JYU DISSERTATIONS 817

Selma Gaily-Luoma

# Co-constructing Recovery in Suicidal Crises

## Service Users' Perspectives on Healthcare and Crisis Services after a Suicide Attempt

UNIVERSITY OF JYVÄSKYLÄ
FACULTY OF EDUCATION AND
PSYCHOLOGY

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Esitetään Jyväskylän yliopiston kasvatustieteiden ja psykologian tiedekunnan suostumuksella
julkisesti tarkastettavaksi yliopiston vanhassa juhlasalissa S212
syyskuun 14. päivänä 2024 kello 12.

Academic dissertation to be publicly discussed, by permission of
the Faculty of Education and Psychology of the University of Jyväskylä,
in building Seminarium, auditorium S212, on September 14, 2024 at 12 o'clock noon.

JYVÄSKYLÄN YLIOPISTO
UNIVERSITY OF JYVÄSKYLÄ

JYVÄSKYLÄ 2024

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ISBN 978-952-86-0282-8 (PDF)
URN:ISBN:978-952-86-0282-8
ISSN 2489-9003

Permanent link to this publication: http://urn.fi/URN:ISBN:978-952-86-0282-8

*This dissertation is dedicated to anyone who has ever been, loved, or tried to help someone living through a suicidal crisis.*

*May it show you that you do not struggle alone.*

# ABSTRACT

Gaily-Luoma, Selma
Co-constructing recovery in suicidal crises: Service users’ perspectives on healthcare and crisis services after a suicide attempt
Jyväskylä: University of Jyväskylä, 2024, 103 p.
(JYU Dissertations
ISSN 2489-9003; 817)
ISBN 978-952-86-0282-8 (PDF)

There is a significant body of research on the epidemiology of suicidal behavior in Finland, along with some important findings on the timing and nature of healthcare contacts among individuals in suicidal crises or near suicidal death. However, the subjective meanings these services hold for service users have rarely been explored. The current research contributes an exploration of Finnish suicide attempt survivors’ interpretations of the healthcare and crisis services they had received and desired during their recent suicidal episode. The research was conducted in collaboration with MIELI Mental Health Finland (MIELI), the City of Helsinki, and the Hospital District of Helsinki and Uusimaa. All three original studies were based on data from in-depth interviews with fourteen suicide attempt surviving adults. Each participant had taken part in the Attempted Suicide Short Intervention Program (ASSIP), a brief suicide-specific add-on intervention provided by MIELI crisis services. Each had also used healthcare services in relation to their recent suicidal crisis. The studies applied content analysis to the qualitative data. Study I focused on how interactions with healthcare were perceived as helping and hindering recovery during the suicidal crisis. Study II investigated the subjective impact of ASSIP. Study III explored the participants’ accounts of their recovery-related agency and the role of services in co-creating it. By providing a window into the subjective meaning-making of suicide attempt survivors, this research shed light on how movements toward recovery or relapse may be perceived as co-constructed in the complex processes of interaction between those in suicidal crises and those responding to these crises in the context of healthcare or crisis services. The findings call attention to the gaps that the current dominance of medicine’s perspective on suicidal suffering may leave in indicated suicide prevention and the opportunities that more pluralistic and multidisciplinary approaches may present for filling them. Based on the findings of the three original studies, I argue that services for suicide attempt survivors should give more priority to providing relationship-focused support, integrating suicide-specific interventions into sufficiently continuous service paths, and acknowledging the agency of the service user as a primary target of and resource for intervention.

*Keywords:* suicide attempt, suicide prevention, service user, healthcare, crisis, brief intervention, recovery, relational, agency, qualitative

# TIIVISTELMÄ (ABSTRACT IN FINNISH)

Gaily-Luoma, Selma
Itsemurhakriisistä toipuminen yhteisen työn kohteena: itsemurhaa yrittäneiden näkökulmia terveys- ja kriisipalveluista saatuun apuun
Jyväskylä: Jyväskylän yliopisto, 2024, 103 s.
(JYU Dissertations
ISSN 2489-9003; 817)
ISBN 978-952-86-0282-8 (PDF)

Suomalaisten itsetuhokäyttäytymisestä ja itsemurhakriisin aikana käytettyjen terveydenhuollon palveluiden ajoituksesta on olemassa suhteellisen laaja tietopohja, mutta palvelunkäyttäjien näille palveluille antamia merkityksiä on tutkittu harvoin. Tässä tutkimuksessa selvitettiin itsemurhayrityksestä selviytyneiden aikuisten tulkintoja palveluista, joita he olivat saaneet ja toivoneet itsemurhakriisinsä aikana. Tutkimus toteutettiin yhteistyössä MIELI Suomen Mielenterveys ry:n (MIELI ry), Helsingin kaupungin sekä Helsingin ja Uudenmaan sairaanhoitopiirin kanssa. Kaikissa kolmessa osatutkimuksessa aineistona olivat neljäntoista itsemurhayrityksestä selviytyneen aikuisen syvähaastattelut. Jokainen haastateltava oli osallistunut MIELI ry:n kriisipalveluiden tarjoamaan Lyhytinterventioon itsemurhaa yrittäneille (Linity) sekä käyttänyt terveydenhuollon palveluita itsemurhakriisin yhteydessä. Laadulliseen aineistoon sovellettiin sisällönanalyysiä. Tutkimuksessa I tarkasteltiin, miten osallistujat kokivat vuorovaikutuksen terveydenhuollon kanssa auttaneen tai haitanneen toipumistaan. Tutkimuksessa II selvitettiin osallistujien käsitystä Linityn vaikutuksista. Tutkimuksessa III analysoitiin osallistujien kuvauksia toipumiseen liittyvästä toimijuudestaan ja palveluiden roolista sen luomisessa. Tutkimus osoitti, miten polkujen itsemurhakriisistä toipumiseen tai sen pitkittymiseen voidaan nähdä rakentuvan vuorovaikutuksessa palvelunkäyttäjien ja ammattilaisten välillä. Tutkimus myös valotti joitakin itsemurhien ehkäisyn kannalta tärkeitä ilmiöitä, jotka lääketieteellisen näkökulman valta-asema terveydenhuollossa ja itsemurhatutkimuksessa saattaa jättää varjoon, ja mahdollisuuksia, joita moninäkökulmaisempi lähestyminen voisi tarjota. Osatutkimusten tulosten pohjalta väitän, että itsemurhaa yrittäneille suunnatuissa palveluissa tulisi paremmin huomioida 1) palvelunkäyttäjien ihmissuhteisiin kohdentuvan tuen tarjoaminen, 2) itsetuhoiseen käyttäytymiseen kohdennettujen interventioiden sisällyttäminen osaksi riittävän jatkuvia palvelupolkuja sekä 3) palvelunkäyttäjän toimijuuden tunnistaminen sekä interventioiden ensisijaiseksi kohteeksi että niiden keskeiseksi voimavaraksi.

*Avainsanat:* itsemurhayritys, itsemurhien ehkäisy, palvelunkäyttäjä; terveydenhuolto, kriisi, lyhytinterventio, toipuminen, relationaalisuus; toimijuus, laadullinen tutkimus

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# ACKNOWLEDGEMENTS

This dissertation illustrates the power that even small interactions can have in shaping, helping or hindering recovery-related action in suicidal crises. Obviously, the prerequisites for my own pursuit and completion of this doctoral research have also been co-created in a world of interactions. As this journey comes to its end, I am filled with gratitude for all that has made it possible.

First, I am thankful to the participants for choosing to share their experiences for the purposes of this research and for all they have taught me by doing so. This project was originally born of my desire to gain further insight into my role as a professional in responding to suicidal crises. I also sought a more comprehensive understanding of the core processes involved in effective intervention. As I conclude this work, I am happy to observe that both aims have been achieved. In my view, the greatest value of this dissertation is its demonstration of the wholly co-created nature of recovery processes in suicidal crises. I have found that an understanding of this co-creative process alleviates many of the (potentially paralyzing) pressures associated with work in high-risk situations with suicidal individuals. For me, it has also served to enrich the meaningfulness of that daunting work. It is my hope that this dissertation may provide similarly helpful insights to other professionals facing these challenges.

I thank my principal supervisor Aarno Laitila for taking me on back in 2017 and for consistently making himself available to address my questions and discuss this project ever since. Aarno, you have been a steadfast lighthouse in what have been, at times, quite foggy waters, and I thank you for helping me navigate them. Juha Holma, thank you for challenging my choices when you did – your criticisms were always well-placed and necessary, even if I sometimes needed a moment to see it. Jukka Valkonen, thank you for your observant comments and especially for recognizing my need for encouraging words during some particularly frustrating periods of this research process. Your expressions of confidence in and recognition of my hard work were more important in restoring my resolve than you may know.

I warmly thank my pre-examiners, Professor Eugenie Georgaca and Professor Sami Pirkola, for their careful review of this dissertation. Professor Georgaca, I appreciate your feedback and thank you for agreeing to act as the opponent in the public examination of my work. Professor Pirkola, I am grateful for your thoughtful comments, questions and suggestions that helped improve the manuscript in its final stage.

This research would not have been possible without the willingness of the professionals at MIELI Mental Health Finland to learn about their clients' point of view and the impact of their work. I am deeply grateful to Frans Horneman, Marena Kukkonen, Outi Ruishalme, Sanna Vesikansa and the MIELI Mental Health Finland Suicide Prevention team for the opportunity to study the experiences of MIELI clients participating in the Attempted Suicide Short Intervention Program (ASSIP). Special thanks go to all the ASSIP therapists who invited their clients to participate. Frans and Marena, thank you for all your

practical help during this project, as well as for your own important work toward a service system that would better serve those in suicidal crises. A thank you also to Juha Metelinen from the MIELI Suicide Prevention Center in Kuopio: your encouragement along the way has meant a lot, and your work on integrating ASSIP and Attachment-Based Family Therapy is an inspiration.

I would also like to thank Professor Emeritus Konrad Michel, with whom I've had the chance to become acquainted through our mutual collaboration with MIELI. Professor Michel, I thank you for making yourself available to comment on Study II as well as for all your contributions to understanding and addressing the needs of suicidal patients throughout your career. Learning about ASSIP through the stories of the participants has instilled in me a deep appreciation and respect for your work.

A number of other collaborators and University of Jyväskylä staff have also been crucial to the completion of this project. I am grateful to Erkki Isometsä and the Hospital District of Helsinki and Uusimaa as well as Kirsi Suominen, Henno Ligi and the City of Helsinki for helping make the data collection for this dissertation possible. Elina Jokinen's writing retreats provided the perfect combination of space and structure and were critical to the birth of each of the original study reports. Michael Freeman's careful proofreading and thoughtful suggestions have made the original studies and this summary much more readable. Tiina Volanen always responded to my questions with amazing and much appreciated effectiveness, patience and supportiveness. I am also deeply appreciative of the financial support provided by the Emil Aaltonen Foundation and the Alfred Kordelin Foundation for this research.

During the years I have worked on this dissertation, I have also had the opportunity to collaborate on several other projects that have taught me a lot. I am deeply grateful to Erkki Isometsä, Petri Arvilommi and Tomi Bergström, as well as all the co-authors in the studies led by them, for the opportunity to take part in their important research. I am also grateful for the many collaborations in which I've been able to transform some of what I've learned into, e.g., training materials and digital resources. I thank all the teams and organisations that have invited me to talk at their events, the professionals that have chosen to take part in my lectures or trainings, and the peers I've had dialogues with in, e.g., conferences and doctoral seminars. All these opportunities to share, discuss and get feedback on the emerging insights of this work have added greatly to its joy and meaningfulness.

My first encounters with suicidal service users were as a psychology intern at the Aurora psychiatric hospital, at which I later worked for several years as a psychologist. I am deeply grateful to my supervisors from those days, Juha Voutilainen and Harri Valkonen, for the support I received in the first months and years of my career. Without their guidance in navigating both the practical and emotional challenges of that work, I would likely have grown overwhelmed and wary instead of developing an interest in further work with suicide attempt survivors. Through their example, Juha and Harri taught me the importance of warm and respectful spaces in which professionals of varying seniority, interests

and theoretical backgrounds may reflect upon their personal experiences of this ever-surprising work and learn from each other. I cherish those shaping experiences. I also thank all the teachers, supervisors and peers who have provided sustaining dialogical spaces in more recent years.

While many friends and colleagues would deserve thanks for their role in shaping who I am and how I work, two have expanded my professional horizons in particularly profound ways. Over dinner one night back in 2016, Arja Sarkio sold me on the idea of joining her for four years of couples' and family therapy training. I am deeply grateful for the transformative experience those four years turned out to be – and for the opportunity to share that experience with you, Arja. For a similarly unexpected yet defining detour I thank Sara Nurminen, who convinced me to join the nascent Terapiat etulinjaan team in 2020. During the two years I spent on that team, I learned a lot about our service system, its service users, and my own profession. I was also challenged to form better-grounded stances on many difficult questions, e.g., 'In a world of limited resources, what do I believe are the most important aspects of mental health services?' Regarding these topics, my simultaneous learning journeys into this research, couples' and family therapy, integrative individual psychotherapy, and healthcare service design resulted in both inner and outer dialogues that could be described as multivoiced on good days and tormenting on the others. I am thankful for the time and space that writing this dissertation summary has provided to reflect upon, clarify, and articulate some of the ideas emerging from those dialogues.

