meaning of suicide and death seemed to fall into three categories: "suicide as mistress" (15:100), purposes such as "to never feel again" (2: 461) and as an identity. (13:226).

1) Suicide as mistress

"*Suicide was uh (sigh) my mistress (laughing) oh (sigh) as long as I can remember it was just the best idea to end everything, it was my solution for all.* (15:100).

Most clients in this group reported believing and wanting to die from young ages, *"all through my childhood I always kept saying you know I want to die, I don't want to be here, um*

I wish I was dead" (16:464-465) with nothing but death potentially offering any relief from the intensity of their pain:

"*I wanted to die. I didn't see any way that I was going to sort out anything that was going on I was in so much pain, and I was sick of it. I didn't see any particular reason why I should put up with it, it wasn't changing, it wasn't getting better slowly ,it was getting if anything worse, more intolerable, more intense, I couldn't do anything to get rid of it, and there was nothing that was holding me (4:208)*

"The mistress" offered comfort as explained by this client:

"*in my day to day life the only little bit of comfort or joy that I was able to get was through interpreting life through death um and I got really good at that. I could see a string on the floor and I'd be like "oh that reminds me of a noose" you know and like everything was seen from the context of suicide and death and that would kind of make me smile and be like "okay this is this is still possible, this is my way out, this is something that I can still control"(12:108-111)*

Having little or no control of the outcome *"that no matter what I did my destiny was almost preordained I guess that this was it was beyond my control* …" (12:85-87) furthering that: "*the increasing anticipation that there was an end and I was taking action to move closer to it. Life was an intolerable sentence, an entrapment to be endured as long as necessary."* (12 addendum: 41). For another client, the "mistress" was not an end rather, something to hold on to as,

"*an option you know,..like well if everything gets bad enough then maybe I could you know find my way out through death" (14: 509)*

2) Purpose / To Never Feel Again

For many clients, suicide and death were meant to deal with "the pain". A group of participants expressed that suicide and death were almost exclusively related to the eradication of the emotional intensity or to communicate the intensity they were experiencing:

"*suicide would be to never feel it again…because it becomes so intense you know, it's like um it's like a you get this feeling and you just want to burst out of your own body um the emotion gets so high.." (2:461)*

When using suicide as a means of communicating the intensity of their distress, death was, in and of itself, not the purpose rather, it was an attempt to communicate not knowing how to live differently or deal with the emotional intensity of their lives: " *suicide attempts before were just crying out with ..with with saying "I don't know what to do someone help me*" (7: 357). For another, *"I think I just wanted to stop hurting, I just didn't want to feel I mean because all I ever felt was pain I didn't feel anything positive (13:205)*

Two clients identified that suicide would be revenge, not only to get away from the pain they were feeling, but also to communicate the message to those whom they identified as incurring that pain:*"I thought that by killing myself it would be the best revenge for what my parents did to me."(9: 178)* with another identifying that the goal of being dead would be, "*so I could you know look back and uh like over them and be like "ha ha ha look what you did" (14:523)*

3) As an Identity

"*I was going to die by suicide either by the time I was sixteen or by the end of high school and when you tell yourself that so many times it becomes so integrated, you know that you not only believe it but it becomes a promise to yourself and so every time I failed an attempt I wasn't just failing myself I was failing that promise you know which really became my whole purpose and identity" (13:220)*

Many clients identified worthlessness or non-deservedness as significant contributors to their belief that ending their lives was the preferable, "*I saw myself as being completely useless, completely pointless, causing more harm than good, there was no reason for me..any of me*" (7:381) When a person believes themselves as unskilled and worthless, ending one's life was the only option for the betterment of themselves and those around them.

"I'm everybody's problem, in everybody's way, if I'm dead everyone will be happy because I'm just a disaster, I don't contribute to society, I can't work, I can't do this and how can this be not my issue if I'm everything, I'm in the way of everyone you know. Going to the hospital is a guilt, I'm taking someone else's bed, I don't deserve that let me die …" (4:244)

B. Moving Away from Death

> *"I was kind of stuck in I was too scared to die and I was too scared to live so I was like in this like limbo area…and that really kind of you know really you know really screwed me up and the hurting became more severe like" (14:582)*

Moving away from death was identified as frightening. The movement can include

transitions, "pockets", stages, phases or a series of life events. Coming to consciously choosing to live was identified by clients in the following: *" I didn't know how to live and it suddenly I think scarier and harder to live than it is to die..and it (dying) was just all I knew…" (13:218).*

One client identified herself as "*transitioned*" going from "*being a taker and a and a hurter and a stealer and just evil, basically evil personified*" (7:1114), identifying that she did not understand what life was, nor did she have the experience of people who could teach her what

life is. Transitioning requires an arduous process from actively trying to die or thinking of death through a period of "limbo" or "existing" to consciously deciding to connect with living. This can be a fearful process when suicide and death have been one's mistress, identity or only coping strategy.

One client remarked: *"awareness is a curse"(10: 332)* to identify that when she became aware that something differently could be done, she had to make a conscious and reflective choice whether she was going to commit to keeping herself safer and weighing the choices: *"...then it became a bit of a battle in my head for a little while…"* (10:335)

The transition to living was identified as a challenge and struggle. The in-between place was described by words such as "existing, "limbo" and "grey"; a place that one must consciously and actively choose to leave, recognizing that thoughts and memories of "living to die" may remain as part of the struggle for some time through the journey.

> "*So from when I came here as I remember I was in a very black, black black spot, death was the only thing I can remember, now I can see the grey, it's not completely white but there's grey.(3 :1805)*

> *"I: where are your "wanting to die" at these days? P: mm (sigh) I have it locked up in the cupboard (laughing) because uh it's still there sometimes, I haven't I I know I haven't gotten to that point in my healing journey where I can say it's not there anymore." (7:1896)*

C. Tipping / Turning Points

Some clients identified that being on the brink of death, either intentionally or not brought them to the awareness that they, even if they did not know if they wanted to live or not, came to understand that they did not want to actively die at this point in time.

