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RESEARCH ARTICLE

Client-reported impact of the Attempted Suicide Short Intervention Program

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ABSTRACT

Background A history of attempted suicide is the most significant predictor of suicidal death. Several brief interventions aimed at tertiary suicide prevention have been investigated in clinical trials. However, suicide attempt survivors' experiences of such interventions have rarely been reported.

Objective To explore how suicide attempt survivors perceive the impact of the Attempted Suicide Short Intervention Program (ASSIP).

Method We interviewed 14 Finnish adults who had received ASSIP as an adjunct to treatment as usual. Semi-structured interviews took place 4–10 weeks after the last ASSIP session. A conventional content analysis of the interview data is presented.

Results Three core categories depicting ASSIP's perceived impact were identified. The core category *life-affirming change* comprised subcategories of *feeling better*, *thinking differently*, *acting differently*, and *having new resources*. The core category *collateral effects* comprised *difficult feelings* and *cognitive overload*. The core category *incompleteness of change* comprised *lack of desired change*, *gains as incomplete*, *need for sustenance*, and *unrealized potential*.

Conclusion Clients perceived ASSIP as effectively facilitating life-affirming change but agreed that further support was necessary to retain and build on these gains. Identified needs for improvement included more predictable post-ASSIP service paths and more support for involving affected loved ones.

Keywords: suicide attempt; brief treatment; clients' perspective; qualitative; ASSIP

Clinical or methodological significance of this article: Suicide attempt survivors are at high risk for further suicidal action and difficult to engage in services. Our findings indicate that the Attempted Suicide Short Intervention Program, a brief suicide-specific add-on intervention, has the potential to make an impact perceived by clients as deeply meaningful. Importantly, ASSIP seems to facilitate remoralization, the formation of credible safety strategies, and motivation to further engage in services and work on long-term recovery. However, our findings also call for closer attention to the accessibility of post-ASSIP support and opportunities for engaging affected loved ones after a suicide attempt.

Introduction

A history of attempted suicide presents a significant risk for eventual suicidal death (e.g., Bostwick et al., 2016). Suicide attempt survivors are not easily engaged in services, especially in the long-term, hence the need for interventions that are both readily available and brief (e.g., Lizardi & Stanley, 2010). Recent research has produced evidence supporting several brief or very brief interventions

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(e.g., Brown et al., 2005; Gysin-Maillart et al., 2016; Jobes, 2012; Rudd et al., 2015; Stanley et al., 2018). Many of these share key components, including collaborative exploration of suicidality, planning for future crises, and "caring contact follow-up" (Jobes & Chalker, 2019). While the effectiveness of brief interventions in reducing repeated suicidal acts has been investigated (McCabe et al., 2018; Sobanski et al., 2021), suicide attempt survivors' evaluations of their impact have seldom been reported.

The Attempted Suicide Short Intervention Program

The Attempted Suicide Short Intervention Program (ASSIP) (Michel & Gysin-Maillart, 2015) is a brief, suicide-specific intervention designed as an adjunct to treatment as usual (TAU). ASSIP's integrative approach was inspired by observations of the poor fit of the prevalent medical model to the needs of those who attempt suicide (Michel et al., 2002; Michel et al., 2017). In ASSIP, suicidal behaviour is primarily understood as goal-oriented action, i.e., a perceived solution to unbearable mental pain. ASSIP also draws on cognitive–behavioural theory, attachment theory, and narrative theory in its understanding of effective post-attempt intervention.

ASSIP comprises 3–4 weekly sessions and follow-up letters over two years. Goals and tasks are manualized for each 60–90-minute session (see Table I). An early therapeutic alliance is facilitated by use of the narrative interviewing style and a non-judgmental, collaborative approach by the therapist. Video-playback of the suicidal narrative invites the patient to review the episode from a (co-)observer position within the safety of the therapeutic alliance. This allows for joint reflection and clarification of the chain of events leading to the suicide attempt, thereby fostering insight and the motivation to develop personal safety strategies. Sessions are highly collaborative and include psychoeducation, case conceptualization, the formulation of long-term goals, personal vulnerabilities, specific suicide triggers, personal warning signs, and safety strategies (Michel & Gysin-Maillart, 2015.).

In Finland, ASSIP has been implemented by MIELI Mental Health Finland (MIELI), a national non-governmental organization (NGO). At MIELI Suicide Prevention Centers, it is provided by healthcare professionals but outside the healthcare system. While the ASSIP manual does not include the client's natural network (e.g., family) in the intervention, clients in Finland are offered an opportunity to invite loved ones along in the fourth session.

Previous Findings on the Outcomes of ASSIP

To date, two randomized clinical trials of ASSIP have been published. Gysin-Maillart et al. (2016) originally compared ASSIP as an add-on to TAU to TAU alone. Respective re-attempt rates for groups receiving ASSIP + TAU and TAU alone were 8.3% and 26.7%. A mean hazard ratio of 0.17 for a suicide attempt in the ASSIP group indicated an 83% reduced risk of attempting suicide during two-year follow-up. In Finland, Arvilommi, Valkonen, Lindholm, Gaily-Luoma, Suominen, Ruishalme, et al. (2022) compared the rates of suicide attempts in groups receiving either ASSIP or crisis counselling as augments to TAU and found the difference in re-attempt rates non-significant.

In the United States, a modification of ASSIP delivered to suicide attempt survivors with substance abuse disorders during hospitalization was tested in a small pilot RCT ($n = 34$). This study reported high patient satisfaction but also relatively high re-attempt rates (Conner et al., 2021). Secondary analyses of the RCT data from Gysin-Maillart et al. (2016) have explored, e.g., cost-effectiveness (Park

Table I. Contents of the Attempted Suicide Short Intervention Program.