Of course, my intentionality and power toward these doctoral pursuits have their roots in my early years and relationships, not just my professional life. I am fortunate to have learned from the example of those who raised me that work can be a source of deep meaning and joy. I am also grateful for all the support I have received from my (extended) family of origin over the years. That support has led me to believe that I can pursue my interests, and that belief, in turn, has led to many deeply rewarding endeavors, professionally and otherwise.

While this work consumes me with excitement at times and with frustration and uncertainty at others, I am grateful for and to my children for reliably grounding me in a reality beyond it. For me, the need to show up for them in the various ways parenting requires has been a necessary antidote to getting (too badly) lost in either procrastination or overdrive during this research process. Having these funny and insightful young people in my life is of course a gift in many other ways, as well.

Jukka, I thank you for our fun young people and for everything else you have made possible. The brilliance, persistence and courage you show in your own work is a constant inspiration. It makes me smile to think how consistent you have been in viewing this dissertation as worth pursuing and me as capable of accomplishing it. Your thoughtful counsel, sense of humor and endless supply of quality memes on academic life have sustained me during trying times and made good times better. I also deeply appreciate the generosity with which you have made it possible for me to pursue this and other professional dreams during these years filled with many competing interests and responsibilities.

I often feel overwhelming gratitude at the recognition that my work primarily involves exploring what I view as life's most meaningful questions, whether with clients in the therapy room, with other professionals during training and supervision, or through scientific writing. I cannot imagine anything I would rather do for a living. Finally, I am grateful to live and practice in a society founded on a commitment to protect the well-being of those among us in distress. I thank all those trying to ensure through their own actions, whether at the grassroots or in positions of power, that we keep working toward fulfilling that commitment instead of betraying it.

Espoo, August 6, 2024

Selma Gaily-Luoma

# LIST OF ORIGINAL PUBLICATIONS

I Gaily-Luoma, S., Valkonen, J., Holma, J., & Laitila, A. (2022). How do health care services help and hinder recovery after a suicide attempt? A qualitative analysis of Finnish service user perspectives. *International Journal of Mental Health Systems*, *16*(1), 52. https://doi.org/10.1186/s13033-022-00563-6

II Gaily-Luoma, S., Valkonen, J., Holma, J., & Laitila, A. (2023). Client-reported impact of the Attempted Suicide Short Intervention Program. *Psychotherapy Research*, *33*(0), 1–14. https://doi.org/10.1080/10503307.2023.2259070

III Gaily-Luoma, S., Valkonen, J., Holma, J., & Laitila, A. (2024) Suicide attempt survivors' recovery-related agency in the relational context of services: a qualitative analysis. Submitted manuscript.

Taking into account the comments made by the co-authors, the author of this dissertation designed the research, collected and analysed the data, and wrote the three original publications.

## FIGURES

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# 1 INTRODUCTION

A non-lethal suicide attempt[1] is associated with a significantly elevated risk of suicidal death persisting over long periods of time (e.g., Aaltonen et al., 2024; Bostwick et al., 2016; Suominen et al., 2002). This makes attending to the needs of suicide attempt survivors a priority in suicide prevention efforts (Erlangsen et al., 2024; Partonen, 2020; Suicide Prevention and Intervention After Attempted Suicide: Current Care Guidelines, 2022). For those with a history of one or more suicide attempts, follow-up studies in Finland (Aaltonen, 2019; Haukka et al., 2008; Suominen et al., 2002) and other Nordic countries (Erlangsen et al., 2015; Probert-Lindström et al., 2020; Tidemalm et al., 2008) report long-term survival rates ranging from 65% to over 95%, with the risk of completing suicide found to depend on a variety of factors, including sex and diagnostic group (e.g., Tidemalm et al., 2008), the method of the index suicide attempt (e.g., Runeson et al., 2016), the decade the service user has entered treatment (e.g., Aaltonen et al., 2024) and the contents of received care (e.g., Erlangsen et al., 2015).

The proportion of suicide attempt survivors dying by suicide should alert policy makers and professionals alike to the serious risk of death associated with these behaviors (Bostwick et al., 2016). However, the survival rates also reveal the dynamic and thus hopeful nature of suicidal phenomena. After a survived attempt, suicide is far from inevitable, and the majority of suicide attempt survivors even in high-risk subgroups do not die by suicide (e.g., Carroll et al., 2014; Maiden et al., 2021; Pajonk et al., 2005; Tidemalm et al., 2008).

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[1] While the intention behind an act of self-injury is often difficult, if not impossible, to ascertain, there is much potential value in differentiating between self-harming acts with intended fatal consequences and those with no such intentions. As a result, the nomenclature and classification of these behaviors is complex, and no consensus has been reached on whether an evaluation of intent should or should not be included in the chosen terms (e.g., Goodfellow et al., 2017; Kapur et al., 2013; Silverman et al., 2007; Tapola, 2014). To harmonize with the language used by the Attempted Suicide Short Intervention Program (Michel & Gysin-Maillart, 2015), this dissertation primarily discusses *suicide attempts* (i.e., takes a stance on the presence of suicidal intent). However, when citing studies that do not differentiate between suicide attempts and non-suicidal self-injury, I use the broader term *self-harm (*including self-injurious acts irrespective of intent). When not differentiating between suicidal thoughts and actions, I use the umbrella term *suicidal behavior*.

While effective intervention after a suicide attempt is possible, preventing suicides within this vulnerable group remains highly complex, making the guidance of service users crucial for developing high-quality service responses (e.g., O'Connor & Portzsky, 2018; Scarth et al., 2021; Watling et al., 2022). This dissertation aims to inform such development efforts by exploring the experiences, needs, and preferences of Finnish suicide attempt survivors in the 2020s.

What do those in suicidal crises have to say about the role of current Finnish healthcare and crisis services in their recovery[2] or in their suffering? How may professionals best help suicide attempt survivors to remain safe and (re-)build a life they perceive as worth living? These are the questions I set out to explore. To contextualize the current findings, I will begin with brief overviews of the history of suicide research and prevention in Finland as well as some of the identified challenges and proposed approaches to intervening in suicidal crises.

## 1.1 A brief history of Finnish suicide research

Suicide is a multifaceted phenomenon that has been explored from a multitude of scientific perspectives. The earliest influential scientific works on suicide were published in philosophy (Hume, 1777/2006) and sociology (Durkheim, 1897/2002). Since the early 20th century, the fields of medicine and psychology have dominated much of suicide research and public discussion. However, the study of suicide continues to be of interest in practically all branches of science that touch on human experience, behavior, or environments. In recent years, dissertations on suicidal phenomena in Finland have been published in such fields as meteorology (Ruuhela, 2018), economics (Huikari, 2018) and cultural studies (Kosonen, 2020). Building upon a long tradition of Finnish suicide research, the current dissertation investigates attempted suicide as a concern for health and crisis services.

The history of Finnish suicide research can be traced back to the 1750s when Finland began recording suicides, establishing what has become the world's longest uninterrupted time series on recorded suicidal deaths (Holopainen et al., 2013). Records of suicides in Finland are considered highly reliable (Erlangsen et al., 2024). While suicides tend to be under rather than over-recorded in all countries, such under-recording seems to apply to only a small proportion of Finnish suicides, whereas it has been found to reduce the reported rate of suicide by more than 100% in some other countries (Tollefsen et al., 2012). This variation in recording bias hampers global or even European comparisons of suicide rates. However, in relation to the other Nordic countries with similarly reliable statistics, Finland was long an outlier with a notably high rate of suicide

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[2] Recovery is a concept with various meanings in the health and psychological sciences. In this dissertation and its original studies, the concept of recovery is used to refer to an idiosyncratic, personal process entailing, for example, (re-)strengthened experiences of safety, relief from suffering, and commitment to living (cf., Ropaj et al., 2023; Sokol et al., 2022), rather than a reduction of clinical symptoms below a nomothetic threshold.

(Erlangsen et al., 2024). During 2000 to 2018, Finland achieved a 35% decrease in suicide deaths, while rates in most of the other Nordic countries showed considerably smaller decreases or remained stable (Oskarsson et al., 2023). These differing trajectories of change have resulted in Finland's age-adjusted suicide rate currently being comparable to those of its Nordic neighbors, although still in the higher range. The most recent (for the year 2022) age-standardized rates of suicide per 100 000 inhabitants were 11.9 in Finland, 12.4 in Sweden, 9.9. in Norway, 7.5 in Denmark and 7.4 in Iceland (Erlangsen et al., 2024).

### 1.1.1 The Finnish National Suicide Prevention Program

In 1986, Finland launched the first nation-wide, research-based suicide prevention program in the world. Spanning the period from 1986 to 1996, the Finnish National Suicide Prevention Program (FNSPP) included a research phase, including psychological autopsies for all 1397 suicide deaths occurring during a one-year period (1986-1987), and an implementation phase with broad cooperation across sectors and regions. The FNSPP was considered a success (Beskow et al., 1999; Kerkhof, 1999; Upanne et al., 1999), and was followed by a steady decline in the number of completed suicides, with the Finnish suicide rate halving between 1990 and 2020 (Statistics Finland, 2024). While the effects of the FNSPP are complex and difficult to determine, it is widely assumed that it was, at least in part, responsible for the decline in completed suicides (e.g., Isometsä, 2022; Korkeila, 2014; Partonen, 2020).

The FNSPP produced over a hundred peer-reviewed publications, making a major contribution to suicide research internationally as well as domestically (Goldney, 2004). Since the completion of the program, suicide research has remained active in Finland. The most prominent contributors in these continuing efforts have been psychiatrists (e.g., Erkki Isometsä, Jouko Lönnqvist, Mauri Marttunen, Timo Partonen, Sami Pirkola), many of whom were involved in the FNSPP and have since contributed to dozens or even hundreds of suicide-related publications spanning several decades. This research has focused on the epidemiology of suicidal behavior as well as clinical trials and register-based studies investigating the delivery, use and outcomes of treatment. These research efforts have made a substantial contribution to the international knowledge base on suicidal behavior, making Finland bigger than its size in the field of suicidology (Goldney, 2004; Wilson, 2004).

### 1.1.2 Finnish research on suicidal service users' experiences

This dissertation is situated in the strand of research concerned with service user experiences and their implications for service development. Internationally, such research has gained more prominence in the last decade, as the involvement of persons with lived experience as informants and/or as collaborators is increasingly seen as valuable or even imperative in both suicide research and prevention efforts (e.g., O'Connor & Portzsky, 2018; Watling et al., 2022; Scarth et al., 2021). The recent publication of the first Cochrane protocols to review also qualitative evidence on service users' experiences of care after an episode of self-harm (Scarth et al., 2021) and corresponding staff attitudes (Fortune et al., 2021) testify to the increasing value ascribed to this perspective.

In Finland, the experiences and perspectives of suicidal service users, their families and the suicide-bereaved have frequently been of interest to students in nursing, education, social work and first-responder occupations such as paramedics and police officers. The dozens of undergraduate theses on these topics may be seen as a reflection of the usefulness of qualitative methods in understanding, learning about, and building expertise in professional practice (McLeod, 2011). However, very little published research has used qualitative methods to investigate suicidal phenomena in Finland, and over the past four decades, only a handful of published studies have specifically explored the perspective of Finnish service users experiencing suicidal crises. A brief overview of these studies is given below.

During the FNSPP, Järventie (1993) used both qualitative and quantitative methods to explore suicide attempts and suicidal deaths occurring in the 1970s and 1980s, respectively. Järventie argued that as the dominant paradigms of both the social and medical sciences were focused on uncovering the causal relationships between environmental influences and/or personal characteristics and suicidal behavior, they were futile in the quest to *understand* suicide. Järventie turned instead to action theory and psychoanalysis to conceptualize human existence as a continuous process of person-world interactions and to explore these processes in the context of suicidal behavior. Järventie's key finding was that suicide and suicide attempts may be understood as the end-result of a process of 'surviving to death', i.e., as motivated by a desire to escape from an experience of psychological and social entrapment.

In the early 1990s, Nissilä (1995) interviewed suicide attempt survivors to explore their understandings of what motivated their suicide attempt as well as their perceptions of their own death or immortality. Nissilä contrasted these accounts to conceptions of death in a group of patients with physical trauma resulting from an accident. Nissilä's findings demonstrated, among other things, the wide variety of stated motivations behind suicidal action and the complicated relationship of suicidal behavior to thoughts – or lack thereof – of death and dying.

In the first published qualitative study focusing on Finnish service users' experiences of suicidality in the new millennium, Hinkkurinen, Rissanen and Kylmä (2014) explored experiences of hopelessness in male in-patients who had attempted suicide. They found that these men associated their suicide attempt with experiences of losing the meaningfulness of life, shame and anxiety associated with a fear of being exposed and having lost/losing one's honor, entrapment, and giving up. Most of the men described a long ebb and flow of suicidal thoughts, with the eventual suicide attempt associated with a perceived dead-end, i.e., experiencing oneself as incapable of doing anything about the circumstances of one's life that felt unbearable.