> *"As I sat staring into the thunderstorm, I felt elated! I expected to drift off to sleep quickly to find the freedom in oblivion I longed for. I congratulated myself, I had finally executed the prefect suicide…I had succeeded, I was a success and in those moments I finally felt happiness. But I did not loose consciousness right away. I did not expect to feel my body struggling to live. Betrayed once again by my body! Only then did I feel fear as my heart started pumping faster and harder then any amount of exercise could account for while I sat still, staring into the storm. This was not what was supposed to happen, I was not supposed to feel any of this! The rest is a blur, a long corridor, trying to talk and not being able to, or not being heard. Someone tried to take my blood pressure but I was shaking uncontrollably. My cheek on the cold floor, and someone was telling me to go*

> *back to bed, because I was a fire hazard. I was all alone. I remember thinking that that was the last thing that anyone would ever say to me. This was not the freedom I was looking for in my last moments; I did not want to die on a floor. For the first time in my life I felt a whole other level of trapped. Unable to effect any change, I had no choices left...that really bothered me for some reason. The discrepancy between gently floating away in happiness and lying on a cold floor, a fire hazard, was too starkly contrasting from my "perfect end". I had failed to actualize my ideal of death, and in that moment of final endings, I knew myself to be indisputably a failure in all capacities. I think I made it back to my room. I lost consciousness believing I would die and finally not wanting to but unable to do anything to stop it."* (12:52)

Some clients identified that it was through experiencing the death or death wish of another person that they were able to connect with the impact of their actions on others. *"…and it kind of made me realize that how awful that must have been for them and then so so I had to help her through that so um I don't know it just little things like that had made me realize how like precious it is to live"(16:587).* Moving away from death was difficult and was identified as requiring a "buffet" (4:1958) of concepts, skills, insights and awarenesses, unique to each client. Tipping/turning points occurred through a series of awarenesses that could be gradual or starkly obvious.

D. Awareness

Participants identified that through participation in the PISA program, other programs and through their journey, awarenesses across multiple levels were significant for them in their process. They identified the most relevant awarenesses included: i. learning that there were choices, ii. learning that feelings were a part of the human experience and they needed to learn to identify them and tolerate them; iii. learning skills and concepts to keep themselves safer; iv. discovering that they had connections and relationships with people who truly cared about them-family members or significant therapeutic alliances and ultimately, v. learning that they either had something to live for or they had something to contribute.

1) Choice

Choice needed to be brought to awareness. It presented itself in many forms, each unique to each client- to live or die, to call for help or not, or to choose to tolerate the present agony recognizing that intensity may dissipate. Participants identified the profound effect that realizing there were choices:

> *"… I never felt as if I had any choices, … and learning that I had choice over really everything you know in my life was so important …so I think recognizing that there was a choice there gives you some amount of freedom …. gives you like a sense of control."(13: 251-259)*

> *"the main thing is the array of choices that you guys presented, … but for me it was the volume of choices that finally convinced me that I did have one …once you have like an entire buffet table … you can't still say you have no choices, you can say you don't like any of them but (laughing) you can't say they're not there" (4:1954-1961)*

Choosing to consciously live is not, for some, a natural desire and flies in the face of their lived experience, events they have survived, beliefs they have about their unworthiness, and believing, from a young age that their lives are not worth anything:*"..making the choice to live is going against everything you know I've told myself for eight or nine ten years" (13:231)*

To ask for help or to not ask for help is a choice. The clients identified that asking for help was a new option and skill not previously utilized. For one person, the reasons primarily related to her sense of self.

> *"It's not easy because there's days you're so vulnerable but the fact that you move from a victim and say to yourself "okay this is the situation, I don't have to be there I can move, you know I have choices now. I can seek help now." As in the beginning when I was back at your group I didn't feel that I could ask for help because I didn't feel I was worth of any help." (3:507-511)*

2) Feelings

Tolerating intense feelings is a struggle many clients identified as a precursor to attempting to end their lives. Participants talked about a number of components related to feelings that needed to come to light. The components which will be discussed further include: a. learning to tolerate feelings; b. fears about feelings and c. identifying feelings. As feelings were beginning to be seen as something identifiable, some participants talked about coming to a different understanding about their d. sense of self and e. recognizing the role of feelings leading to behaviour. As participants discussed their recognition of choices for behaviours in relation to identified feelings, they also began to mention their f. awareness of consequences of their behaviours. These components will be discussed in further detail.

a) Tolerating the Feelings

Learning that there were choices in how one can keep oneself safer while experiencing those feelings was something this client identified as a struggle in and of itself: Tolerance of the feelings was a concept to be learned.

"*Feelings have never changed, okay the extent of the agony before, during, after, never changed, my beliefs about whether I could tolerate it come and go, like I don't know probably group was the first time I ever considered tolerating it as like a viable choice like "why the heck would I want to do that?" but it's that whole it might change one day and then I'd really be screwed because even then I had to start to admit that there were even just small things that I actually liked about like what is the universe (*4:227).

Clients throughout the interviews identified their struggles with feeling feelings and naming them. The struggles included and continue to remain for some as, fear of the intensity, tolerating that intensity and an inability to name the components, or different feelings they are experiencing. For others, there was a parallel process that occurred in coming to understand feelings as a "human experience" and coming to a different understanding of "self".

b) Fear of the Intensity

Fear of the intensity of feelings kept many participants in the position of "existing". Participants discussed the need to be taught that feelings were feelings; part of the human experience and it was their choice in behaviour that would determine the outcome of those feelings, "*trusting myself that I can express emotions and not lose control cause that was one thing with me that I found that if I started crying I would never stop crying, if I expressed anger then I would go into rage and not be able to stop it*" (1:386).