Session 1	Clients are asked to narrate, in their own words, how it came about that they attempted suicide. This narrative interview is videotaped with the client's consent. The first session ends with a collaborative suicide risk assessment using the Suicide Status Form (Jobes, 2006).
Session 2	Client and therapist watch the videotaped narrative together, pausing to jointly reflect on important episodes. At the end of the second session, clients are given a psychoeducative handout ("Suicide Is Not a Rational Act") and asked to return it with personal comments in the third session, after which the therapist prepares a draft summary of the client's narrative for the case conceptualization.
Session 3	The client's comments on the psychoeducative handout are discussed. The case conceptualization is completed collaboratively. This includes reviewing and revising the summary of the client's narrative; addressing key vulnerabilities and triggers associated with the suicidal episode; and identifying warning signs, safety strategies and long-term goals. These are documented in writing and given to the client.
(Session 4)	In the ASSIP manual, clients are offered an optional fourth session to complete tasks or practice safety measures. In our sample, clients were encouraged to invite their loved ones along for this fourth session.
Continued contact	After the sessions are completed, semi-standardized letters reminding the client of the work done and the possibility of contacting the therapist are sent for the next two years at 3, 6, 9, 12, 18 and 24 months after the last session. Clients are invited to reply to the letters with updates if they so wish.

et al., 2018), the association between the therapeutic alliance and suicidal ideation during follow-up (Gysin-Maillart et al., 2017; Ring & Gysin-Maillart, 2019/2020), changes in coping (Gysin-Maillart et al., 2020), and changes in reasons for living and reasons for dying (Brüdern et al., 2018; Gysin-Maillart et al., 2022). Ongoing studies include a large ASSIP RCT in Sweden (National Library of Medicine, 2020).

Quantitative research on ASSIP has accumulated, but qualitative reports of clients' experiences of the intervention remain scarce. This is typical in suicidology, as quantitative methods dominate the field and qualitative data – while often collected in some form during the developmental phases of novel interventions – remain unpublished. To date, the only empirical report from ASSIP clients' perspectives is from an unpublished mixed-methods effectiveness study conducted in Lithuania (Latakienė et al., 2022). In this study, the five women and two men who received ASSIP as an add-on to TAU reported a positive perception of the respectful, collaborative nature of the therapeutic relationship and the focus on suicide-specific treatment tasks in ASSIP, while being rather critical of TAU.

Aims of the Current Study

We explored participants' reports of how their engagement in ASSIP had affected them in the short term. Our aim was to produce a data-driven interpretation of participants' experiences that can inform the further development and implementation of ASSIP.

Method

This study applied an exploratory qualitative design in a naturalistic setting. Participants had recently attempted suicide and subsequently received both healthcare services (TAU) and ASSIP. Here, we report our findings on participants' experiences of ASSIP. The present participants' experiences of TAU have been published elsewhere (Gaily-Luoma et al., 2022). Our primary data consist of in-depth participant interviews focusing on experiences of services received after the suicide attempt. We also had access to participants' ASSIP case conceptualizations. These were reviewed to enhance contextual understanding of the participants' situation and routes to suicidal action.

Study Recruitment

Participants were recruited through the MIELI Mental Health Finland Suicide Prevention Center (MIELI) in Helsinki, Finland. Clients entering ASSIP, excluding those under age 18 and/or resident outside the Hospital District of Helsinki and Uusimaa, were invited to participate. In ASSIP, a suicide attempt is defined as a completed or interrupted action that, in the person's own understanding, is aimed at taking their life. ASSIP is not recommended if (1) the suicide attempt occurred during a psychotic episode, (2) a current substance abuse disorder is serious enough to impede engagement, or (3) serious self-harm is habitual. These eligibility criteria were applied in this study.

ASSIP was provided by four therapists, all of whom were trained healthcare professionals. The therapists were members of a team centred on the provision of ASSIP, with regular ASSIP-related team supervision. Three had completed their ASSIP training with the developers of ASSIP (Konrad Michel, MD and Anja Gysin-Maillart, PhD) some years prior to the study, and one completed training during the study. All eligible clients were informed about the study by their ASSIP therapist at the beginning of the first ASSIP session.

Participants

Of the 104 eligible clients informed about the study, 18 gave their initial consent and 14 participated in the research interview. The participants were diverse in both their demographics and history of suicidality. Seven (50%) were registered as female and seven as male. Five (36%) were aged 18–29 years, four (29%) 30–45 years, three (21%) 46–59 years and two (14%) were over age sixty. Ten (71%) participants were currently students or employed, two (14%) were unemployed and two (14%) were pensioners. Highest education ranged from a high school diploma to a graduate degree. Thirteen (93%) participants were white, and one was of mixed ethnicity.

We use the term "index attempt" to refer to the suicide attempt that led the participants to engage in ASSIP. Eight (57%) participants reported a lifetime history of one or more suicide attempts before the index attempt. Methods planned or used in the index attempt included intoxication, self-cutting, leaping from a height, motor vehicle collision, and electrocution. Physical consequences ranged from need of emergency medical intervention to no physical injury. During the current episode, all participants had used emergency services, twelve (86%) were psychiatric outpatients, four (29%) had been inpatients, and two (14%) were receiving psychotherapy in addition to ASSIP.

ASSIP is designed to target suicidal behaviour and is not focused on psychiatric diagnosis, and hence participants' diagnoses were not systematically

documented. However, past and current diagnoses spontaneously reported by the participants included a range of mood disorders, anxiety disorders, trauma-related disorders, eating disorders, substance-abuse disorders and borderline personality disorder. Some participants reported a life-time history of delusions and/or hallucinations, but none during the current suicidal episode.