The work of Järventie (1993), Nissilä (1995) and Hinkkurinen et al. (2014) focused on experiences of the suicidal process or act and did not elaborate on experiences or expectations of professional help as part of these processes. Similarly, few others have taken such a focus in Finnish suicide research. Suominen et al. (2004) interviewed service users to explore their perspectives on the psychosocial assessment they had received after their suicide attempt. However, only a quantitative summary of these results was reported: key findings included the observation that those at highest risk of further suicidal action were most likely to be indifferent about receiving an assessment in advance (meaning that indifference should not be a reason to withhold an assessment), and that assessments were often perceived by service users to have happened too soon after the suicide attempt, especially among those recovering from intoxication (Suominen et al., 2004). A dissertation by Tapola (2014) included findings on a novel brief intervention administered to nine patients who had engaged in deliberate self-harm. However, patient satisfaction was only inquired about via quantitative methods and only the percentage of those willing to recommend the treatment and the mean satisfaction ratings were reported. While these studies provided valuable information on what was directly inquired about (e.g., Did you find the timing of the assessment appropriate? Would you recommend this intervention to others?), there was no room for the kind of novel or surprising contributions that qualitative research allows participants to deliver in the form of, e.g., their own analyses of what was valuable or suggestions for improvement.

Most recently and most closely related to the aims of the current study, Miettinen's (2022) dissertation explored service users' experiences of help received in relation to suicidal behavior. Through essays, interviews and an electronic questionnaire, Miettinen investigated the perspectives of persons with a history of self-harm in adolescence, as well as the perspectives of their parents. In these participants' view, meaningful interventions consisted of creating a trusting environment, asking about and hearing adolescents' talk of self-harm and accounting for individual needs and preferences in helping interventions. Help was expected to be provided for both adolescents and their loved ones, including parents and siblings. Both adolescents and their parents reported a multitude of barriers to receiving such help through the service system. Thus, Miettinen's findings illustrated both the opportunities and the challenge of effective intervention in suicidal crises.

## 1.2 The challenge of preventing suicides after suicidal action

The World Health Organization (WHO) proposes the Universal, Selected and Indicated prevention model to guide national suicide prevention efforts (Nordentoft, 2011; WHO, 2014). *Universal* prevention targets the whole population with the aim of promoting health and reducing risk for suicidal outcomes by, e.g., removing barriers to health care, promoting responsible media coverage of suicides, and strengthening protective processes such as social support (WHO, 2014). *Selected* prevention measures target vulnerable groups with an elevated risk of developing suicidal behaviors, and may include, e.g., screening, and enhanced access to care, such as providing crisis helplines (Nordentoft, 2011; WHO, 2014). This dissertation is concerned with *indicated* prevention, i.e., the prevention of further suicidal acts in persons with a history of suicidal behavior (WHO, 2014). The task of indicated prevention is complicated by both the limited evidence on effective intervention and by the difficulty of translating extant research findings into effective real-life practice (e.g., Fox et al., 2020; Franklin et al., 2017; O'Connor & Portzky, 2018).

### 1.2.1 Suicide prevention in changing healthcare contexts

For most of the 20th century, suicidal persons who had access to mental health care were frequently treated with long-term psychotherapy and/or in-patient treatments (Jobes, 2000; Rudd et al., 1999). Beginning in the late 1980s and early 1990s, a sharp decline in the relative dominance of in-patient treatment in mental health care both internationally and in Finland led to a growing number of suicidal crises being treated exclusively or predominantly in out-patient settings (e.g., Jobes, 2000; Pirkola et al., 2007). In the US, due to changes in managed care companies' and insurance providers' policies, this turn coincided with pressure to replace long-term out-patient psychotherapy with more time-limited interventions (Rudd et al., 1999), as well as the emergence of the evidence-based medicine paradigm (Evidence-Based Medicine Working Group, 1992) and associated movements toward evidence-based practice in, e.g., psychology (Lovasz & Clegg, 2019). Together, these developments presented new challenges for responding to and engaging acutely suicidal persons in services and awakened the field of clinical suicidology to the scarcity of scientific data to inform clinical practice (Rudd et al., 1999).

Starting in the 1990s, a new paradigm for responding to suicidal patients begun to emerge. It was born out of efforts to better accommodate patients' needs, the changing service system, and the wider societal climate, which especially in the US involved and continues to involve the threat of litigation (Jobes, 2000; Michel et al., 2002; Rudd et al., 1999). The challenge presented by the changing environment brought many of the leading experts in clinical suicidology together to re-think and articulate what was known about effective practice, and what remained unknown and needed to be recognized as such (Michel et al., 2002; Michel & Jobes, 2011; Rudd et al., 1999). While emerging within the healthcare context, this new paradigm also came to challenge some aspects of the more traditional medical approach to suicide prevention, as it shifted the emphasis from the expert stance of professionals to more collaborative efforts to understand and manage suicidal risk (Jobes, 2000; Michel & Jobes, 2011).

Publications articulating this new paradigm were preceded and influenced by, e.g., Edwin Shneidman's (1998) conceptualization of 'psychache' at the heart of suicidal behavior and Marsha Linehan's work with dialectical behavior therapy (Linehan, 1991). The new paradigm proposed that for clinical practice to be effective, 1) suicidal behavior should be framed as serving a psychological purpose (i.e., as an attempt at coping) rather than as mindless symptomology; 2) an understanding of the patient’s frame of reference (i.e., their reasons for considering suicide) should form the basis for interventions; 3) building a therapeutic alliance should be prioritized as it is key to engaging the suicidal patient and thus succeeding in any other helping efforts; and 4) interventions should target suicidality directly rather than (only) associated diagnoses such as depression (Jobes, 2000; Michel et al., 2002; Michel & Jobes, 2011).

The emotional challenge that working with suicidal clients presents for the clinician was put front and center in articulating the need for new frameworks (Jobes, 2000; Michel et al., 2002; Rudd et al., 1999). Practices such as avoiding addressing suicidality, excluding suicidal patients from services, and administering coercive or omnipotent interventions (such as involuntary hospitalization or no-suicide contracts) were described as clinicians’ common dysfunctional efforts to deal with the anxiety provoked by encountering suicidal individuals, whereas the new frameworks for practice were seen as a way to alleviate the pressure felt by clinicians, allowing them more freedom to engage the suicidal individual in a human, therapeutic relationship and thus improve the quality of care (Jobes, 2000; Michel et al., 2002; Michel, 2011; Rudd et al., 1999; see Ferracioli et al., 2023, for a recent synthesis of professionals’ experiences of working with suicidal individuals). These ideas have informed the development of all the current empirically supported suicide-specific psychosocial interventions. However, they may be seen as co-existing with rather than replacing the more traditional medical approaches in healthcare systems (e.g., Jobes & Chalker, 2021; Michel, 2021).

### 1.2.2 Struggling to meet the needs of suicidal service users

In a recent register-based study, Partonen et al. (2022) found that in Finland 46% of those who had died by suicide from 2016 to 2018 had attended health care services within a week of their death, and 21% had done so on the day of their death. These and similar findings in other Western countries (e.g., Ahmedani et al., 2019; Bergqvist et al., 2022) suggest that the identification of suicidal individuals remains a challenge for services, as does effective intervention once risk is identified (Partonen et al., 2022). In follow-up studies of suicide attempt survivors presenting in healthcare, the highest risk of repeat suicidal action has consistently been found in the period immediately following a suicide attempt (Aaltonen, 2019; Arvilommi et al., 2022; Haukka et al., 2008; Isometsä, 2020; Tidemalm et al., 2008). Adding to the challenge of effective intervention, suicidality is associated with a high risk of early dropout from treatment (Dyvesether et al., 2021; Kasteenpohja et al., 2015; Lizardi & Stanley, 2010), with more severe symptomology associated with higher levels of non-engagement and attrition (Hom et al., 2015; Hom & Joiner, 2017), and non-attendance in follow-up psychiatric services after deliberate self-harm associated with risk of death (Qin et al., 2022).

Suicide attempt survivors’ high risk of further suicidal behavior combined with the high risk of withdrawing from service interactions makes effective follow-up in the days, weeks and months following a suicide attempt a priority for suicide prevention efforts (Erlangsen et al., 2024; Lizardi & Stanley, 2010; Mann et al., 2021; Michel et al., 2002; Turecki & Brent, 2016; Zalsmann et al., 2016). However, the majority of service users presenting with suicidal behavior attend no mental health follow-up after an emergency room visit (Feng et al., 2023; Hom et al., 2015; Hunter et al., 2018). Concerns about the quality of mental health care received by suicidal individuals have been raised by studies focusing on completed suicides (e.g., Isometsä, 2001; Roos af Hjelmsäter et al., 2019) as well as those investigating at-risk groups (e.g., Hunter et al., 2018; Kasteenpohja et al., 2015; Uddin et al., 2023).

The availability of evidence-based interventions in routine healthcare is typically limited, and the effect of any single intervention is modest at the group level (Fox et al., 2020). Qualitative research also demonstrates that healthcare systems often struggle to provide responses that the heterogeneous group of suicidal service users would find meaningful or helpful, and both the quality, continuity and comprehensiveness of healthcare responses is often perceived as lacking (MacDonald et al., 2020; Miettinen, 2022; Scarth et al., 2021; Taylor et al., 2009; Uddin et al., 2023). Both inpatients (Berg et al., 2017) and in-patient staff (e.g., Awenat et al., 2017) have perceived inadequacies in in-patient care. Service users frequently find staff attitudes stigmatizing (e.g., Frey et al., 2016; Shand et al., 2018; Sheehan et al., 2019) and studies directly assessing staff attitudes show that attitudes may be negative, especially in general hospitals and toward those with repeated suicidal episodes (e.g., Karman et al., 2015; Saunders et al., 2012).

In Finland, the shift toward de-institutionalization and decentralization in mental health services has been associated with a decline in suicide rates (Pirkola et al., 2007; Pirkola et al., 2009). Recently, Aaltonen (2019) found that in line with the decline in the national suicide rate, suicide mortality after psychiatric hospitalization for depression was considerably and consistently lower in later as compared to earlier cohorts of patients admitted to in-patient care during 1991-2011, and this encouraging trend was also evident in more recent cohorts (up to 2017; Aaltonen et al., 2024). However, Aaltonen et al. (2024) called attention to the extremely high risk of suicide that was continuing to be detected immediately post-discharge, highlighting the importance of timely, continuous, and effective post-discharge care.

While prompt follow-up and continuity of care have been proposed as key, convincing evidence for specific interventions to reduce suicides in the recently discharged is lacking (Erlangsen et al., 2024). The peak in the occurrence of suicides found in the days following admittance to a psychiatric hospital (Erlangsen et al., 2024) presents a further challenge. Suicidal deaths have also been found to be associated with reductions or breaks in the continuity of care (Appleby et al., 1999; Choi et al., 2020) and it has been debated whether there may, in some cases, be an actual causal link between hospitalization and suicide (e.g., Large & Kapur, 2018; Ward-Ciesielski & Rizvi, 2021). Together, these observations and speculations illuminate the complexity and potential complications of intervening in suicidal crises.

## 1.3 Psychosocial interventions in indicated prevention

Receiving psychosocial support after deliberate self-harm has been found to reduce the risk of repeated suicidal action in both short- and long-term follow-ups (Erlangsen et al., 2014; Fox et al., 2020; McCabe et al., 2018; Nuij et al., 2021; Sobanski et al., 2021). Recently, Fox et al. (2020) meta-analyzed treatments targeting suicidal outcomes, Nuij et al. (2021) meta-analyzed safety-planning-type interventions, Sobanski et al. (2021) reviewed suicide-specific psychotherapeutic interventions and McCabe et al. (2018) presented a narrative synthesis of suicide-specific brief interventions, each concluding that the suicide-specific psychosocial interventions were in general more effective than control conditions. Evidence has also recently been shown for the cost-effectiveness of providing a suicide-specific psychosocial intervention to service users presenting with self-harm (Krysinska et al., 2023; Park et al., 2018).

While suicide-specific interventions (i.e., interventions directly addressing suicidal behavior) seem to outperform less specific support in preventing further suicidal action, convincing evidence for the superiority of any particular suicide-specific psychosocial intervention remains lacking (Fox et al., 2020; Hawton et al., 2016) and the effect of any individual intervention is relatively small (Fox et al., 2020). Erlangsen et al. (2024) suggest that the rigorous methods of investigation used for evaluating clinical interventions (i.e., randomized controlled trials with active treatment control groups) may lead to very conservative estimates of the effectiveness of these interventions when compared to the evidence for other suicide prevention measures (e.g., means restriction) which is mostly based on pre- and post-measurement data. Other authors have noted that due to the relatively low base-rate of suicidal outcomes even in high-risk groups, trials tend to be underpowered for detecting suicide-related effects (e.g., Brown & Jager-Hyman, 2014; Fox et al., 2020; Nordentoft, 2011; O'Connor & Portzky, 2018). There are also complex ethical and safety implications both for including high-risk patients in randomized controlled trials and for excluding them from such research (e.g., O'Connor & Portzky, 2018)

Randomized controlled trials (RCTs) conducted on suicide-specific interventions in the Nordic countries have yielded mixed results, often finding no significant difference in outcomes between the target intervention and active treatment controls (Erlangsen et al., 2024; for a recent Finnish clinical trial, see Arvilommi et al., 2022a). In interpreting these null results, it becomes relevant to ask whether comparing the group-level performance of two or more bone fide psychological therapies designed for the same purpose is a useful route to building knowledge about effective intervention. While it is a reasonable target of investigation within the medical model paradigm of psychotherapy (emphasising the specific ingredients of therapies in producing outcomes), proponents of the contextual model (emphasising the common ingredients) would not expect such trials to yield useful insight (Wampold & Imel, 2015).