"I see that um today I'm able to tolerate the emotions [tape unclear] feelings even so I don't like them and my first reaction is to escape and go cut, it's like this too shall pass, just wait, whether it's going to take two minutes, ten minutes, or half and hour to an hour it will pass if I just give it a chance. So that's a difference in my life" (3:345-348)

c) Identification

Identification of feelings seemed to allow for a different understanding of the role of feelings and offered a way to choose a way to tolerate the intensity more safely.*"I'm able to to to feel them a little even so their not comfortable still but I'm learning to identify and you know say "it will pass just give it time". (3:1057).* Other clients identified that "*the expanded vocabulary has done me well*" (10:858-859) and *" well I I knew what I was feeling you know what I mean but I didn't really know how to you know express it…I like*

*especially you know um it's really hard to name that feeling verbally and in front of people…" (*14: 1351)

d) Different understanding of self

Within the context of a supportive and accepting group of people with similar struggles, participants identified being able to see themselves in relation to others and this facilitated a variety of awarenesses or turning points:

"*I think it really truly started [tape unclear] realizing that I am not an outsider in the way I feel, and that was a big turning point. … once I accepted that and was able to start trying to identify feelings and emotions and understand that I'm going to be okay with that you know it was like I hit another level of awareness and and then I fell on my ass (laughing) quite a few times but I think there's a constant validation that you know it's okay to feel the feelings you feel…"(15:251)*

"and I can give myself permission to accept my feelings and accept my faults and all those things and that made a very big difference for me just in how I talk to myself ". (13:874)

"*group was a huge outlet cause it I got to express my feelings and you know be who I am"* (16:722)

"….on my way to group I'm like "they're not going to I don't know why I'm going I'm going to be there I'm going to be this freak and they're not going" to you know what I mean and if it hadn't of been for the acceptance and support you know what I might, some things might not have changed" (10:1179)

Other clients identified that participation in the group allowed them to see themselves reflected in the voices of others, lending credence to the understanding that they were not alone or seeing the progress they had made when hearing and or seeing others whom they saw as "*people who had it worse than me were smiling*" (2:230). One person identified that seeing others with similar struggles was "*too real*" (15:35) initially, then moving to feeling "*relieved*" that she was "*not crazy*" or "*not different*" (15:36)

e) Role of Feelings in Behaviour

Some clients identified becoming aware of the role feelings had in their behaviours

"I think that was actually part of the problem in all the group homes and in the hospitals is that it was always about the behaviour and as long as I could focus on the behaviors I wasn't looking at the reasons behind the behaviours and the foundations for them and I mean really I was acting out what I was feeling" (13:901-905)

"I still have my moments but I mean I'm learning to be more comfortable with myself, with your feelings.… and learning that it's okay to have feelings and not act out on them."(9:643)

" *sigh, I think it was about me getting my frustrations out and um me not knowing how" (6:97)*

f) Awareness of Consequences

A few respondents articulated that they became aware that they "*can't make people responsible for my issues and vice versa*" (11:1269) thus taking control and responsibility for their own feelings, choices, behaviours, and/or relationships. In becoming more aware, clients also identified taking the time to think about the consequences of their actions, consequences for themselves and/or for others.

Some clients identified having little memory of the intervention(s) they participated in, or not utilizing concepts or skills taught at the time until it had relevant meaning or they were able to integrate it into their lives. Others identified that they have little awareness of how they were able to bring themselves to the place of skills use outside of remembering "*it was hard*" (5:331). Awareness sometimes indicated readiness, and for others, readiness was an indescribable concept:

"I started listening to myself, to others around me, cause people have been telling me for a long time … and I refused to listen" (1:1403) "I think it would have happened anywhere, I was just ready for that and they just happened to be the ones that were around me to support me through that …." (1:419)

3) Learning New Skills

Clients identified that in becoming more aware, different skills and concepts were identified as helpful in moving away from death. These included a. diagnostic education, b. developing a "language"to communicate their distress, c.. boundaries, and d.. negative self talk.

a) Diagnostic Education

Participants discussed the need to become better educated regarding their diagnoses and symptom management. Not only was it important to learn that their identity and "self" was not their diagnoses, "recovery" for one person would in part, mean learning to manage her symptoms of depression (13:1132) however she:

"..*needed people to point out to me that I was not my depression. That I was not my eating disorder um to start to realize it."* (13:678-679);

b) Language

Respondents identified that learning the skills of language to identify and state what they were experiencing:

"*being able to identify and say "this is what I'm experiencing this" and and be direct and right to the point and they understand that, … before that I didn't know you know I'm going in and I'm not presenting it I I thought that I was presenting it well but I wasn't .. it ended up me not getting the treatment that I needed*" (10:800)

c) Boundaries

Participants identified that learning skills such as "not my issue":

"*yeah well, not my issue I like I mean I should be paying you money (laughing) I mean that's how often I use it now, or sometimes I say "not my problem"* (10:1187);

and "personal rights":

"*the first thing that I latched onto was the whole idea that I had personal rights, and I remember the first time I went through the session the whole deal with me was the fact that I had them*" (4:339)

d) Negative Self Talk

Some participants reported that highlighting the ways in which they spoke to themselves was important. They utilize this awareness to continue to try to be gentler with themselves:

"*stuff like constantly telling myself negative things like "oh I'm fat or you know or I because I'm fat no one's going to look at me and like me" and just like negative thoughts like and constantly putting myself down and I think now it's like subconsciously it's like as soon as I start to say something like I'll be sitting on the streetcar … like I'll think of something and I'm like "no" (laughing) I'm like "stop the negative repeating record now" (11:557)*

4) Learning About Connections and Relationships

Participants spoke of the importance of connections with people in their lives, professional and personal, learning how to develop a network, and setting realistic expectations regarding how to obtain help and support.

a) Professional

Characteristics of individuals identified as being helpful included *"Sincere…open" (2:922) "just having them listen" (5:561); "understanding" (6:69)*. Several people concurred that:

"*… I never had to guess, appropriate, not appropriate, good idea, not a good idea, acceptable way of acting, not. She was always up front and she was completely consistent"* (4:487)

"*everything in my life was just so chaotic and so unbalanced whereas I knew what to expect when I walked in there*" (1:1221)

The importance of therapists working with clients where the client is at was also identified as important..