Participants reported a variety of reasons for their suicide attempt in their ASSIP narrative. Most narrated relationship troubles as key triggers of their suicidal crisis, citing, e.g., a recent break-up, strained or abusive family relationships and/or loneliness as a major contributor to the attempt. Other prominent stressors included financial issues, work exhaustion, no fixed abode, and lack of work/meaningful pastimes. About half of the participants cited traumatic childhood experiences (e.g., loss of a parent, physical, sexual and/or emotional abuse in the family and/or in peer relationships) as contributing to their suicidality. Several reported having experienced the suicidal death of a close friend or family member. While in most narratives the suicidal process had begun in childhood or early adulthood, two participants reported having experienced psychological well-being into middle-age and linked their suicide attempt solely or primarily to a current stressor (e.g., unbearable physical pain due to a somatic illness).

Study Interviews

To allow participants some distance to review their experience of ASSIP, the study interviews were planned to take place 3–5 weeks after the last ASSIP session. Scheduling difficulties led to slightly longer delays (4–10 weeks). Differences between participants in their schedules for entering and/or completing ASSIP meant that time from the index attempt to interview ranged 3–6 months. The semi-structured interviews were conducted by the first author, a psychologist experienced in the care of suicidal individuals, and took place at the MIELI Suicide Prevention Center. The interviews lasted 45–120 min and were video recorded. Experiences of ASSIP were investigated first, followed by exploration of any other services received by the participant. In addition to the participants' general experience of each service, the interview topic guide explored which aspects of services participants perceived as helpful, unhelpful, or even hurtful, surprising elements, suggestions for improvement, and participants' subjective assessment of whether each service received had been helpful to them. The interviewer had no part in the provision of ASSIP, and efforts were made to make participants feel comfortable in sharing both positive and negative experiences of ASSIP. Although all participants answered all the questions in the topic guide, the order of the topics varied, as the interviewer followed the participants' narrative lead. Initial impressions, insights, and questions elicited during each interview were documented in a reflective journal by the interviewer.

Data Analysis

To achieve a data-driven description and interpretation of participants' experiences of ASSIP's impact, we used conventional content analysis (Hsieh & Shannon, 2005). The primary steps taken to ensure the quality and validity of the analysis included prolonged engagement, persistent observation, iteration, reflexivity, and a degree of investigator triangulation (e.g., Stiles, 2003). The analytical process was led by the first author and reviewed and refined jointly by all authors. First, the interviews were transcribed verbatim and read/listened to multiple times to enable immersion in the data. Next, data excerpts relevant to the research question were systematically identified in each participant's transcript. These included all the meaning units in which the participant discussed being impacted in any way by their engagement in ASSIP. After identification, all meaning units were open coded. Open-coded units similar in content were then organized into clusters, creating emerging categories. This was followed by a cyclical process of (1) choosing a descriptive label for each tentative category, (2) checking for the fit of each piece of open-coded content under the chosen labels, and (3) either re-labeling or re-organizing the data when the open-coded content and category labels showed poor fit. As the meaning units often contained multiple meanings, we allowed the same unit to be assigned under more than one category (e.g., when a positive change was also described as incomplete or accompanied by collateral anxiety). While clusters closely corresponding to the current core and subcategories emerged early in the analysis (e.g., as clusters of positive experiences; negative experiences; changes in ways of feeling and ways of thinking), the labels and hierarchical relation of the categories to each other were repeatedly refined throughout the writing process.

In presenting the results, we report the number of participants informing each finding in general terms: 2–3 participants = "a few" or "some", 4–6 = "several", 7–10 = "many" and 11–13 = "most" of the total of 14 participants. Data quotes have been translated from the original Finnish and edited for readability, while preserving the original meaning as closely as possible. Brackets in quotes indicate where text has been altered or added for clarity and

an ellipsis indicates where text has been removed to shorten a quote.

Ethical Considerations

Ethical considerations during the design and data collection of this study have been presented earlier (Gaily-Luoma et al., 2022). Here, we focus on the impact of researcher positioning on the validity of the current analysis. The study design was inspired by the first author's wish to better understand the experiences of suicide attempt survivors, a population she was treating as a psychologist in healthcare services. ASSIP had been introduced in these services as an add-on opportunity for service users, inspiring this study design. The only member of the research group employed by the NGO providing ASSIP (JV) joined the research group after the basic study design had been agreed upon. No member of the research group has had any involvement in the development or provision of ASSIP and no vested interest in ASSIP has affected the study design or analysis.

Results

Participants' accounts of how they had been impacted by ASSIP ranged from an appraisal that the intervention had provided some benefits but not made a significant difference to its being seen as a turning point providing crucial resources for a hopeful future. Many participants expressed surprise that such meaningful gains were achievable in such a brief time frame. The suicide-specific programme was perceived as allowing for the depth of the process, while also being adequately flexible or "personal". While all participants agreed that ASSIP had provided at least some gains, they differed on the components they regarded as responsible for these gains. The therapeutic relationship was reported as a meaningful catalyst of change by all participants. A majority cited the safety planning and video playback as sources of gains. Half of the participants cited the narrative interview and continued contact as personally important. Some described the case conceptualization, psychoeducative handout and/or collaborative suicide assessment as having a meaningful impact on them.