### 1.3.1 The proliferation of suicide-specific psychotherapies

Psychotherapeutic interventions specifically targeting suicidal behavior have been developed since the 1980s (for a summary of current interventions with trial evidence, see Table 1). The first showing evidence of effectiveness in preventing suicide attempts was dialectical behavior therapy (DBT), which was developed for treating chronically suicidal patients with a diagnosis of borderline personality disorder (Linehan et al., 1991; Linehan, 1993). Rooted in behavioral therapy, DBT views self-harm as a form of dysfunctional coping, i.e., as reflecting a lack of adaptive coping skills, and thus emphasizes the importance of skills training in targeting it (Linehan, 1993). Designed for the challenging task of alleviating pervasive and severe suicidal behavior, DBT integrates individual therapy, group-based skills training, and team-based support for therapists (Linehan, 1993).

TABLE 1 Suicide-specific psychosocial interventions for adults

| **Abbrev.** | **Title of intervention** | **Theoretical background** | **Typical duration** | **Reference** |
|---|---|---|---|---|
| SPI | Safety Planning Intervention | Cognitive-behavioral | 1 session | Stanley & Brown, 2012 |
| CRP | Crisis Response Planning | Cognitive-behavioral | 1 session | Bryan et al., 2017 |
| TMBI | Teachable Moment Brief Intervention | Integrative | 1 session | O'Connor et al., 2015 |
| ASSIP | Attempted Suicide Short Intervention Program | Integrative | 3-4 weekly sessions | Michel & Gysin-Maillart, 2015 |
| CAMS | Collaborative Assessment and Management of Suicidality | Integrative/ 'Non-denominational' | 6-12 weekly sessions | Jobes, 2000/2023 |
| BCBT-SP | Brief Cognitive Behavioral Therapy for Suicide Prevention | Cognitive-behavioral | 6-12 weekly sessions | Bryan & Rudd, 2018 |
| CT-SP | Cognitive Therapy for Suicide Prevention | Cognitive-behavioral | 6-12 weekly sessions | Wenzel, Brown & Beck, 2009 |
| DBT | Dialectical Behavior Therapy | Cognitive-behavioral | min. 1 year, 2 sessions / week | Linehan, 1993 |
| MBT | Mentalization-Based Therapy | Psycho-dynamic | min. 1 year, 2 sessions / week | Bateman & Fonagy, 2016 |

While DBT was the first intervention to evidence a reduction in suicidal behavior in an RCT, it is actually borderline personality disorder-specific rather than suicide-specific per se, i.e., designed for addressing self-harm in the context of personality disorder. Mentalization-based therapy (MBT) was designed to address the same population of patients and, like DBT, also combines individual and group therapy (Bateman & Fonagy, 1999; 2016). Drawing on the psychoanalytic/psychodynamic tradition, and especially attachment theory, MBT views self-harming behaviors as arising from problems with mentalizing evident, e.g., in the inability to understand that feelings of hopelessness do not equate a hopeless reality or a need to make psychological pain 'real' by inflicting it on the body (Bateman & Fonagy, 1999; 2016). The development of a stronger mentalizing capacity (and thus a better capacity for emotion-regulation and impulse control) is the goal of MBT (Bateman & Fonagy, 1999; 2016).

Both DBT and MBT target chronic self-harming behavior in intensive therapy programs, with weekly group and individual sessions for at least a year. Several more brief suicide-specific interventions have also emerged from the cognitive-behavioral tradition in an attempt to balance suicide attempt survivors' needs and diminishing resources for care (Rudd et al., 1999). From the beginning, alternative models of cognitive and/or cognitive-behaviorally based suicide-specific therapies have been proposed, and several variations of interventions in this 'family' have been investigated, the most prominent being cognitive therapy for suicide prevention (CT-SP; Wenzel et al., 2009) and brief cognitive behavioral therapy for suicide-prevention (BCBT-SP; Bryan & Rudd, 2018). These interventions share much of their theoretical basis but differ somewhat in their therapeutic foci. In contrast to interventions originating from specific theoretical traditions, the collaborative assessment and management of suicidality (CAMS; Jobes, 2000;2023) was developed as a 'nondenominational' approach, i.e., as a framework for suicide-focused intervention that is able to accommodate a variety of treatment settings and theoretical orientations. CAMS originated from research on the Suicide Status Form, a collaborative assessment method, and centers around it (Jobes, 2023).

Cognitive and cognitive behavioral therapies for suicide prevention seem to reduce suicidal behavior, but they only outperform non-specific treatment controls (i.e., TAU) rather than other suicide-specific interventions, and have not outperformed TAU in in-patient settings (Hawton et al., 2016; Yiu et al., 2023). Evidence of publication bias also casts a shadow on the findings (Tarrier et al., 2008). Similarly, DBT has been found to be effective in preventing self-harm when compared to TAU (DeCou et al., 2019), but did not outperform another suicide-specific intervention (CAMS) (Andreasson et al., 2016) or TAU in in-patient settings (Yiu et al., 2023). Evidence for MBT in the prevention of self-harm is similarly promising but inconclusive (Hajek Gross et al., 2024), while some evidence also exists for the effectiveness of other psychoanalytic/psychodynamic therapies over TAU (Briggs et al., 2023). Finally, CAMS has been found to outperform TAU in reducing suicidal ideation but not suicidal behaviors (Swift et al., 2021), and its effectiveness did not differ from that of DBT in a trial

(Andreasson et al., 2016). Evidence to support the matching of specific subgroups of service users with specific treatments remains lacking (Fox et al., 2020).

### 1.3.2 (Ultra)brief suicide-specific interventions

The 1990s and early 2000s saw the proliferation of structured suicide-specific treatments that were also considered brief in relation to the preceding standard (Rudd et al., 1999). However, even shorter interventions have been rolled out in the last decade in hopes of tackling the challenges of early treatment dropout and limited healthcare resources (Doupnik et al., 2020; Lizardi & Stanley, 2010). The most recent empirically supported, suicide-specific psychosocial interventions vary in length from one to three sessions; they are sometimes referred to as 'ultrabrief' to differentiate them from the group of (brief) interventions averaging 6-12 sessions (i.e., CT-SP, BCBT and CAMS). Recent meta-analyses have found that suicide-specific (ultra)brief interventions reduced suicide attempts and enhanced linkage to follow-up care (Doupnik et al., 2020; Nuij et al., 2021). While suicide-specific (ultra)brief interventions have shown promise in reducing suicidal behavior, none of them have been shown to outperform any other suicide-specific treatment (McCabe et al., 2018; Nuij et al., 2021).

The (ultra)brief interventions with current evidence of effectiveness include the Brief Intervention and Contact (BIC; Fleischmann et al., 2008), the Safety Planning Intervention (SPI; Stanley & Brown, 2012), the Crisis Response Plan (Bryan et al., 2017), the Teachable Moment Brief Intervention (TMBI; O'Connor et al., 2015) and the Attempted Suicide Short Intervention Program (ASSIP; Michel & Gysin-Maillart, 2015). The BIC consists of one in-person session in which the suicide attempt survivor is informed about suicidal behaviour, alternatives to suicidal behaviours, and referral options, and this session is followed by brief contacts (via telephone or in-person) over 18 months (Fleischmann et al., 2008). BIC was developed for use in low- and middle-income countries, but has also been piloted in the US (Riblet et al., 2021). Both SPI (Stanley & Brown, 2012) and CRP (Bryan et al., 2017) draw on cognitive-behavioral therapy to identify warning signs of suicidal action and plan for strategies to divert action to a safer route. While CRP was originally developed to be used as part of on-going treatment, SPI was specifically designed for use in emergency rooms and similar settings allowing only one-time contact with suicide attempt survivors (Stanley & Brown, 2012). It should be noted that all of the multiple-session suicide-specific interventions incorporate a version of safety planning, although with varying nomenclature and techniques.

Of the (ultra)brief interventions, ASSIP (Michel & Gysin-Maillart, 2015) is of special interest in this dissertation: all the current participants took part in it, and Study II specifically investigated experiences of it. With its 3-4 weekly sessions and 24-month letter follow-up (including an invite to reach out to the ASSIP therapist if in crisis), ASSIP is situated in intensity between the one-session interventions and those in the 6-12 session group. ASSIP was developed in Switzerland to serve as a suicide-specific add-on to treatment as usual and was provided as such to the current participants. The most distinctive component of

ASSIP is the video-taping and collaborative viewing of the suicidal narrative, which forms the basis for the subsequent collaborative case conceptualization and identification of personal long-term goals, warning signs and safety strategies (Michel & Gysin-Maillart, 2015). Illustrating the frequent overlapping of key components in suicide-specific interventions (Jobes & Chalker, 2019), ASSIP also utilizes the Suicide Status Form (constituting the heart of CAMS; Jobes, 2023).

## 1.4 Current Finnish suicide prevention efforts

In Finland, the continuing need for suicide prevention efforts has been recognized on a national level. The first national current care guidelines for suicide prevention and intervention after a suicide attempt were published in 2020 and updated in 2022. These guidelines emphasize the importance of quality care for suicide attempt survivors in the prevention of further suicide attempts and suicides (Suicide Prevention and Intervention After Attempted Suicide: Current Care Guidelines, 2022). The guidelines state that all suicide attempt survivors should receive a psychosocial assessment led by a medical professional with expertise in psychiatry, a chain analysis of the suicidal episode and safety planning should be conducted, and further need-based care provided with minimal delay.

Finland also set a new national program for suicide prevention for the years 2020-2030 (Partonen, 2020). Action points of the program include influencing attitudes (e.g., reducing stigma; promoting information on mental health and suicide prevention in the community), affecting the availability of suicide methods, providing early support (e.g., expanding accessibility to help lines, establishing 24-hour chat support and referral from social media platforms, strengthening low-threshold mental health services), supporting risk groups (e.g., those with a history of suicidal behavior; the suicide bereaved; at-risk minorities), developing care (e.g., availability of evidence-based interventions; continuity of care; ensuring a compassionate care culture), increasing media competence and strengthening the Finnish knowledge base and research on suicide (Partonen, 2020). However, execution of the program currently lacks sufficient earmarked government funding, despite the importance of long-term planning and dedicated funding for the effectiveness of national suicide prevention efforts (Erlangsen et al., 2024).

Funding for the non-governmental organizations (NGOs) responsible for many aspects of preventive efforts (e.g., providing crisis help lines and support for the bereaved) is currently also under threat. The first FNSPP was built upon widespread collaboration between regions, organizations and sectors. In its wake, many Finnish suicide prevention efforts have taken the form of multi-sector collaborations, with NGOs, associations for service users and/or families, including those bereaved by suicide, and public healthcare services working together. The NGO MIELI Mental Health Finland (MIELI) has been a leading force in these efforts. As one of the longest-standing mental health NGOs in the world, MIELI has a long tradition in suicide prevention. This includes providing crisis services, educating professionals, fostering attitudinal changes towards mental health and suicide through widespread informational campaigns, and advocating for new policies.

In 2013, MIELI imported ASSIP (Michel & Gysin-Maillart, 2015) and initially implemented it in the MIELI crisis centers in Helsinki and Kuopio. In 2018, MIELI's long-standing work on suicide prevention was re-organized under newly launched Suicide Prevention Centers in Helsinki and Kuopio. Some of the crisis workers involved in providing ASSIP have since been certified as ASSIP-trainers and have gone on to train other professionals to use the intervention. To date, MIELI's efforts have led to the availability of ASSIP in over a dozen cities nation-wide, through crisis centers and some public healthcare providers. MIELI has also collaborated in ASSIP-related research projects, including a clinical trial by Arvilommi et al. (2022a, 2022b) and the current dissertation, which explores the service experiences of ASSIP clients. However, MIELI's operations currently face downsizing due to a substantial decrease in its governmental funding.

## 1.5 Informing suicide prevention through qualitative research

Despite advances in the understanding and treatment of suicidal behavior over recent decades, considerable gaps persist in service systems' ability to effectively identify, engage and help those at imminent risk, making clear the need for further research and development efforts (Erlangsen et al., 2024; Partonen, 2020; Scarth et al., 2021; Uddin et al., 2023). Throughout this dissertation I will argue that in pursuing advances in the field of suicide prevention, qualitative research designs provide a crucial complementary perspective to that provided by quantitative research. To date, some exemplary qualitative studies have shed light on, e.g., in-patient psychiatric care (Samuelsson et al., 2000), the meaning of psychiatric nurses' work (Cutcliffe et al., 2006) and recurrent suicidal acts (Bergmans et al., 2017) from the perspective of suicide attempt survivors. I have previously summarized some of the practice-relevant insights provided by qualitative research on suicide attempt survivors' experiences in a narrative review written for Finnish clinicians (Gaily-Luoma, 2020).