"*she was able to let go of those goals and just let me work in therapy in my in my own pace … at first she was so threatening with those goals that she turned me off I didn't want anything to do with her, she scared me.*" (3:110)

"Being able to be real" (12:136) in a therapy session was important:

"*she made a very a very interesting choice to give me the space to be real without fear of consequence [tape unclear] um without ever condoning what was going on for me um what I wanted to do she was very um conscious of my need to have a space where I could connect with an individual*" (12:230-234)

Another facet to the client-therapist relationship noted by some, was the willingness of the therapist to work outside of the confines of the therapeutic hour, being available via e-mail, telephone or visiting while the participant was in hospital.

b) Family and Friends

Participants identified friends and family could be both significant in the progress of their journey or, they saw it as imperative that they terminate relationships to continue their transition from death.

"*I: what are the most significant pieces of your journey do you remember? The things that have helped move you a place that's further along.*

*P: people that believed in me, that stuck by me."(*9:651-654)

"*so for me to have to to build a life for myself to see a future for myself to see that there might be hope for me I can't be part of her life*" (3:2084)

Further, participants described finding friends who are "*not friends based on crisis or anything like that.*" (1:689) as being significant in their transition.

5) Learning to Contribute

When participants reported believing they had a future and recognizing that they were doing better, they identified having something/someone to live for and/or saw themselves as having something to contribute:

" yeah yeah I don't want to be miserable anymore (laughing) … I don't want to really be sad anymore, at least not so sad that like I can't do anything, …. I think the next stage is to find something a little closer to what makes me happy" (11:2224)

"I want to do something for uh to help my people." (9:1094)

POCKETS/PHASES/SECTIONS/STEPS: The Nature of The Process

Each client had a unique perspective on their journey toward living, what it meant, how to get there, and where they are now. For one person, the journey was a series of "*pockets of recovery*" (1:1070) and for another it was:

"… phases …they're like sections of my life where it's like "okay that section's over now, now I'm in a nicer section… where I feel better like I don't feel as suppressed and and ….I don't want to hurt myself on purpose (11:145)

Clients saw moving toward life from the concrete: "*"learning skills and how to live your life with healthy skills" (10:75);* "*to be able to do daily tasks*" *(8:695)* to finding out who they are and what they are capable of; accepting who they are and tolerating the intensity of emotions "*to be more comfortable with myself and your feelings… it's okay to have feelings and not act out on them" (9:643).* Participants identified the process of transitioning very differently from one another with no two participants offering the same description or pathway:

"I'm like a colouring book, black and white pages but every day I fill in another picture or a piece of a picture with colours" (15:416)

"living a life that is really mine by the choosing, not by what society deems successful" (12:715)

Reconnecting with family, developing boundaries and making a choice to actively work on the relationship was part of the "steps" for this client: "*I decided I wanted them to be proud of me*" (11: 1116) "Dying to live" meant that she has to "*fight the demons every day, so that you see*

tomorrow…step by step, moment by moment" (15: 714-722) relating that the process is *"easier said than done obviously*" (15:726) Most clients echoed the difficulty, the "*ups and downs*" (1:1927), the "*back and forth*" (9:607) the process requires:

> *"okay maybe it's like I go down and then I go and I do better and I come back and then I go back down and then I come back" but now I think it's like there's it's a shorter drop down now (laughing) (11:925-928)*

Recognizing the multiple issues and complexities to her life, one participant remarked that her process was "*conquer them one by one it's like having a heavy back pack (laughing) and you take out one book at a time until you can carry it " (15:501-502)* and another client reports change *"sneaking up on her" (9:48)* and it taking *"small steps*"(9:1132).

Discussion: Quantitative

This study of young adults with a history of suicidal behavior provides a better understanding of the transition, both quantitatively and qualitatively, from a higher to lower risk of suicidal behaviour. The young adults reported a significant increase in their satisfaction with life and a significant reduction in depression, hopelessness, alexithymia, and attentional impulsivity in the Barratt Impulsivity Scale since initially beginning the PISA intervention. It has been noted in other works that over time, symptomology and behaviours including suicide attempts and self injury do decrease over time however, identifying the precise ingredients leading to these changes remains unknown. (Bales, Grijzen, Verheul, Andrea, Smits 2007; Davidson, Norrie, Tyrer,et al. 2006; Korner, Gerull, Meares, Stevenson, 2006, Linehan, Comtois, Murray, Brown, et al. 2006)

Participants reported two or more lifetime diagnoses which is consistent with previous literature identifying people with recurrent suicide attempts as potentially distinct from the group who have attempted to end their lives by suicide once (Rudd, Joiner and Rajab 1996; Horesch, Orback, Gothelf, et al 2003; Brown, Have, Henriques et al. 2005; Forman, Berk, Henriques, Brown, Beck, 2004 Ystgaard, Hetetun, Loeb et al. 2004; Michaelis, Goldberg, Singer et al.2003.) All participants had suffered one or more kinds of child maltreatment. The group of people with recurrent attempts have been identified as having greater symptom severity, greater comorbidity, and often have a history of trauma and abuse, and substance abuse. It has been suggested that different types of suicidal behaviour, i.e. single versus multiple attempts might have different underlying etiologies thus requiring different treatments (Horesch, et al 2003).

The overall TAS-20 scores showed significant improvement and the subscales showed a trend toward improvement. The small sample size may have effected this outcome, or alexithymia may interfere with the development of cognitive processes which could require further growth