Three core categories comprising ten subcategories were identified in the participants' accounts of the impact of ASSIP. The first core category described *life-affirming change* in four subcategories: *feeling better*, *thinking differently*, *acting differently* and *having new resources*. The second core category described the *collateral effects* in ASSIP in two subcategories: *difficult feelings* and *cognitive overload*. The third core category described *incompleteness of*

Table II. Categories in participants' accounts of ASSIP's subjective impact.

Core Category	Life-affirming change				Collateral effects		Incompleteness of change			
Subcategory	*Feeling better*	*Thinking differently*	*Acting differently*	*Having new resources*	*Difficult feelings*	*Cognitive overload*	*Lack of desired change*	*Gains as incomplete*	*Need for sustenance*	*Unrealized potential*
Examples of open codings	*feeling relief; feeling valued; finding self-compassion; finding hope*	*realizing what happened to me; knowing what needs to change; gaining clarity*	*functioning better; not bottling it all up anymore*	*credible safety plan; having a safety net*	*exhaustion; feeling anxious; worrying about my therapist*	*dissociating due to stress; confusion; forgetfulness*	*achieving no enlightenment; no change in the underlying desire to die*	*need to verify insights; not all the way back to my normal functioning; need for further work*	*gains vulnerable to set-backs; need for sustaining resources*	*insufficient support for involving loved ones; hurried safety plan; no peer resources*

change in four subcategories: *lack of desired change*, *gains as incomplete*, *need for sustenance* and *unrealized potential*. The results are presented in Table II.

Life-affirming Change

All the participants reported that ASSIP facilitated some kind of life-affirming change. Change was described as new emotions, new cognitions, new behaviours, and new resources.

Feeling better. Positive emotional experiences such as feeling "relieved", "safe" or simply "better" were reported by most participants. Within the therapeutic relationship, participants' described feeling "valued", "taken seriously", "free to talk", "free to set boundaries", "not feeling judged or guilty" or "not feeling like such an alien". Many described feeling that their ASSIP therapist was genuinely interested in them, cared, and wanted to help. This was often presented as a surprise (e.g., "I even wrote in my journal about it, that it felt like someone actually *wants* to talk to me and hear my thoughts!") and/or as a contrast to other experiences of interactions with healthcare professionals. These positive experiences were reported as facilitated by organizational practices (e.g., "[the fact that] my therapist called to make the first appointment [instead of a clerical employee] made me feel welcome"; "there was no hurry"), the skill of the ASSIP therapist (e.g., "[they] really knew how to *listen*") and the ASSIP programme (e.g., "it was crucial that I got to start by telling the story of my life"; "I got to really talk about my suicidality … the topic has been avoided in my other treatments"). Several participants reported feeling differently toward themselves as a result of ASSIP, typically describing more self-compassion and/or less guilt. This was attributed to the therapeutic relationship, video playback, and/or psychoeducation. One participant described the effect of the psychoeducation component: "It's good to understand that it's a dissociative state, an exceptional state … I was able to accept it so that I no longer blame myself for it … before I just wallowed in self-blame."

Many participants described feeling differently about the future. One participant expressed it thus: "Already in the first session I started feeling hopeful, I got so scared, thinking I'd never want to kill myself again." Although only a few participants spoke explicitly of hope, most communicated a renewed motivation to see what the future would bring. No participant reported feeling actively suicidal at the time of the interview; instead, most spontaneously reported a determination to never attempt suicide again.

Thinking differently. New insights were reported by most participants and typically concerned elucidation of the reasons behind the suicidal crisis and/or changes needed to prevent such crises recurring in the future. Some participants (particularly those reporting a proneness to dissociation) described as meaningful the realization that their suicide attempt was psychologically caused rather than a random occurrence: "Maybe I understood why I was there only when I started talking, and I realized that I've had quite a lot of stressors around me and it hasn't happened in a vacuum that I suddenly feel really bad again". Insights into the suicidal episode were attributed to the opportunity to discuss it thoroughly, something which many participants had found wholly lacking in their encounters with other healthcare professionals. Being able to narrate their suicidal episode, the use of video playback, and participating in safety planning and/or receiving psychoeducation were all cited as facilitators of these insights.

Most participants reported personally meaningful insights into the specific dynamics fuelling their suicidal crisis. Such insights concerned a wide range of topics, including the effect of their upbringing (e.g., how difficult emotions were handled in their family of origin), significant life events (e.g., losses, significant relationships), interpretations of significant events (e.g., how a traumatic event had affected their self-image) and personal characteristics (e.g., a tendency to bottle up difficult feelings) on their suicide attempt.

Insights into the suicidal process were often described as powerful, empowering and/or transformative, one participant stating, "I've been able to dig out of myself a perhaps significant insight … in the course of three short sessions I [realized] that I have no need for another suicide attempt, that's amazing." This participant reported that insight into the causes of the suicide attempt also offered an alternative route out of suffering and thus resulted in no longer needing to die. Another participant described a meaningful insight concerning a behavioural pattern they experienced as frustratingly irrational:

> The problem was that when I get depressed, no one at work notices anything, but at home I'm absolutely devastated. In ASSIP I realized this pattern came from my childhood family … It felt important to find some reason for it, because I have wondered why I can't act like others at work: that if I'm exhausted, I'd do [less].

Many participants described gaining a new perspective on themselves and/or their situation and commonly reported that this had also resulted in new thoughts and emotions. The therapists' questions, comments and/or active listening were often credited

for facilitating such insights. One participant described the effect of hearing their expressions of suffering echoed by their ASSIP therapist:

> When you hear it from another person's lips, even if it's exactly the same thing [you've said], it brings a new perspective to it … it's not so like selfish … and then you might experience a little feeling of sympathy … it doesn't feel the same in your own head as when the other person says it, so it just opens your perspective a little more.