Through their rich descriptions of patients' experiences, individual qualitative studies may provide professionals with insights that facilitate their relating to suicidal patients and thus providing effective care (Gaily-Luoma, 2020). Systematic reviews of qualitative research, in turn, serve to provide a more comprehensive or over-arching understanding of their target themes, e.g., what service users find to be relevant aspects of meaningful services across populations and contexts (Tong et al., 2016). To date, systematic reviews including both quantitative, mixed-methods and qualitative studies on suicidal service users' treatment experiences have illuminated the universal importance of perceived staff attitudes for service users' experiences of care as well as their choices to engage in or withdraw from services (Taylor et al., 2009; Uddin et al., 2023). Reviews and syntheses focusing exclusively on the small body of qualitative research on suicidal service users' experiences have shed light on what contributes to experiences of safety during in-patient stays (Berg et al., 2017) as well as experiences of service users presenting at hospitals for treatment after self-harm and these experiences' relation to further self-harming and help-seeking behaviors (MacDonald et al., 2020). However, the scarcity of qualitative service user research as well as the contents of its findings suggest there remains much more to be learned from the first-person accounts of those experiencing suicidal crises and, more specifically, of those in the high-risk group of recent suicide attempt survivors.

# 2 THE AIMS OF THE STUDY

The main aim of this research was to provide insight into the service experiences and preferences of Finnish suicide attempt survivors. The three original studies explored 1) helpful and hindering aspects of healthcare services as perceived by the participants, 2) the subjective impact of ASSIP as an add-on intervention provided by crisis services, and 3) the co-construction of recovery-related agency as presented in the participants' accounts of their interactions with services.

# 3 METHOD

In this section, I will outline the philosophical premises of this research as well as the ethical considerations concerning its design and execution. I will also describe the participating sample and the invited population of ASSIP clients in more detail than in the original publications. More detailed descriptions of data collection and the qualitative analyses employed can be found in the original studies.

## 3.1 Philosophical assumptions underlying the research

This dissertation applies a pragmatic approach to qualitative knowledge-building in a field largely committed to positivistic and postpositivistic paradigms. The pragmatic approach suggested by Morgan (2007) is less concerned with metaphysical questions related to the nature of reality and truth (ontology) than with epistemological and methodological questions related to the possibilities of generating knowledge regarding the research questions and aims of the research. A pragmatic approach allows for the possibility of meaningful communication across the boundaries of paradigms that are sometimes understood as incommensurable, e.g., constructivism and (post-)positivism (Morgan, 2007).

Specifically, the aim of the current research was to produce a rich understanding of suicide attempt survivors' perspectives on the helping efforts of crisis and healthcare services and to communicate these findings in ways accessible to relevant audiences, including healthcare professionals and service developers. To be compatible with the pragmatist approach proposed by Morgan (2007), the methodological choices made throughout the study (from the design and data collection to analyses and reporting) should serve this aim. Hence, this dissertation draws on more than one research paradigm and tradition of qualitative inquiry, reflecting the 'bricoleur' approach typical of qualitative research (McLeod, 2011; Ponterotto, 2005).

The study design and analyses were primarily influenced by what has been called the constructivist-interpretivist paradigm of science (e.g., Ponterotto, 2005). This paradigm derives from, e.g., philosophical hermeneutics and phenomenology (Ponterotto, 2005). Research in the constructivist-interpretivist paradigm seeks to produce a contextually bound, deep understanding of phenomena as experienced by the subjects affected, rather than to explain the phenomena per se. The perspective is idiographic, i.e., knowledge is produced through a detailed analysis of the singular or particular, while more generalized understanding may only be produced through an abductive logic. Consistent with the philosophical assumptions underlying the paradigm, the assessment of research quality is concerned with credibility, transferability, dependability, confirmability, and authenticity, rather than reliability, generalizability or objectivity (e.g., Ponteretto, 2005; Stiles, 2003; Yardley, 2000).

While the research questions led this research to adopt a constructivist-interpretivist epistemology and methodology, the original studies and their reporting have also been influenced by some postpositivist ideas. These influences reflect both my 'postpositivist socialization' (Ponterotto, 2005) into psychology as a science and the dominant (post)positivist paradigm(s) of the field(s) in which these studies sought to contribute (Park et al, 2020; Young & Ryan, 2020). Postpositivist paradigms acknowledge the impossibility of achieving completely objective observations of reality but are nonetheless committed to pursuing generalizable knowledge that is as free as possible from such sources of error as, e.g., researcher bias, unrepresentativeness of study samples and unreliability of measures (Young & Ryan, 2020). (Post)positivist influences evident in the current research include, e.g., concerns about the representativeness of the study sample and the resulting implications for the transferability or even generalizability of the findings to a larger population, as well as, e.g., assuming that investigator triangulation is a meaningful way of ensuring quality and validity.

## 3.2 The co-construction of the interview data

The primary data for analysis in each of the three original studies are research interviews. From the epistemological stand-point of this dissertation, the data from any interview are an outcome of (co-)construction rather than of mere retrieval, i.e., it is assumed that the data produced in any interview are, in part, created in and by the situation in which they are delivered (Brinkmann & Kvale, 2018). To enable readers to interpret the current findings, a closer look at this process of co-creation is warranted.

### 3.2.1 The positioning of the interviewer

All interviews were conducted by the author of this dissertation. At the time of the interviews, I was in my late thirties and had about 10 years of work experience as a psychologist in psychiatric in-patient and out-patient services provided by the City of Helsinki. From the very beginning of my career, my responsibilities prominently involved assessing and treating individuals experiencing suicidal crises and following suicide attempts. In fact, this dissertation was primarily inspired by my wish to better understand the experiences and perspectives of the service users I was trying to help. I was thus very much 'inside' the topic of research as it pertained to experiences of interactions with healthcare services during suicidal crises.

My interest in ASSIP was also sparked in the context of my work in healthcare. In 2013, ASSIP was introduced into the psychiatric services I was working in as an additional resource available to suicide attempt survivors, and we were encouraged to refer any potential clients to take part in it. I found ASSIP's focus on the suicidal narrative intriguing (in an early outline for this dissertation, I planned to focus on these narratives). However, I found the idea of subjecting a suicide attempt survivor to the videotaping and playback of this narrative initially almost out of the question, and I was thus hesitant to refer clients to ASSIP. I also strongly doubted what could be achieved by such a brief intervention. Over time, I started to hear good things about ASSIP from clients who had taken part in it, thereby arousing my curiosity. Thus, at the beginning of this research project, I had no personal stake in ASSIP but was curious to learn more about it.

I had recently begun my studies toward a degree in couple and family psychotherapy when I began outlining this study in the beginning of 2017; I finished these studies during the data collection. Both my previous studies and my work in healthcare had promoted (psycho)diagnostics of the individual as a basis for delivering specific evidence-based interventions. In contrast, my studies in family therapy promoted an understanding of human suffering through relationships rather than individuals or pathologies. These ideas had a profound impact on me and, consequently, on this research, as they provided an antidote to the 'postpositivist socialization' (Ponterotto, 2005) and allowed me to consider a study design that intrigued me as a practitioner, i.e., one privileging the voices of service users and focusing on mental health services as interactions.

From these beginnings, I reached for 'qualified naïveté' (Brinkmann & Kvale, 2018) in the interviews. As recommended by Brinkmann and Kvale (2018), I aimed to use my pre-knowledge of the topic area to allow for a sensitive and nuanced exploration of it, while remaining open to new and unexpected phenomena. My genuine curiosity and interest in learning more about the participants' viewpoints helped with achieving the latter: I was hoping to be taught and surprised, and often was.

### 3.2.2 The process of the interviews

During the study period, all eligible ASSIP clients were informed of the study by their ASSIP therapist at the beginning of their first ASSIP session and asked for their consent to participate at the end of their final ASSIP session. When a client consented to enroll in the study, the client's ASSIP therapist informed me and I contacted the potential participant as soon as possible, i.e., within a couple of days. The interviews were arranged via a phone call to the participants (which, in turn, was often arranged via a text message). I perceived these interactions as the starting point for an alliance and paid careful attention to ensuring they were sensitive to and respectful of each participant. Despite the research context, these interactions were not designed to be neutral in emotional tone, but instead warm and encouraging. This choice was for both ethical (above all, the aim was to not harm the participants, and withholding interpersonal warmth in interactions with persons in vulnerable positions may well be harmful) and practical reasons (I expected this would facilitate the formation of a strong alliance that, in turn, would generate richer data in the research interviews, as the participants would feel more comfortable with sharing their experiences).

At the beginning of each interview, I introduced myself as a psychologist and explained to the participant that I was pursuing my PhD with the goal of gaining deeper insights into the experiences of suicide attempt survivors who had undergone ASSIP and possibly other related services. I made it clear that I was genuinely interested in hearing any views and experiences the participant would be willing to share with me, while also reassuring them that they were free to decline answering any question. I told them that while the papers I was holding (the interview topic guide, see Table 2) were there to remind me of questions I wanted to ask, I would primarily follow their lead, the idea being that we would have a conversation rather than going through a sequence of questions and answers. I reminded the participant that I would ask them again at the end of the interview whether they were still willing to share their data with the research team, and that declining to do so would have no negative consequences for them. I also informed them that they could ask me to pause or stop the interview and the recording at any time.

After checking that the participant had no further questions about procedure, I began with the first question ('What made you decide to participate in this interview?'). I then proceeded with the questions in the order presented in the interview topic guide or in the order they naturally arose in relation to what the participant had already narrated. After the first four interviews, one question was dropped from the interview protocol ('Do you feel that your situation has been understood by the professionals treating you; has their understanding matched yours?'), as it seemed to confuse the participants rather than invite reflection.

Throughout the interviews, I focused on forming and maintaining a safe alliance. I aimed for 'neutrality' in the sense that my questions would not invite answers with specific content or of specific valence, i.e., I posed them as openly as possible in both wording and tone. However, I did not attempt to remain emotionally 'neutral', but rather responded with emotion when this seemed to be expected or appropriate (e.g., shared in the participant's delight when they were narrating a particularly positive experience and in their frustration when narrating setbacks or unsatisfying interactions). I also let it show when I was emotionally moved by the participants' accounts and often thanked them during (and not only after) the interview for the effort they put into sharing their experiences.

TABLE 2 Interview topic guide

| # | Interview question |
|---|---|
| 1 | What made you decide to participate in this interview? |
| 2 | How did you become a client of ASSIP? |
| | a. How did you find out about ASSIP? |
| | b. What made you decide to participate? |
| 3 | What has participating in ASSIP been like for you? |
| | a. Has any aspect of ASSIP surprised you? If so, what and how? |
| | b. What aspect of ASSIP, if any, has been most helpful for you? |
| | c. Have you found any aspect of ASSIP unhelpful or even hurtful in some way? If so, what and how? |
| | d. Has ASSIP helped you to move forward? |
| | e. What, if anything, could have been done better or differently? |
| 4 | What other services related to your suicidal crisis have you received, either before or since the suicide attempt? |
| 5 | What has participating in (or receiving) this service been like for you? [Asked separately for each service mentioned by the participant.] |
| | a. Has any aspect of this service surprised you? If so, what and how? |
| | b. What aspect of this service, if any, have you found most helpful? |
| | c. Has any aspect of this service been unhelpful or even hurtful in some way? If so, what and how? |
| | d. Has this service helped you to move forward? |
| | e. What, if anything, could have been done better or differently? |
| 6 | What, if anything, has been expected of you as a user of these services? |
| | a. How have you felt about these expectations? |
| 7 | What hopes or expectations do you have regarding services now or in the near future? |
| 8 | What aspects of care do you consider most important, if you think about helping a suicidal person or a suicide attempt survivor in general? |
| 9 | What has help from non-professionals meant for you during your suicidal crisis? |
| 10 | Is there anything else you would like to say about your experiences? |
| 11 | What has participating in this interview been like for you? |

The most frequent follow-up questions were prompts to elicit more about an issue or episode they had mentioned (e.g., ‘Can you tell me more about that?’ or ‘Is there anything else that’s important that comes to mind about that?’). I could ask for concrete or specific examples when participants spoke in general terms. When participants described an episode that seemed meaningful to them but did not elaborate on their subjective take on it, I used meaning-oriented follow-up questions (Brinkmann & Kvale, 2018) such as ‘What did that mean for you?’, ‘What did you think happened there?, ‘How did you understand that situation?’ or ‘How did that affect you?’ to gain an understanding of their subjective viewpoint. When participants narrated a decision-making situation, I often asked them to elaborate on how they came to the decision they had made (e.g., to disclose or withhold information in a specific situation) or what had made it possible to, e.g., act in a way they described as unfamiliar or new to them. When participants contradicted themselves, I might gently confront them to address the contradiction (e.g., when a participant first narrated something with emotion and then stated that it didn't really matter).

Throughout the interviews, I attempted to check on the validity of my initial interpretations of the participants' accounts. When I was unsure if I was correctly understanding the implicit idea or reading 'between the lines' (Brinkmann & Kvale, 2018), I tried to gain clarification by asking open questions. If that did not help, I sometimes offered a bolder interpretation of what the participant had said at the end of the sequence of questions on that topic (e.g., by introducing a concept such as 'hope' or 'self-compassion' that the participant had not used but that seemed to me a likely component of the experience they were describing). In the analyses, these sequences were not used unless the participant had been prompted by my interpretation to elaborate in ways that made it clear that they were not simply acquiescing in my point of view.