and maturation over time. Problem solving total scores also showed a trend toward improvement however, not significant. It might be hypothesized that with an externally oriented thinking style, and an inability to describe emotion, clients might have more difficulty problem solving or imagining different ways to solve a problem. Clients might become aware that something is not right however, have not yet developed or have the skill to use insight in making or imagining their situation to be different, particularly when in the midst of a crisis episode. Izard (2002) reports that in times of emotional flooding, emotion, acting as a primary signaling system (Greenberg, 1997), could "drive" a person along a "low road" or non-thinking path to action; a process that could occur within milliseconds. This might also interfere with help seeking behaviour, particularly if helpers are asking for specifics or descriptives that go beyond naming a feeling. Ciarrochi et al. (2003) identified suicidal thinking as an impulsive coping strategy to stress. They hypothesized that people with difficulty expressing emotions may not make their needs known to others, potentially resulting in less frequent or satisfactory support. Difficulty identifying emotions was also related to stress and anxiety. The authors suggest that interventions to reduce anxiety could be targeted at difficulty identifying emotions. They also suggest that to reduce depression, the focus would be on describing emotions. Joiner et al (2000) report that for people with recurrent suicide attempts, in crisis, symptom reactions were experienced more severely than for non-multiple attempters. Taylor (2000) reports that the alexithymia construct reflects deficits in cognitive processing and regulation of emotions. It could be suggested that prior to being able to problem solve, emotional intensity needs to decrease significantly enough for the individual to begin the activity of problem solving.. Thus, our findings from the quantitative analysis is hopeful in that it does point to young adults becoming more stable over time with respect to both their suicidal behaviour, self injury and symptomology. Positive findings in the areas of the overall TAS-20 score, depression and hopelessness indicate that the targets for the PISA intervention are being met. Decreases in these scores are consistent with decreased risk of suicidal behaviour. Participants identified that they saw themselves getting better at identifying and tolerating emotion, they also reported struggles in dealing with the intensity of feelings and describing how that intensity was affecting them behaviourally and in their thinking. It could be hypothesized from these findings that young adults with recurrent suicide attempts may first require assistance in the development of an emotional literacy, i.e. developing ways of understanding the role of emotions, the language of emotions and skills to manage the intensity, before skills in problem solving increase as indicated by near, but not significant results in the PSI total score.

Discussion: Qualitative

a) Suicide / Death

Participants in this study raised the issue that suicidal behaviour is about a relationship they have with death. The relationship is both intimate and serves a purpose; is long standing and not easily left behind or forgotten. "Death" was identified by participants as a "mistress"; having a purpose, or as being part of one's identity. Paris (2004), via a literature review, identified that for the person with BPD (73% of this sample), suicidal behaviour can serve the function of a wish to escape inner suffering suggesting that suicidal thoughts can offer comfort to the individual. This is akin to "the mistress" identified in our group: *"…only little bit of comfort or joy that I was able to get was through interpreting life through death*." (12:108).

Our participants identified suicide attempts as serving a purpose; to regulate feelings: "*suicide would be to never feel it again"* (2:461) and/or communicate distress: *"I don't know what to do someone help me*" (7: 357). Paris (2004) also identified suicide attempts as a means to communicate distress. His third categorization suggested that suicide attempts might serve to establish some sense of control. Our participants did not speak of control per se.

Our participants identified a third position that suicidal behaviour plays; identity. It is part of who they are,: "*I was going to die by suicide either by the time I was sixteen or by the end of high school"* (13:220), or a way of seeing themselves: "*I saw myself as being completely useless"*(7:381). These perceptions of identity are related to what has been identified in the literature as perceived burdensomeness (Joiner, Rudd, Lester, 2002; Van Orden, Lynam, Hollar, Joiner, 2006). Burdensomeness is a perception that the person holds, believing themselves to be a liability to others due to their own incompetence: "…*I don't contribute to society, I can't work… Going to the hospital is a guilt, I'm taking someone else's bed, I don't deserve that let me die …"* (4:244). Similar to Hoover and Paulson's work (1999) a disconnection from the self and life was brought on by attributing worthlessness and hopelessness to their own identity as opposed to the life situations they had grown up in or survived through. Unlike Hoover and Paulson's group, our participants were younger and some still engaged in suicidal or self injurious behaviour. It could be argued that for our sample of young adults, both identity development and skill development in the arenas of emotion and problem solving are "in process" given that life circumstances including psychopathology, multiple hospitalizations through adolescence and histories of childhood maltreatment could have had a profound effect on their emotional, social, cognitive and identity development. Everall, Bostik and Paulson's (2005) case presentation clearly points to the necessity of considering developmental issues that might come into play in the adolescent's experiences of suicidal behaviour. We would contend that with the young adults in this study, the developmental milestones to be attained during adolescence may be delayed and they are still in the process of playing "catch up".

With regards to understanding how adolescents perceive death, Noppe and Noppe (1991) suggest that as part of regular adolescent development, the concept of death holds dialectical themes in the cognitive, social, physical, and affective realms noting that interactions with others can be one of the "clearest indications of being alive" (p.35). Holcomb, Neimeyer and Moore (1993), identified that people who had had previous suicide attempts identified that their death would have a low personal impact suggesting little regard for their lives. Again, given the developmental issues raised previously, the concept of dying holds a different meaning for young people with recurrent suicide attempts than one would encounter with non-clinical adolescents. It is with this understanding that therapists clearly need to rework their own personal understanding regarding the expectations and unwritten rules that surround death. For this to take place, a conversation with the client regarding the meaning death holds and place it holds for them is critical to the therapy. To dismiss or negate the client's understanding could be putting the therapist in the position of dismissing and/or negating the client's understanding of their identity, skill level and/or experience.

b) Moving Away From Death – Tipping and Turning Points

Moving away from death initially began as an ambivalent process whereby clients sat in a position of existence or "limbo" for some time, having some idea that they didn't want to die however, not knowing how to live**.** The first decision to be made was "*deciding to tell yourself that you deserve to live" (13:232)* and then once that decision was made, to "*have to teach myself those things" (13:232)* including the skills of: living without acting on suicidal thoughts, believing oneself to be a deserving person, having an array of choices to keep as safe as possible, learning a language to articulate and understand one's distress, (re)connecting with people in their lives, and learning how to belong. Participants identified tipping and turning points that enabled them to move away from death that included awarenesses on multiple levels and in multiple arenas.