New compassion for oneself and/or the alleviation of guilt were often reported as a result of new perspectives and insights. One participant also reported a new perspective offered by the ASSIP therapist as directly impacting their reasons for wanting to die:

> [The reason for my suicidal behavior was that] I wanted to cause as many problems as possible for the [institutions that had done wrong by me] … I wanted those people to feel bad … [my ASSIP therapist] found a counterbalance in saying that you won't gain anything from it … that the only ones who will grieve are your family, and you don't want to hurt your family like that, do you? That had a really important [influence].

Psychoeducation was reported by some participants as affecting their ability to understand what had happened, their emotional reaction to the situation and/or their capability to resist the possible re-emergence of suicidal impulses in the future. A first-time user of mental health services described its effect: "[The psychoeducative hand-out was] useful in that everything kind of rang true … It [was] a bit of a wake-up call for me … I had never read or even thought about such things before." Another participant with previous suicide attempts and ample experience of mental healthcare described a similarly meaningful impact:

> It helped me to understand what happened in me and that it is not such a rational act … to remember that [the attempt] leaves a memory mark so that you can understand that if you have the same kind of thoughts, you can know that it's because of that … maybe it helps you so that you can maybe not go there or maybe you can resist those thoughts, when you can remind yourself [of the psychoeducative information].

Acting differently. A few participants reported the emergence of new observable behaviour as a result of ASSIP. For example, one participant's insight that a family pattern had been fuelling their perfectionistic work performance had resulted in behaviour change: "At work, I find that maybe I no longer think I need to be an excellent employee, it's enough that I'm good. … I do certain things well, but I don't worry too much about the other stuff." Some participants cited their silence around meaningful issues as a key contributor to their suicidal crisis: "Everything has always gone wrong because I haven't talked, and I want to change that." These participants described their engagement in ASSIP as breaking this behavioural pattern:

> For the first time we talked about things starting from my childhood. I had insights about why I am the way I am. These things had never been discussed or even asked about. My problem is that I don't talk. It was important to be able to tell [my story].

While many participants described a marked positive change in their functioning in comparison to the period immediately following the suicide attempt, they typically made no explicit attribution of this change, or they attributed it to causes other than ASSIP. However, one participant reported that ASSIP had directly resulted in better day-to-day functioning:

> A month after [the attempt] it was really difficult to do the cleaning at home or get things done, everything felt like a burden, but then ASSIP made it easier to get back to my everyday life. When you could talk about things directly and not just have those thoughts stuck in your head, it was much easier to deal with them afterwards.

Having new resources. Most participants reported gaining new, meaningful resources through ASSIP. Many participants emphasised the importance of a credible personal safety plan, as in the following example:

> We made me the safety plan, which seemed like a really good idea, because even though I've been in therapy for many years I've never actually had one … it was really concrete and specified how before I feel completely self-destructive, what precedes it, and I had to think about it and articulate it on paper and there were suggestions for interventions at different points, it wasn't left so abstract … I like having very precise instructions so that if you're feeling really confused, it's easier to understand them.

Several participants referred to a specific piece of advice that had made the safety plan feel usable. As one participant put it:

> At first I thought that the safety plan is no use in real life. The problem is, if I call emergency services when I'm standing there with the rope in my hand, what do I say? … But then [my ASSIP therapist] told me to

> say that I'm calling because my safety plan says so … That made it useful for me.

Many participants mentioned appreciatively the opportunity to contact ASSIP if in crisis, and some described that having knowledge of the follow-up letters made them feel good and safe. Knowledge of other crisis resources was also described by some as providing safety.

Both the case conceptualization and the psychoeducative homework sheet were cited as resources for further work on recovery. The summary of the participant's narrative, (typically referred to by participants as "my own story in writing") was reported by several participants as a valuable resource for sharing with loved ones and/or professionals. Some participants described using ASSIP materials as a resource to remind themselves of the important insights and plans made in the ASSIP process. The two participants who were currently in psychotherapy reported having shared their case conceptualizations with their psychotherapist and working on goals identified in them. Several others hoped to do the same, once (or if) they found a stable enough post-ASSIP treatment relationship.

Collateral Effects

While all participants' accounts of ASSIP were predominantly positive, many also reported difficult feelings and/or cognitive overload related to their engagement in the intervention.

Difficult feelings. The most commonly reported negative impacts were anxiety before or during sessions and/or exhaustion after sessions. One participant reporting a traumatic history of being filmed and severe anxiety at the idea of videotaping described the situation as follows:

> I was really anxious, but it was handled really nicely so that when I said I was nervous, it was like 'okay, the camera doesn't have to be right in front of you', like your anxiety is a circumstance that can also be taken into account.

Video playback was described by this participant as deeply meaningful, inspiring insight and an unexpected emergence of self-compassion. Another participant described a common experience of exhaustion after sessions: "Between [the sessions] I was perhaps a little exhausted, and they were anyway so exhaustive, so between them I didn't really think or linger on [topics discussed in sessions], they kind of stayed in the sessions."

These quotes are representative of how collateral effects were reported: while some ASSIP-related anxiety and/or exhaustion was reported by many participants, none presented these feelings as especially problematic. Anxiety provoked by ASSIP was reported as resolved or made tolerable by the sensitive actions of the ASSIP therapist. Reports of exhaustion were accompanied by positive notions such as feeling relieved after having "let it all out" and/or a sense of achieving meaningful gains through the tiring efforts.

The clearest description of collateral distress was given by a participant who had not fully understood why they were videotaped in the first session. They reported that this confusion combined with a tendency to paranoid ideation about cameras led to considerable anxiety. The issue was resolved in the session and the participant reported feeling safe and comfortable afterwards. However, they emphasised the importance of explaining the presence of the video camera in a way that an overwhelmed client can understand.