Some participants needed very little prompting to share their subjective reality, while others needed more encouragement. As an interviewer, I was persistent in inviting the participants to elaborate on the subjective meanings of their experiences. To my delight, most participants produced very rich narratives, and all provided material that enabled access to their meaning-making on at least some of the issues they had presented as key in their experiences.

### 3.2.3 The implications of the co-construction of the data

Above, I elaborated on the co-construction of the interview data. However, in the original studies the co-constructed nature of the interview data is either not discussed or is only touched upon in passing. This apparent paradox reflects a conscious methodological choice consistent with the pragmatic approach employed in the current research (Morgan, 2007). Epistemologically, I view the interview data as constructed rather than as 'mined' (Brinkmann & Kvale, 2018), i.e., as representing a contextually created version rather than an uncovered essence of the participants' subjective 'truth'. However, I perceive this to be equally true for all data concerning human experience or behavior, including, e.g., data collected through psychometric measures. If human information processing is perceived of as contextual and memory-recall as a process of (re-)construction – as would be stated in any textbook of cognitive psychology (e.g., Kellogg, 2015) – then it must be accepted as inevitable that *any* form of inquiry into human experience or psychological processes evokes a variety of reactions, some more conscious than others, and thus leads to responses that are affected (i.e., co-constructed) both by the context and manner of that inquiry and by the subjectivity of its target.

In other words, my epistemological stance is that there is no way to access 'pure' data on human experience or mental processes (cf., Guyon, 2018), and hence the methodological choices I have made are primarily pragmatic. In conducting this research, I have opted to consider the interview data as a meaningful and relevant, if in no way pure, reflection of the participants' subjective reality. I have made this choice not merely because this assumption supports the use of this data for the aims of the current study, but because the same issues of co-construction would affect any other means of data collection and no unproblematic means of achieving these aims is thus available. While the current data could arguably also be used to investigate research questions related specifically to the co-construction of understandings in a qualitative research interview, this is not the focus of the current research and is thus not elaborated on.

From a constructivist-interpretivist perspective, knowledge is co-constructed, and the process of understanding is always interpretative in the sense that it is mediated by the observer (e.g., Ponterotto, 2005). I perceive this co-construction to also affect the consumption of reported research: not only are qualitative findings co-constructed in the processes of data collection and analyses, they are also re-interpreted by each audience of the published results. Although the co-constructed nature of the interview data was not given much attention in our reported analyses (the original studies), I believe that enabling the reader to better imagine the context of the interviews gives the research more transparency and thus adds to its credibility, trustworthiness and perhaps also persuasiveness (cf., Morgan, 2007). Thus I have included this information here to facilitate readers' informed (re-)interpretations of the findings.

## 3.3 Ethical considerations

Studying persons at risk for suicide is an ethically multifaceted issue. On the one hand, it is of utmost importance to make members of this vulnerable group heard and have their voices shape high quality care for others in similar crises. On the other hand, participating in a study on an issue as sensitive as suicidality may include potentially harmful elements and risks that need to be considered at all stages of the research. Examinations of the the ethical aspects of research into suicidal individuals such as those by Lakeman & Fitzgerald (2009), Lees et al. (2015) and Andriessen et al. (2019) have guided the planning and execution of this study. The following ethical concerns were identified and addressed based on the work of these authors as well as on the relevant national ethical guidelines. This research received ethical approval from the Helsinki University Hospital Ethics Committee and all participants gave their written consent for participation.

### 3.3.1 Informed consent in qualitative research

The question of informed consent is a challenge in research involving individuals in vulnerable positions and on sensitive topics, and in some ways further complicated by the use of a qualitative methodology. Ethical guidelines require participants, before consenting, to be informed of the study and of their continuing right to decline or later withdraw from the study without any consequences for their care. However, some qualitative research experts argue that informed consent for a qualitative study cannot really be given in advance, as it is impossible to inform the participant fully of what is to come (McLeod 2011). In the current study, this concern was taken into consideration by the practice of returning to the question of consent at the end of the study interview. At that point, participants knew what kind of data they had produced and were given an explicit opportunity to withdraw their data from the study, if they so wished. Special attention was also paid to the manner in which consent was requested, so that those invited to enroll in the study would feel as free as possible to decline. The high proportion of participants who declined at the first step (invitation to enter the study) may be interpreted as evidence that participation was perceived as genuinely voluntary. No participant wished to withdraw at the end of the study interview.

### 3.3.2 Safety and privacy of the participants

Potential risks to participants' safety are a key concern in suicide research (e.g., Andriassen et al., 2019; Lees et al., 2016). In the current research, the risk to participants was greatly reduced by the naturalistic study design. The participants were invited to participate in one study interview, but in all other ways their treatment was undertaken exactly as it would have been in the absence of the study. However, the topics explored in the interview were of a kind that could induce strong emotional reactions, and there was no way of anticipating how vulnerable the participants might feel at the time of the interview. In response to these concerns, the study was designed so that the interviews took place in a safe environment familiar to the participants (the MIELI Suicide Prevention Center, where they had also received ASSIP).

To ensure researcher competency (Lees et al., 2019), the interviews were conducted by a psychologist experienced in the care of suicidal individuals (the author of this dissertation). The forming of a safe alliance was given special attention, and the experience of the interview and its present and anticipated effects on each participant's emotional state were explored and their management planned for together with the participant. The practices inherent in narrative interviewing (e.g., respect and value for the interviewee's unique account) were expected to further reduce the risks for the interview inducing harmful effects (Michel & Valach, 2011). In similar research, participants have most commonly described the research interview as a positive experience (e.g., Lees et al. 2015; Littlewood et al., 2019; Pavulans et al., 2012). This was also the case for the current participants.

To ensure the participants' safety further, participants were asked (in advance) for their consent to a breach of confidentiality in special circumstances: should a concern for the immediate safety of a participant arise during the study interview, the interviewer would have the right to contact the healthcare professional in charge of their care to enable intervention. The course of action in such an instance would, of course, be negotiated and executed in collaboration with the participant as far as possible. No need for such action arose during the study.

The privacy of the participants was ensured with careful planning for the collection and storing of their data as well as consideration for careful concealing of their identities in reporting the research. Due to the participants' right to privacy, none of the original data was published with the study reports.

### 3.3.3 Quality of the research

The participants made a significant contribution by sharing their stories and experiences for use as data in this study, thereby motivating the research team to ensure that this valuable data were translated into research of high quality. I draw on the work of Yardley (2000), McLeod (2011), Stiles (2003), O'Brien et al. (2014) and Brinkmann and Kvale (2018) in summarizing the key efforts made to ensure quality in the different phases of this research.

#### 3.3.3.1 Study design and data collection

The key concerns addressed during the study design and data collection were closely associated with the ethicality of the research (discussed above) as well as the appropriateness of the study procedures for the research questions (e.g., the importance of a naturalistic design). The exploratory qualitative design in a naturalistic setting allowed for access to the real-world experiences of service users. Collaboration with MIELI allowed for the collection of data from a group of participants both sufficiently homogeneous (i.e., sharing the experience of a recent suicide attempt and participation in ASSIP) and heterogeneous (diverse) to produce meaningful data concerning the research questions. The first author's experience with the research topic and training in interviewing skills enabled sensitivity (Brinkmann & Kvale, 2018; Yardley, 2000) and made possible an adequate focus on both the interpersonal aspects of the interview and the knowledge quest at hand. Access to the participants' narratives of the suicide attempt (constructed as part of ASSIP) helped further contextualize the interview data.

#### 3.3.3.2 Analyses

Qualitative analyses may be subjected to a variety of quality criteria depending on the methodological assumptions associated with them (e.g., Yardley, 2000). The quality criteria employed in the current research emphasized the commitment of the researcher(s) to a comprehensive interpretation of the data facilitated by, e.g., prolonged engagement, immersion in the data, persistent observation, and iteration (Stiles, 2003; Yardley, 2000). Multivoiced challenges to the emerging interpretations were also sought: first from the participants during interviews and later within the research group and through presentations of preliminary analyses, illustrated with excerpts of raw data, to a variety of audiences including fellow researchers and practitioners. Inter-rater agreement was not pursued, but a degree of investigator triangulation was sought and accomplished in discussions of the raw data and emerging codes and analyses with co-authors. The comments of journal editors and reviewers also helped improve the quality of the research.

#### 3.3.3.3 Reporting of the research

The presentation for publication of a study and its findings is a crucial phase of any research project aiming to make an impact and be useful (O'Brien et al., 2014; Yardley, 2000). The current research aimed for adequate depth and thickness of interpretation and coherence of presentation so as to effectively and persuasively 'tell a story' and thus be useful to both practitioners and researchers interested in the questions it addressed. In the reporting phase, special attention was paid to the transparency of the research process (including both data collection and analysis) and grounding of the findings in the original data, i.e., the participants' accounts.

## 3.4 Participants

The participants were recruited upon entering ASSIP at the MIELI Suicide Prevention Center in Helsinki. Their ASSIP therapist informed them of the study at the beginning of the first ASSIP session and asked for their consent to participate at the end of the final session. The study sample thus consisted of suicide attempt survivors who had completed ASSIP. No exclusion criteria beyond that used in ASSIP (i.e., adequate fluency in Finnish, absence of a substance abuse disorder severe enough to impede engagement in ASSIP, and that the suicide attempt had not taken place during a psychotic episode) were applied, except for the requirement that participants be at least 18 years old.

### 3.4.1 Selection and representativeness of the sample

Of the 104 eligible service users invited to take part in the study, 18 gave their initial consent. Of these 18, three withdrew before the interview (citing scheduling difficulties and/or a lack of resources) and one could not be interviewed due to the onset of the COVID-19 pandemic. Thus, fourteen participants were interviewed. While this uptake of 13.5% may be considered good for a qualitative study requiring such intense involvement, the participants represent a small minority of the eligible service users. From a (post)positivistic viewpoint, the self-selection of the participants presents a serious threat to the validity and transferability (generalizability) of the findings (Park, 2020; Young & Ryan, 2020). As I wish to communicate with audiences holding such views, a closer look at this threat is necessary.

No data beyond their stated reason for declining (if the declining service user volunteered one) was collected on those deciding not to participate. However, MIELI relies on governmental funding that requires it to collect data on both user demographics and feedback on its services. These data were available for use in anonymous form. This allowed comparing the characteristics of our sample with data collected from a more representative sample of clients entering ASSIP during the study period, thereby enabling some insight into the selection of the study sample.

In the following figures I will present feedback data from a more representative sample of ASSIP clients (n=109) alongside data from the sample of participants interviewed in-depth for this dissertation (n=14). The feedback data were collected from the ASSIP clients at the end of the last session of the intervention, i.e., the feedback dataset only includes individuals who completed ASSIP. The response rate for feedback during the study period was 68%. If should be noted that as all feedback was given anonymously, the current participants may be amongst those completing the feedback form. In addition, the feedback data includes some underaged participants as well as some participants from outside the study area (receiving ASSIP in Kuopio), i.e., groups that were excluded from the current study. While the feedback data are imperfect, they nevertheless help illustrate the population from which the participants were recruited.

#### 3.4.1.1 Demographic variables

The demographic data of our participants alongside the data on ASSIP clients giving feedback are presented in Figures 1 and 2. Figure 1 shows that the age distribution of our participants closely corresponded to that of the ASSIP clients giving feedback, except for the underaged participants who were excluded from the study sample. Figure 2 shows that men were slightly overrepresented in our sample (in our sample, the proportions represent registered sex and are thus binary, wheras the MIELI data are based on self-identification).