Mandelbaum (1973) identifies turnings as "major transitions" which can occur as single events or experiences or might be gradual and King (2003) describes them as **"** emotionally compelling experiences and realizations that involve meaning acquired through the routes of belonging, doing, or understanding the self or the world." (p. 184)

Choices:
Participants identified that recognizing there were choices was an awareness/skill not necessarily always available to them. Psychology research has suggested that judgement and choice are related to the processes of cognition involving intuition, reasoning and/or analytic processing It could be suggested that our young people with recurrent suicide attempts experience a set of emotions that are overwhelming and without language and in that intensity, their first response is behavioural, i.e. a suicide attempt or self harm resulting in "comfort", de-escalation of intensity, eliciting help or alignment with their sense of identity. Joiner (2002)

reports that suicide related cognitions and behaviours may become more accessible as suicidal experiences accumulate. He furthers that the more accessible and active the thoughts and behaviours become, the more easily they are triggered. An interesting note is that their work identified that as suicidal episodes increase, the relationship to external triggers decreases, with suicidal behaviour being more easily triggered even in the absence of negative events. (Joiner, & Rudd, 2000; Joiner, Rudd, Rouleau, and Wagner, 2000,). Kahneman (2003) proposes that doubt is a "metacognitive appreciation of one's ability to think incompatible thoughts about the same thing" (p.702). Vukman (2005) in her study investigating developmental differences in metacognition and the connection with cognitive development in adulthood found that dialectic problem solving begins to emerge in young adulthood with the highest point being in mature adulthood. Perhaps for our clients, presenting identified choices is one of the steps in identifying some level of doubt that death was the only way to meet the need being unsuccessfully met through suicidal behaviour and self harm. Planning and decision making skills associated with the development of the prefrontal cortex, has been identified as maturing more slowly, therefore potentially not only affecting problem solving abilities but also, the ability to manage or control impulse (Krawczyk, 2002). Giedd (2004) speculates that the area of the brain most responsible for the inhibition of impulses, the weighing of decisions and the abilities to prioritize and strategize (dorsolateral prefrontal cortex) is "under construction" (p.83) for a decade beyond puberty. Despite the direct linkages between behavioural manifestations and particular brain area developments are not yet known and require further research, it can be hypothesized that the challenges our participants are reporting and experiencing, are beyond "manipulation" or "willfulness" and in order for there to be skill development, they may require actual teaching, practice and support. One client identified that coming to understand there were choices provided a sense of "*freedom*" (13:255) suggesting that a life of suicidality may in fact be a life of feeling trapped and it is the clinician's role to validate the subjective experience and assist the client to find the doors "out" of the sense of entrapment.

Emotions:

Participants identified that becoming aware of emotions, understanding the role of emotion as part of human experience, and learning to identify and tolerate emotions were important. Participants, without exception, identified themselves as still struggling with areas of identification and tolerance of intense feelings, with a particular struggle for many being around the choices they made in managing their way through the intensity. Individuals who have been identified as having alexithymia show an impaired ability to mentalize, a skill which is associated with the ability to take the perspective of others (Moriguchi et al. 2006). Moriguchi et al (2006) suggest this inability might influence the ability to regulate emotions in that skills involved in comprehending the self and others are inter-related and necessary in order to modulate one's own emotions. Wolff, Stiglmayr, Bretz, Lammers, Auckenthaler (2007) reported that for clients with BPD, the inability to identify emotions in real-life situations is a struggle that characterizes the disorder. Developmentally, Monk, McClure, Nelson, Zarahn et al (2003) suggest that

adolescents will modulate activities based on emotional needs more often than adults who will base their responses on attentional demands, thus utilizing a part of the brain that is more in keeping with the prefrontal cortex. Everall et al's (2006) study identified that emotion processes that seemed most significant to healing included facing painful feelings and expressing feelings through journal writing and interpersonal communication. The authors identify that their participants' willingness to work with emotions often paralleled an increased sense of agency and control over life circumstances. Experiencing, expressing and regulating emotion were seen as highly active processes and important steps toward altering adverse circumstances for young people who had experienced suicidal thoughts. Expressing oneself was also identified as a feature of healing in Paproski's (1997) work. Our participants reported finding that there are times when they still struggle with suicidal and self harm behaviours. Our participants identified experiencing emotions and the intensity and fear of that intensity which often led to unsafe behaviours. Most participants in this study identified needing to learn the role, function, and for some, names of emotions, as almost an intellectual exercise before being able to move to working with the experience emotion.

Relationships: self, family, friends, professionals:

Our study identified the importance of "connections and relationships." The role of group and significant caregivers, both professional and personal impacted our participants, and some further identified the importance of letting go of significant relationships if they were to move toward life. Support and secure attachments have been discussed in the literature as being of significance to the healing process for young people with a history of suicide attempts (Everall et al. 2006; Bostik and Everall 2007; Paproski, 1997; and Taylor, 2002). Bostik and Everall (2007) reported that secure attachments were the thread that allowed previously suicidal young people to move through negative self perceptions, to change emotional and cognitive states and provided hope and meaning moving beyond suicidality. Taylor (2002) identified that it was the perception of support which enabled her participants to manage the overwhelming pain they experienced and to connect to hope. Within this study, support was identified as important in the transition from higher to lower risk of suicidal behaviours as was the termination of toxic relationships. However, to say their relationships reflected secure attachments would be attributing more significance to the personal and group relationships than the participants offered. Many participants identified the group as significant to a sense of being understood and this began the journey away from death "*if it hadn't of been for the acceptance and support you know what I might, some things might not have changed" (10:1179)*. In being understood, they identified being able to "*express my feelings and you know be who I am"* (16:722). It could be that the group itself became a pseudo peer (group) interaction in which adolescents are known to learn about self and other and grow in the areas of social and cognitive development. Clients first had to learn that their feelings were not the sole indication of who they were as people, i.e. because I feel bad does not mean I am bad. In seeing themselves in others and others in themselves, perhaps they were able to begin to identify that because someone feels badly it

does not make them a bad person, thus adding another skill to the repertoire of listening to how they talked to themselves. King (2003) noted that belonging provides a point of feeling connected. It could be that when one feels connected, one can only know they are alive.

"Dying to Live" - Future:
Participants identified that once they felt some sense of future, they wished to contribute to the world and decide on goals for themselves. They identified goals for themselves from the perspective of where they saw their tomorrow: *"at this point in my life each day is just day by day living in the moment, cause you know what like I said there is no tomorrow for me, I don't see it* (3:856-862). Arising out of a sense of personal control came a sense of purposeful and goal-directed action, taking risks and making changes whether large or small (Everall et al, 2006).. They point out that as their participants experienced success across the four domains of resilience, (i.e. social, cognitive, emotional processes and action), hope and a desire to plan for the future rose, notably, a sense of purpose often evolved through helping others, and feeling valued by significant individuals in their lives. Many of our participants identified parenting, working with small children, volunteer work, school or employment as being important to them in terms of not only giving them something to look forward to or a sense of pride, but also to help them get a sense of what it was they did not want for themselves: "*I think the next stage is to find something a little closer to what makes me happy*" (11:2224). Our participants only spoke of future when they had moved beyond "existing", and had consciously and actively chosen to live. Even then, when a crisis occurred, it was a tenuous hold for many.