A few participants reported experiencing difficult feelings in relation to their ASSIP therapist. One participant reported worrying about causing their therapist distress: "I've always felt bad when I've left, that I've given them shit like this … I know they're trained but hearing a horror story like [mine], I hope they're able to shut it out". However, this worry had not prevented meaningful participation. Another participant reported sadness coinciding with gratitude: "After [the last session], I had some difficult days when I was like, 'Help, I'm not allowed to come anymore!' [ASSIP] had become an important journey, so I had to spend a few days mourning that it was over."

Cognitive overload. Some participants reported that engaging in ASSIP contributed to cognitive overload reflected in experiences of confusion and/or memory problems in the early phase after their suicide attempt. One participant described a tendency to dissociation triggered by stressful situations, including ASSIP sessions, resulting in partial amnesia regarding what had been discussed. Another reported that being a client of both ASSIP and mental health services had resulted in stressful confusion over the dates, times, and locations of sessions. Some others also reported impaired cognitive function compromising their ability to engage with ASSIP in the initial sessions, explaining that it took some weeks for their "thoughts to be set in motion again", some crediting ASSIP with helping to bring this about.

Issues with cognitive overload, even when resulting in dissociation, were not presented as representing a problem with ASSIP *per se*, but rather as an inevitability to be dealt with in the vulnerable post-attempt period. A few participants commented on the importance of notes, text messages and other written reminders, and for some the video playback and/or written materials in ASSIP seemed to serve as meaningful reminders.

Incompleteness of Change

Most participants reported that despite its brevity, ASSIP had felt like a "whole process with closure" and "achieved what it was meant to do". However, even the most satisfied participants stated that their recovery process remained ongoing and required further support. Some also reported disappointment that a specific desired change and/or potential benefit had remained unrealized in ASSIP.

Lack of desired change. The most explicit expression of disappointment with change achieved in ASSIP came from a young participant, who presented other gains as subsidiary in the absence of change in the underlying desire to die:

> I don't know [whether ASSIP helped me move forward], maybe in the sense that it helped me to be able to talk freely, because usually the suicide topic is avoided. And I was always crying in ASSIP, I was free to cry. But I don't know if it helped – well, it hasn't helped so much with the feeling that you don't want to kill yourself, but it has helped more with just how to recognize that you are going in that direction. [There could have been more of a focus on] how to get away from thoughts of suicide … I feel like that was pretty much disregarded.

Another participant's disappointment was expressed more subtly in that despite ASSIP being perhaps "a crucial support" in the interim period after discharge from hospital, it had provided "no enlightenment". This participant attributed their recovery from suicidal ideation primarily to other sources (e.g., medication) and described the ASSIP experience as follows:

> After the [last] session I was a bit like "Well, that's it then." Although luckily ASSIP has continued contact planned, at that point I was still in a pretty dark place. So I was thinking like "So this was it and what was the use in the end?", it felt a bit like am I left on my own here.

Gains as incomplete. Participants reported new ways of thinking but also that more insights remained to be discovered, new understandings to be consolidated and/or a need to check if their insights held: "There's terrible self-criticism going on in my head that I should confirm as true … confirm this [new] observation about myself". Similarly, participants reporting behavioural change were pleased with the changes they could already observe, but their accounts made it evident that the process was incomplete. The participants citing "learning to talk" as a central recovery goal described this task as ongoing and a crucial focus of their post-ASSIP psychiatric treatment. Several participants reported that they were not yet functioning at the level they wished for or that was typical for them, one participant describing being in a state of in-between in the recovery process:

> This isn't over yet … I want to live but I don't want to work and those who know me from before know I've always been a hard worker … You need to get back to your own life and [for me] work is an integral part of it.

Need for sustenance. Even participants describing pivotal gains often emphasised the incompleteness of their recovery and/or its contingency on further support. Many made clear their motivation and need to continue actively working towards further gains. One participant with a history of two suicide attempts described this experience:

> I'm going to seek long-term psychotherapy now. [In ASSIP] I gained a more holistic picture of my life, so now I feel like, when I get therapeutic help, I can maybe finally break this pattern. Because the crises in my life, they're no longer disconnected experiences, but they became like a kind of a story … When at the end of ASSIP we wrote down my goals for future psychotherapy, it somehow clarified the picture a lot. … It opened up a perspective of hope … it's not just hope to survive this one crisis, but somehow it seems to bring hope that the rest of my life may be a bit different.

In this and similar accounts by other participants, the incompleteness of change was not experienced as negative *per se*, but instead strongly associated with hope, a sense of agency, and a motivation to do the work. However, this hope was presented as contingent on the availability of appropriate support. This participant, like several others, reported painful awareness of the likely obstacles between their current situation and finding the desired therapeutic relationship or other resources critical for further recovery gains. At the time of the interview, half of the participants seemed fairly confident that they would be provided with necessary support after ASSIP, while the other half expressed considerable concern over the availability of such support.

While many participants described a desire to keep actively working on further change, some were satisfied with the gains already made. However, even those who reported satisfaction felt that sustaining their gains required further support. Whereas all the other participants wished for continued support beyond ASSIP's follow-up, one participant described feeling that the resources acquired in ASSIP along with its continued contact constituted enough of a "safety net". Those desiring further support also frequently stated that knowledge of ASSIP's continued contact was an important sustaining factor for them.