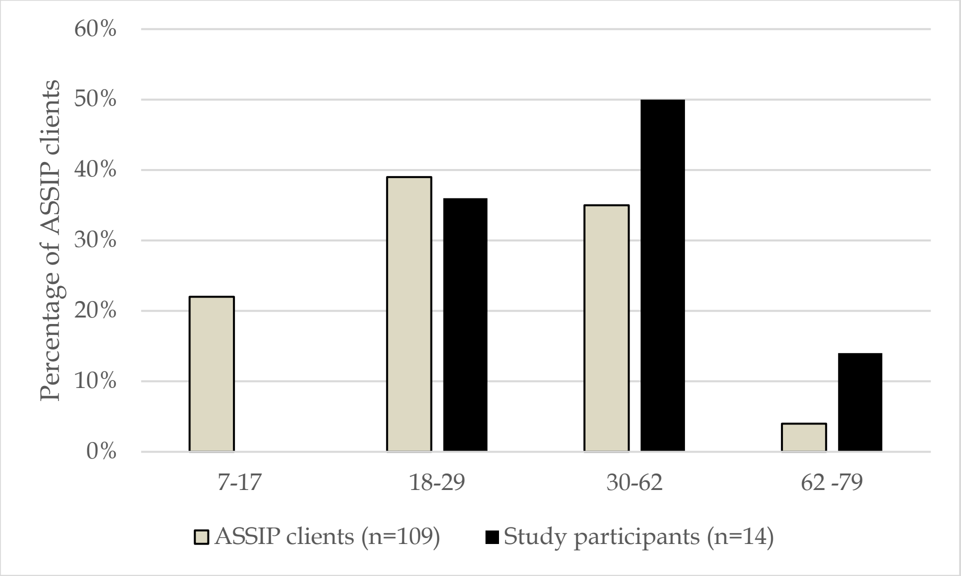

FIGURE 1 Age of ASSIP clients and the study sample

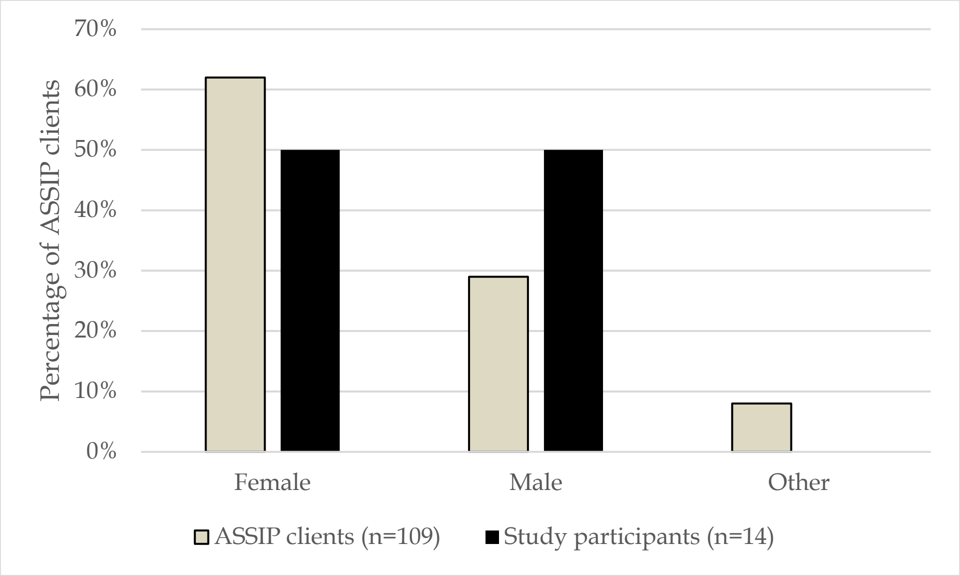

FIGURE 2 Sex of ASSIP clients and the study sample

### 3.4.1.2 History of mental health, suicidality, and service use

Information on diagnoses or history of suicidality is not collected by MIELI and is thus not available for ASSIP clients. While our sample may not be representative of the population of ASSIP clients in these respects, it is encouragingly diverse. First, it included both first-time attempt survivors and persons with a history of one or more previous suicide attempts. Second, based on participants' accounts and self-reported diagnoses, the sample included both persons with a history of milder and/or more transient mental health issues (e.g., depressive episodes, anxiety disorders, acute stress reactions) and those with more pervasive and serious impairment (e.g., borderline personality disorder, a history of psychotic depression, severe dissociative symptoms). Third, it included both participants with experiences of in-patient treatment and those who had not been referred to specialized services at all, and thus represented the diversity of service paths for suicide attempt survivors. Fourth, while the most serious substance abuse disorders were excluded by ASSIP's entry policy, several participants reported significant problems with alcohol use. This enhanced the representativeness of the sample, as suicidal behavior is often associated with alcohol use (e.g., Pirkola, 1999).

### 3.4.1.3 Evaluations of ASSIP

The finding that the participants all had a positive impression of ASSIP, while many of them reported critically on other services, raised the question of whether the sample was (self-)selected based on satisfaction with ASSIP. Again, I was able to investigate this concern by examining the routine feedback collected from ASSIP clients at the end of the last ASSIP session. As described above, while the responses to the feedback form are from a slightly different population (e.g., including underaged participants), they nevertheless give a fuller picture of ASSIP clients' views on the intervention.

The feedback is summarized in Figures 3-6. Figure 3 shows that (in retrospect), most respondents rated their hopefulness to have been quite low upon entering ASSIP and quite high after their last session. It should be noted that this was not a pre- vs. post-measurement of hopefulness. Instead, participants were asked to think back to the time when they first contacted ASSIP and rate their hopefulness at that point, and then think about their current situation and rate their current hopefulness about the future.

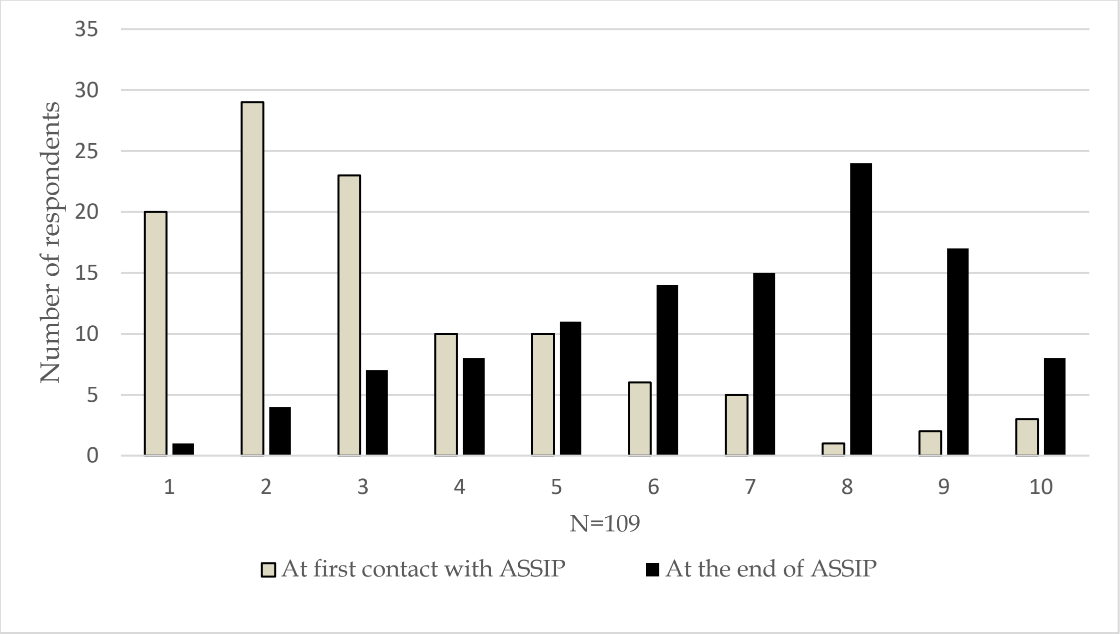

FIGURE 3 ASSIP clients' self-evaluated hopefulness

ASSIP clients were then asked to rate how much of the (potential) change in their hopefulness they attributed to ASSIP. Figure 4 shows that most respondents viewed ASSIP as having attributed considerably to the change.

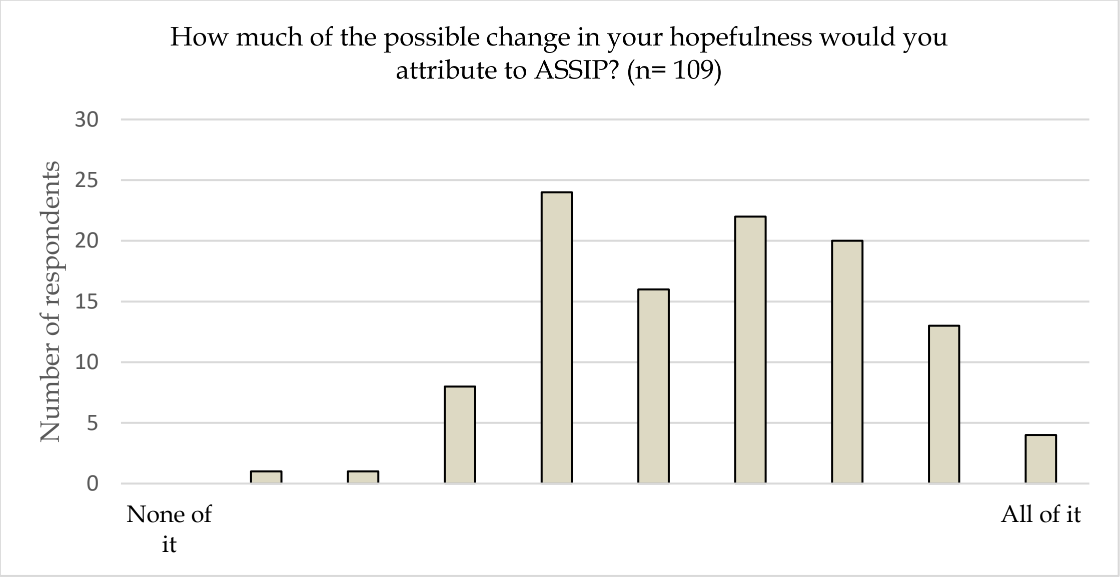

FIGURE 4 ASSIP clients' attribution of changes in hopefulness

Figure 5 shows that most respondents reported high satisfaction with ASSIP's program (clients were instructed to evaluate its length, the videotaping, the conversations and the safety plan). However, there was also some diversity in these evaluations.

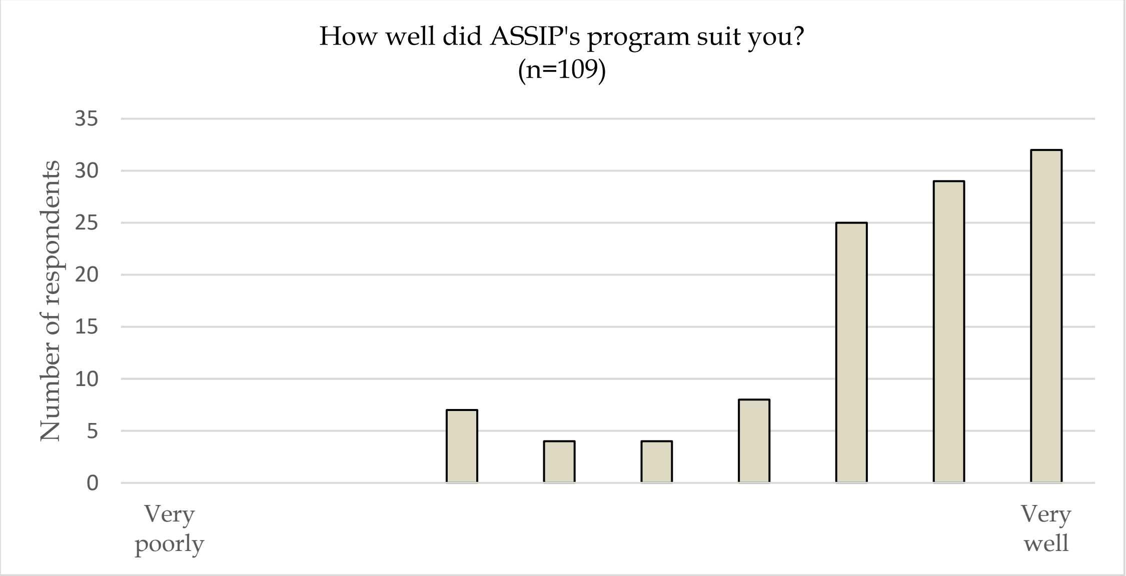

FIGURE 5 ASSIP clients' satisfaction with ASSIP's program

Figure 6 shows that with few exceptions, ASSIP clients reported very high satisfaction with their collaboration with the ASSIP therapist.

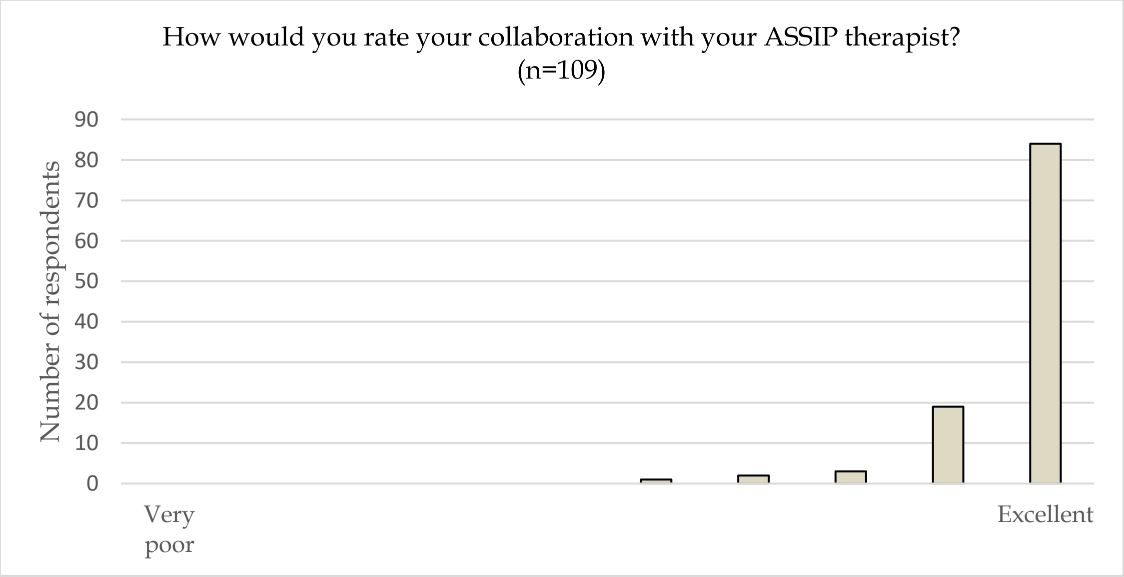

FIGURE 6 ASSIP clients' satisfaction with the collaboration

Finally, Figure 7 shows that the majority of the respondents perceived ASSIP to have had a positive effect on their wellbeing, and no iatrogenic effects were reported.