The Nature of The Process:
Participants in this study identified in very personal terms that moving away from death is a unique, frightening and highly individual process. Regardless of how one went through it, the process in moving toward life is active. Some participants reminded us that even if they had made a commitment toward living, there would be times when they would return to living to die. They could return to this place even if they now remained there for shorter periods and less often. The intensity of a crisis episode remains as intense despite the better coping skills.

Limitations and Future Directions:
This model is one that begins the discussion asking the question "what enables a person to move away from a lifetime of recurrent suicide attempts to move toward life" and what are the elements necessary for this to take place. The clues to these questions came from participants who had completed at least one cycle of the PISA intervention. This limits the sample to a very select group of people as the PISA intervention has not been widely adopted. It would be important to understand the transitions for participants who had been in other therapeutic modalities. Aside from a small sample size, another challenge for this study was the interview process. It was decided by the team that (YB) be the interviewer. She is also the creator and lead facilitator for the intervention. It was believed that given a pre-existing trusting relationship, this would increase theoretical sensitivity. It could be suggested that participants over-reported

their successes to “look good”. On the other hand, they could equally have minimized the effect of their personal transitions. They may have also minimized the negative aspects of the intervention. Given the response variability, including some who identified remembering very little from the period of time that they worked with us, this suggested that there was a balance in the responses given by participants. The interviewer was aware of her personal biases in terms of her previous experience and knowledge of each participant and her relationship to the intervention itself and thus used the team discussions to air her concerns regarding these issues. All conclusions were approved by the entire interdisciplinary team. The interviewer had also engaged in a fairly comprehensive literature search and participated in several conferences dealing with the concept of “recovery” in preparation for submitting this project for funding. The realization that “recovery” was not what was being identified by participants pulled the interviewer into uncharted territory, thus necessitating “a tabula rasa” that might not otherwise have been as “rasa”.

The zone of existing or limbo could be further explored in future studies, elucidating what happens in this “zone”, what takes one out of it and is the term “limbo” or “existing” unique to the participants in this study. It would also be helpful to understand if people above the age of 25, who acted on thoughts to end their lives later in their lives also experience this “zone”

Another issue raised in the discussion is the generalizability of the model. Recognizing that graduates were anywhere from 6 months to 6 years out of the program and between 18 and 25 years of age when they were initially assessed for the intervention, developmental issues impact on where a person situates themselves related to the model. Particular diagnoses may also play a role in the transitioning or the learning that a person finds useful or helpful from the group intervention.

This is an overview of the transition process. Each of the factors found in model 4 will be further analyzed. Further analysis may change and/or consolidate further the model presented in this paper.

Future Work:

- To present this work to the participants of the study for draft editing and model/pathway modification.
- To have each participant rate themselves on the established model/pathways. Have a blinded clinician read the anonymous transcript and rate where the participant is on the established model/pathway to identify if clinicians and participants understand the transitioning in the same way.
- To extend the qualitative study to group graduates who were older than 25 years at the time of group start.

- To further investigate the role of hope and understand where it takes a foothold and shapes the transition from death.
- To investigate transferability of the model and/or PISA outside of the Toronto area and across cultures

Treatment and Policy Implications:
It is hard to know how these young people's lives would be different had they not suffered maltreatment, suicide attempts and hospitalizations early in their lives. This continues to speak to the need for systemic changes in how childhood maltreatment and mental health are conceptualized, talked about and investigated for those in their younger years. There is an ongoing need to investigate the current efficacy of the following service delivery arenas:

- early intervention in the areas of childhood maltreatment;
- early screening and intervention for youth at risk for mental illness;
- safe places for our youth to go to for assistance with resources in place to meet the needs of these youth;
- Acknowledging that maltreatment crosses all barriers. Clinicians have to ask the question as to whether or not maltreatment was experienced in a person's life and how this has impacted the client's current sense of safety.

Service Delivery Factors:

- Seeing oneself on a continuum can be important for some clients.
- Utilization of peer facilitators can be helpful for clients to see someone further along in the process toward healing
- A single treatment does not guarantee an end to suicidal ideation, suicide attempts or self injury. Clients may require several types of treatment over many years before they are able to live free of self harm

Conclusions:
Transitioning away from death toward life remains a struggle for some of the participants who graduated from the PISA intervention. However, based on symptom measures, each person who participated is doing better than when they first began the intervention. Clients in this group of recurrent suicide attempters are not returning to a level of previous functioning or returning to a "life" lived previously. They are having to create a life. Their lives have been about dying and "living to die/dying to live" remains a delicate or fragile balance for some time. We are hopeful that this model of transitioning away from higher to lower risk of suicidal behaviours and the insights we have provided into the individual experience of the clients may help inform

therapy. Behaviour is a communicator providing information that "something is wrong". Therapists, family, and schools need to learn the "language of behaviour" and understand the distress that lies behind the behaviour. The therapist needs to be able to tolerate and be comfortable with the concept not only of death, but the intensity of the emotion and hold the tension of the client's seemingly intractable relationship with death and the possibility that the intensity "shall pass". The therapeutic environment must accept, hear, and use the words "death" and "suicide" where it is understood as a communication, not an inevitable action. Clients can live without self injury and suicide attempts but this does not mean they stop thinking about these options. Living without suicide attempts and self injury is a choice clients have to make and enact for themselves. No one can make them do it. No one can do it for them. The struggle to live continues through this process of transitioning.