Unrealized potential. None of the participants had taken up the opportunity for an ASSIP session together with loved ones. Several participants expressed the view that including their loved ones in the ASSIP process would or might have been important, but that for it to happen, the opportunity would have needed to be "pushed more". These participants reported that inviting loved ones along seemed daunting, and that they would have needed more support to be able to go through with it. One participant described this ambivalence:

> There was talk about that fourth meeting with loved ones … I think that could be something to consider, whether it could be a bit of a must. I think that for me at least it's easy to let [the opportunity] pass … I think it might be good, because it could be a good opportunity for those close to me. I don't know how much my loved ones have talked about or gone through [what happened], because it's obviously been a tough thing for them as well, so it could be an opportunity for them to get therapy. It would be good to have more encouragement, because even though I thought that "yes, after the holidays [I'll do it]", it's easy to let it slide when you have other things to do. And of course approaching loved ones to see if they want to is a bit of a hurdle, although I think it could be good for them too.

Two other comments on ASSIP's failure to realize a desired resource were made: one participant reported that coming up with alternative routes of action in a crisis situation felt difficult and rushed, implying that a credible plan for future crises had not been achieved; another expressed disappointment that peer resources had not been available in the form of written material or opportunities for contact with peers.

Discussion

This study explored clients' experiences of change following participation in the Attempted Suicide Short Intervention Program (ASSIP), a brief suicide-specific intervention delivered as an adjunct to treatment as usual (TAU). We have previously reported on the same participants' perceptions of the helpful and hindering aspects of TAU (Gaily-Luoma et al., 2022). Here, we investigated the subjective impact of ASSIP as an add-on intervention.

Participants reported a range of impacts that they experienced as meaningful and attributable to ASSIP. These impacts included both internal change (new emotions, cognitions, and behaviours) and acquiring new resources (to enhance safety and to enable sharing and further change). Many of these gains were directly related to key risk factors for suicidal behaviour, e.g., not feeling so alone, guilty or worthless, finding hope and self-compassion, and forming strategies and acquiring resources for remaining safe in future crises. In line with Owens et al. (2020), many of the reported changes (e.g., being able to talk, feeling more motivated or having insights) were understood by participants as both a meaningful outcome and a route to further change.

The reports of remoralization early in the intervention may best be understood as general effects induced by factors common to *bona fide* psychotherapeutic interventions (Wampold & Imel, 2015), such as the relief provided by a strong therapeutic alliance and hopefulness created by the credibility of the treatment frame. The participants' reports indicate that ASSIP in its current delivery context effectively facilitated these general effects, whereas TAU often failed in this respect (Gaily-Luoma et al., 2022).

Participants also commented on the role of ASSIP's suicide focus and "specific ingredients" (Wampold & Imel, 2015) in providing both suicide-specific gains and further remoralization. They reported having gained a clearer understanding of the dynamics and drivers of their suicidal behaviour, allowing the formation of safety strategies, recovery goals and a more hopeful and/or confident outlook on the future. This was attributed to ASSIP's persistent focus on and multimodal exploration of the suicide attempt as part of the participants' life-career. Congruent with reports on ASSIP in Lithuania (Latakienė et al., 2022), the suicide-specific focus was highly appreciated, partly because opportunities to explore the suicidal episode had been found lacking in TAU (Gaily-Luoma et al., 2022).

While ASSIP's direct focus on the suicidal episode was uniformly appreciated, participants differed in the relative value they accorded its various components. Interestingly, participants with widely different emphases on what specifically was meaningful in ASSIP reported that the intervention was well-suited to their personal situation. Their accounts

suggest that the experience of genuine collaboration with the ASSIP therapist (rather than feeling they were objects of the intervention) allowed participants to retain their engagement in ASSIP even when a specific task did not feel of particular use personally.

Perhaps the most novel "specific ingredient" of ASSIP is the videotaping and playback of the suicidal narrative. This was found highly impactful by the majority of participants. Their descriptions of its cognitive impact resembled the observations of Valach et al. (2018) on suicide attempt survivors' verbalization of insight in a self-confrontation interview. Many also reported meaningful emotional change, such as the emergence of self-compassion. However, similar gains from ASSIP were also reported by a minority of participants who had found this specific task non-important or had been unable to fully complete it due to anxiety. While the causal role of any "specific ingredients" for gains in ASSIP or in other psychotherapies remains debatable (Wampold & Imel, 2015), ASSIP's current combination of ingredients seems to be one way of effectively facilitating both general remoralization and suicide-specific gains after a suicide attempt.

However, several participants felt that the current combination could be further improved by adding a relationship-focused component. In exploring these participants' experiences of TAU, we previously identified seven key aspects of services that participants found helpful (Gaily-Luoma et al., 2022). Four of these key aspects were consistently reported as present in ASSIP, including the experience of being valued, support in exploring both suicidality and related meaningful topics, and an adequate sense of psychological continuity and predictability. Two aspects, a responsive partnership in navigating recovery (e.g., arranging for basic needs) and involving clients in medication decisions, were only reported as relevant for TAU (not ASSIP). However, the seventh aspect, accounting for clients' relationship context, was found lacking in both ASSIP and TAU. Neither was experienced as providing adequate support for engaging with significant others or finding supportive peer interactions.

We deem this an important finding, given how individually focused current suicide-specific interventions for adults are. In recent years, the potential value of peer relationships in tertiary suicide prevention has received increasing attention (see Schlichthorst et al., 2020). However, interventions or practices targeting existing meaningful relationships (e.g., the family) in a suicidal adult's life are largely absent in the tertiary prevention literature (Frey & Hunt, 2018). The current participants welcomed the new relational experiences (e.g., opening up, feeling accepted, and allowed to set boundaries) that originated and were manifested in the therapeutic relationship. A more direct focus on the suicidal individual's relationships might allow for similar relational gains in natural networks.