> *Suicide is not something I think of every day like I used to but there is days that it's still very um close to surface and the idea seems very appealing,.. just to stop the fighting, the struggling, the just the stress that each day comes with..but I know that deep inside that's not all what I want even so some days it just seems like the only thing I want.* 3:*642-651*

> "*I:…How will you know that you've moved along far enough in your journey to say "no I'm away from this and I'm really [aware of this?]"*
>
> *P: I think- (pause) I think I'll I'll know when that is when something really triggering happens, like something like astronomical and my first thought won't be dying, or cutting or getting drunk or getting high, it will be to cry and move on.*" (7:1911-1917)

> "*I have the skills and the agony*" (4:267)

Table 1

Age In Years Distribution at Time of Assessment

Age	Frequency
18	1
19	2
20	1
21	-
22	2
23	3
24	4
25	3

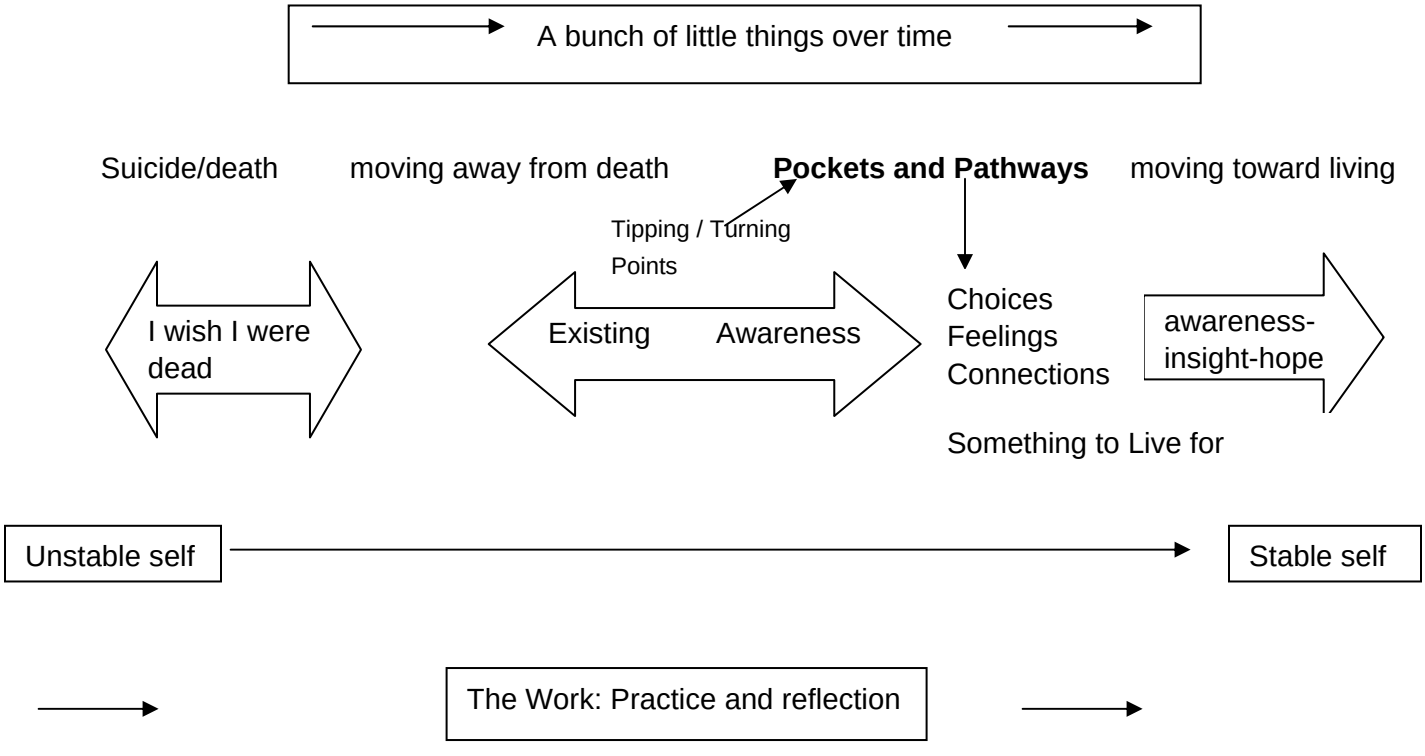
Table 2

Suicidal behaviour identified since group participation

Av. # attempts/ at time of study participati
-
5.2
1.2
0
0
1.5
0.5
0

0
0
0
0
0
0
0
0

Figure 1: FROM "LIVING TO DIE" TO "DYING TO LIVE"



Project Outcomes

Hayley Eisenberg, a Master in Science student was able to work with us to complete her dissertation investigating the relationship between childhood maltreatment and suicidal behaviour.

CAP members have strongly encouraged skill building for front line workers in their particular agencies as a beginning and the feasibility of this dissemination plan is being examined.

The project team members are working with Emergency Physicians, the Psychiatric Emergency Service and the new Psychiatric Emergency Alliance to develop more effective interventions for recurrent suicide attempters. These interventions will be informed by our research and current model of the transition.

Dissemination

Initial analyses were reported at the Canadian Association for Suicide Prevention Conference as part of a plenary symposium, October 26, 2006.

The results from this stage of the analysis were presented at the following conferences:

International Association For Suicide Prevention: September 2007; paper presentation

Canadian Association for Suicide Prevention: October 2007; workshop

Submission of this qualitative analysis to BMJ and/or Social Science and Medicine and/or Suicide and Life Threatening Behavior.

Next Steps

An application will be made for further funding to do a similar study with graduates of the PISA program who are older than 25 to investigate if the same process is in operation. We anticipate continuing to have secondary analyses focusing on the topics of death, therapeutic implications of the proposed model; specific modifications that may be needed for our existing PISA intervention and the relationship to the development of self, relationships and boundaries and emotion.

It was identified with the CAP members that the clinical utility of this project has implications for education for front line workers. Clients in this project spoke of the utility of the skills learned from the intervention hence, the intervention has the potential to be taught in community

agencies working with people with recurrent suicide attempts. One of the CAP members reported doing a workshop for her agency about the intervention and is now looking into the possibility of a collaboration whereby her staff will be trained to do the intervention in a manner that will be relevant to their clientele.

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