The need for more relationship-focused interventions seems particularly poignant in the context of the reasons for suicidal action typically reported by suicide attempt survivors. The present participants, like others across cultures and age groups (e.g., Beniwal et al., 2022; Burón et al., 2016; Kim et al., 2020), stated that relationship issues were a major contributor to their suicide attempt. Interpersonal experiences have been found to be common as reasons for both living and dying (e.g., Jobes & Mann, 1999), and a suicide attempt attributed to interpersonal conflict may present an elevated risk for repetition (Burón et al., 2016). Many survivors experience guilt and shame over the consequences for others of their suicide attempt, often finding themselves both worried about loved ones and unsure how to approach them. These feelings, relational in nature and often difficult to endure, may perpetuate suicide risk. In the current study, some participants reported an alleviation of guilt as an outcome of ASSIP, but several were left wishing for an opportunity to discuss the suicidal incident with affected loved ones. We believe this should be considered in the further development of ASSIP and other suicide-specific interventions.

The current qualitative findings complement those of a recent Finnish randomized clinical trial (RCT) (Arvilommi, Valkonen, Lindholm, Gaily-Luoma, Suominen, Ruishalme, et al., 2022), which compared ASSIP with crisis counselling (CC) as adjuncts to TAU. During the two-year follow-up, 29.2% of service users receiving ASSIP re-attempted suicide, a non-significant difference from the 35.2% of service users receiving CC. The RCT had no control group and thus gave no estimate of ASSIP's effectiveness *per se*, but rather provided a re-attempt rate for suicide attempt survivors receiving services (brief intervention + TAU). As such, the results leave much to be desired. Of the 160 service users participating in either ASSIP or CC, 31.9% re-attempted, with 80.4% of first re-attempts taking place within one year of the index attempt and 57% of those re-attempting making more than one re-attempt during follow-up (Arvilommi, Valkonen, Lindholm, Gaily-Luoma, Suominen, Gysin-Maillart, et al., 2022).

The current qualitative study and Arvilommi et al.'s RCT were not related, but participants in each were served by the same healthcare system. The current participants' accounts suggest that the system's effectiveness in preventing re-attempts may be undermined by a lack of adequate continuity

in suicide attempt survivors' service paths (also discussed in Gaily-Luoma et al., 2022). Most of the current participants found that despite its brevity, ASSIP was of an appropriate length for its suicide-specific focus and achieved an effective working through of the suicide attempt. However, almost all participants asserted that they required further post-ASSIP support (e.g., talking therapy, medication and/or occupational services) to achieve the longer-term recovery goals identified in ASSIP. This support, in turn, only seemed readily available to some of the participants.

The observation that participants typically emerged from ASSIP motivated to engage in further services and continue working towards permanent change is encouraging. Lack of service engagement is a key obstacle in suicide tertiary prevention (Lizardi & Stanley, 2010), as suicidality is associated with the risk of non-attendance (e.g., Kasteenpohja et al., 2015), and non-attendance in follow-up psychiatric services after deliberate self-harm is associated with an elevated risk for death (Qin et al., 2022). However, these participants' expressions of motivation, hope and agency inspired by ASSIP were often intermingled with uncertainty and worry, sometimes desperation, as the availability of further meaningful support remained uncertain at the time of the interview.

In conclusion, the current participants described ASSIP as a highly valuable add-on treatment for suicide attempt survivors. They found its suicide-specific focus and programme to facilitate remoralization, the formation of credible safety strategies, and motivation to engage in further life-affirming efforts. While they were mostly satisfied with ASSIP's outcome, they underlined the incompleteness of their recovery process, suggesting that adequate continuity of post-ASSIP service paths may be key in realizing its full potential in suicide prevention. Participants were also left wishing for more approachable opportunities to engage affected loved ones in their processing of the suicide attempt, a finding worth considering in the further development of ASSIP and other suicide-specific interventions.

Strengths and Limitations

This study is a rare qualitative exploration of suicide attempt survivors' experiences of a brief, suicide-specific intervention. As ASSIP is designed to target a diverse population of suicide attempt survivors, we believe that the heterogeneity of our sample (representative of the heterogeneity of Finnish ASSIP participants) is a strength of this study. We found no evidence that, e.g., age, sex or history of mental health, suicidality, and/or service use were critical factors in our participants' perceptions of ASSIP. However, the small sample size (typical of an in-depth qualitative study) did not allow a fine-grained exploration of how experiences of ASSIP may vary within vs. between subgroups of ASSIP users. Also, with participants representing a self-selected minority of eligible service users, it is likely that those with better base-level functioning, a more positive experience of ASSIP, and/or further along in their recovery are over-represented in this sample. It is possible that, e.g., more critical views of ASSIP may have been elicited with a different sampling method.

This study explored clients' subjective experiences of the short-term effect of ASSIP. Our findings allow us to conclude that ASSIP has the potential to provide short-term gains that suicide attempt survivors find highly meaningful. However, we can only speculate on how these gains translate into longer-term outcomes. Future studies should aim to combine qualitative information on clients' first-person experience of suicide-specific interventions with both baseline and follow-up data on, e.g., suicidal action, service use, psychiatric symptoms and well-being. This would allow for rich insight into their effectiveness, limitations, implementation issues, and needs for further development.

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No potential conflict of interest was reported by the author(s).

Ethical Approval and Consent to Participate

This study received ethical approval from the Helsinki University Hospital Ethics Committee. All participants gave their written consent to use of their data for the purposes of this study.

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