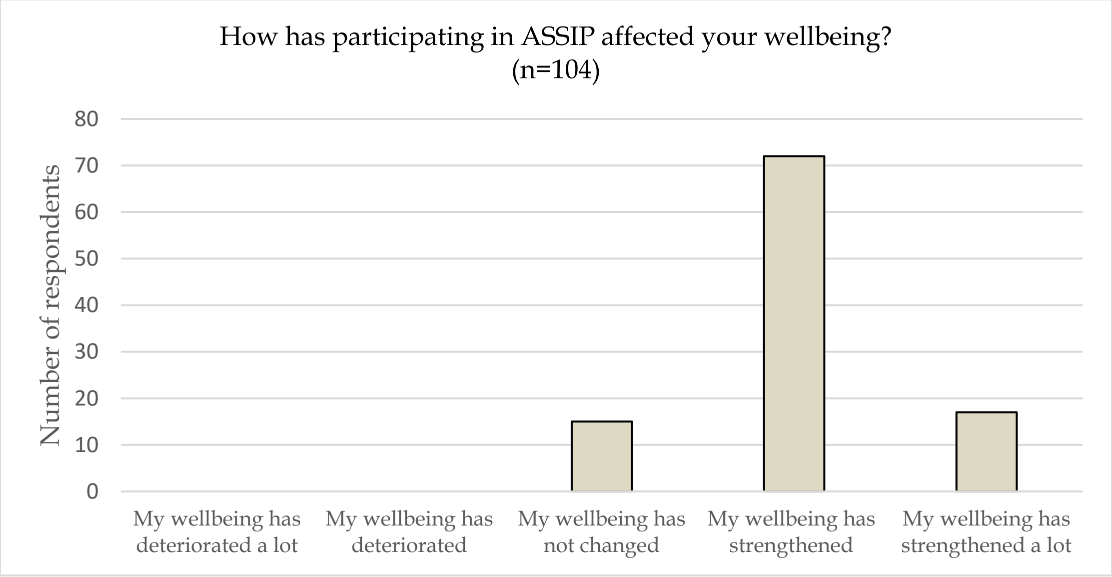

FIGURE 7 ASSIP's subjective effect on ASSIP clients' wellbeing

The feedback data thus seemed to diminish suspicions that the current study's participants were (self-)selected based on, e.g., exceptionally high satisfaction with ASSIP or an exceptional subjective rate of change during ASSIP. However, it should be noted that feedback was only collected from those who had completed ASSIP and hence feedback from clients who dropped out is not available. Statistics collected by MIELI showed that during the study period, 12% of ASSIP clients did not finish the intervention.

While the major concerns over the representativeness of the sample based on demographics, history of mental health or satisfaction with ASSIP seem unfounded, it remains likely that the high rate of self-selection has biased the sample in more subtle ways. Based on all the available data, I would assume that survivors who are more open about sharing their experiences in general and/or with better base-level and/or current functioning are likely to be overrepresented in the sample. This assumption is primarily based on two observations. First, participation required showing up and subjecting oneself to an interview with a stranger, i.e., having both the motivation and resources to do so. Second, of those who declined to participate, the minority who gave a reason for this most often cited a lack of resources and/or privacy concerns. However, the sample also exhibited some diversity in these respects. For example, one participant reported deciding to take part in the study *because* they found talking about their experiences very difficult – a behavioral pattern that they believed had led to the suicidal crisis – and hence they now wish to take every opportunity to practice talking more openly.

# 4 OVERVIEW OF THE ORIGINAL STUDIES

## 4.1 Study I

The aim of Study I was to explore suicide attempt survivors' experiences of and perspectives on the healthcare services they had received in relation to their suicidal crisis. Qualitative and mixed-methods studies in other countries have found that services may struggle to meet the subjective needs of this vulnerable group (e.g., Hom et al., 2017; Taylor et al., 2012). Study I sought to provide in-depth understanding of current Finnish service users' perspectives.

Fourteen participants were recruited through the MIELI Suicide Prevention Center. All persons over the age of 18 entering the Attempted Suicide Short Intervention Program (ASSIP) were invited to take part in the study. The fourteen participants represented a diverse but self-selected sample of the 104 eligible service users invited to participate. Each participant took part in one in-depth interview exploring their experiences of and perspectives on the services they had received or desired in relation to the suicidal crisis. We used conventional content analysis to allow data-driven insights to emerge from the data (Hsieh & Shannon, 2005). First, the transcribed interviews were read multiple times to enable immersion in the data. Second, all meaning units in which participants expressed some kind of personal view on healthcare services were systematically identified and open-coded. Third, open-coded units of similar content were organized into clusters which were then tentatively conceptualized as themes. This was followed by a cyclical process in which data excerpts not yet belonging to established clusters/themes were reviewed, resulting in the refinement of existing conceptualizations (incorporation of variations of closely related thematic content) and the formation of new clusters (when data did not fit in any of the existing clusters/themes).

The findings illustrated the participants' subjective needs and preferences as well as their experiences of how well these had been fulfilled in their interactions with services. We found that the participants primarily evaluated services in relation to the recovery goals and tasks they found personally meaningful: services were found helpful when experienced as providing help in achieving personal recovery goals and/or working on personal recovery tasks and unhelpful or even hurtful when experienced as not supporting personal goals/tasks and/or promoting goals/tasks that the participant did not find personally meaningful.

Seven elements were reported as key to service responses that participants found meaningful and helpful. The strongest emphasis was placed on *meeting the service user as worthy of help*, i.e., on professionals' and services communicating a genuine willingness to help. Second, participants emphasized the importance of having an opportunity to *explore personally meaningful topics*, i.e., that professionals took an interest in the participant's subjective reality and facilitated deeper understanding of it. Third, participants found it imperative that there be a direct focus on and support for *exploring the suicidal episode* in order to better understand what had precipitated it and hence what was needed for future safety and relief. Fourth, participants wished for *psychological continuity and predictability* of service paths. Fifth, participants expected *a responsive partnership in navigating recovery*, i.e., a dialogical relationship with professionals who were prepared to respond to varied and changing needs. Sixth, participants wished to be *involved in decisions concerning their medication*, i.e., receive adequate information and opportunity for dialogue on biological treatments. Finally, participants considered it important that services *account for their relational context*, i.e., provide opportunities for relatedness within services through, e.g., caring contacts and linkage to peer-support, as well as support for their affected loved ones and relationships.

In narrating their personal encounters with services, the participants reported both positive and negative experiences concerning each of these key aspects. In line with previous research, the participants reported that empathic and respectful service interactions had fostered a sense of hope, self-worth and belonging, while being met with hostile or dismissive staff attitudes had created barriers to care and even accelerated self-harming behaviors. While the participants wished for a collaborative relationship with professionals, most had found opportunities for collaboration to be inconsistently available in their treatment encounters, and many reported being subjected to authoritarian control and/or being left to deal alone with critical recovery tasks even during ongoing treatment. The responsiveness of services to individual needs and preferences was described as key to the perceived helpfulness of these services, with participants expressing their hope that both (bio)medical remedies, psychological interventions, and interventions targeting their relational context and sense of social belonging be available as needed. However, participants perceived many obstacles to this need-based availability concerning, e.g., access to psychotherapy; interventions targeting the social aspects of recovery (e.g., attention to affected loved ones; facilitation of peer support and social belonging) were most consistently described as lacking.

The seven themes raised by the participants provide Finnish professionals and service developers with insights into suicide attempt survivors' needs that are currently not consistently met by service interactions. The findings also contribute to the international knowledge base on suicidal service users' experiences and preferences.

## 4.2 Study II

The aim of study II was to explore clients' experiences of the Attempted Suicide Short Intervention Program (ASSIP; Michel & Gysin-Maillart, 2015), a brief add-on intervention for suicide attempt survivors. Consisting of three to four sessions and a two-year follow-up by letters, ASSIP aims to allow thorough processing of the suicide attempt, leading to the formation of credible safety strategies and long-term goals. ASSIP was designed as an individual intervention, but its Finnish implementation includes an optional session together with loved ones.

The fourteen participants had received ASSIP at the MIELI Suicide Prevention Center, an non-governmental organization providing crisis services upon self-referral. All participants had also received healthcare services. In study II, we focused on participants' experiences of the impact of ASSIP as an add-on to these other services. Experiences of ASSIP were explored through in-depth research interviews. In the data analysis, we used conventional content analysis (Hsieh & Shannon, 2005) to achieve a data-driven description and interpretation of the participants' experiences of ASSIP's impact. The process of analysis involved first identifying in the transcribed interviews all meaning units pertaining to the research question, i.e., excerpts in which the participants discussed ASSIP's impact on them in any way. These excerpts were then open-coded and, in a cyclical process, clustered to form categories of meaning until all the meaning units could be assigned to a category.

The findings showed that all participants perceived ASSIP positively. Perceptions of the magnitude of ASSIP's impact varied from viewing it as providing some benefits but not making a significant difference to its being seen as a turning point providing crucial resources for a hopeful future. All participants reported that ASSIP had provided *life-affirming change* expressed in two or more of the following categories: *feeling differently*, *thinking differently*, *acting differently,* and *having new resources*. Many participants also perceived ASSIP to have had *collateral effects*, i.e., that it had contributed to *difficult feelings* and/or *cognitive overload* during the intervention. However, these collateral effects were not reported as especially problematic but rather accepted as part of the investment in change. Finally, all described the *incompleteness of change* after ASSIP. Typically, participants found the impact of ASSIP highly meaningful, but also viewed the *gains as incomplete*, i.e., that the process of recovery was ongoing and required further support. Even those who were satisfied with their recovery perceived that to maintain these gains they were in *need of sustenance*, i.e., some form of further support from services. Some reported a *lack of desired change* in one or more areas of recovery. A few noted an *unrealized potential* of ASSIP, e.g., that there was insufficient support for engaging loved ones. None of the current participants had invited their loved ones to join despite several reporting that this would have been necessary or important.

The findings of Study II serve to inform the further development of ASSIP as well its implementation in real-world service settings. The findings support the value of ASSIP as an add-on intervention after a suicide attempt. Importantly, participants found its suicide-specific focus and tasks to yield gains, as a thorough processing of the suicide attempt was considered important but was typically not accomplished in healthcare services. However, some participants also suggested that more support for including loved ones in the intervention was needed.

Suicidality is associated with high drop-out rates from services (Lizardi & Stanley, 2010). The fact that participants emerged from ASSIP motivated to actively engage in further treatment was thus an encouraging finding. However, many participants reported a halt in their treatment following ASSIP, underscoring the importance of more seamless integration of the brief intervention into ongoing service paths to fully leverage its benefits.

## 4.3 Study III

Study III explored suicide attempt survivors' agency in relation to their recovery process and in the context of service interactions. Healthcare responses to suicidal service users are typically based on understandings of suicidality emphasising the perspective of medicine, and may give little weight to the subjectivity of the service user beyond questions directly related to diagnostic assessments (e.g., Hawton et al., 2022). In contrast, several alternative models of facilitating health-related change emphasize service users' subjective point of view and agency as relevant for service outcomes (e.g., Ryan & Deci, 2017).

For the purposes of Study III, we defined recovery-related agency as *having (some) intentionality and (some) power in bringing about a transformative process resulting in life-affirming change*. The data for Study III were drawn from the same research interviews as the data used in Studies I and II. Using directed content analysis, we identified transcribed excerpts in which participants discussed their recovery-related agency (i.e., their ability or lack thereof to act towards their self-identified recovery tasks and goals) and categorized these based on whether both recovery-related intentionality and power were present (agentic expression) or one or both were lacking (non-agentic expression). A further categorization of these excerpts was made based on whether or not the relational context provided by services was perceived by the participants as supporting their work on their self-identified recovery tasks. The resulting two-by-two table of recovery-related agency in the relational context of services contained four categories, labeled *sustained agency*, *contained non-agency*, *strained agency* and *uncontained non-agency*.

All participants expressed both agency and non-agency in relation to the recovery process. When the context was experienced as helpful, participants often described *sustained agency*, i.e., being able to work on a recovery task and feeling that their agency was further sustained by the support received. When participants remained non-agentic in contexts perceived as supportive, they described *contained non-agency*, i.e., perceived the context to provide safety and protection from the most harmful effects of their non-agency. Sometimes participants remained or even became agentic in service contexts perceived as unhelpful or even harmful. In these situations, they described *strained agency*, i.e., being able to work on recovery tasks but feeling that these efforts of forced self-reliance depleted their resources for further agentic effort. Finally, participants could find themselves both non-agentic and lacking any meaningful support. In the participants' accounts, these experiences of *uncontained non-agency* could result in dangerous situations, including suicidal action.

Study III provided a novel perspective on service users' agency and its interplay with support provided by various services involved in responding to suicidal crises. The concepts of recovery tasks and recovery-related agency helped identify agentic effort, distinguish between lack of recovery-related intentionality and recovery-related power, and illuminate the complex ways that participants sought the necessary support. The findings serve to inform professionals in identifying and making use of service users' agentic resources as well as help avoid undermining their recovery-related efforts in suicidal crises.

# 5 DISCUSSION

The main objective of this dissertation was to explore suicide attempt survivors' perspectives on services designed to help in suicidal crises. Encouragingly, we found that all the participants had experience of service interactions that they had found meaningful and helpful. However, almost all also had experience of interactions that they had perceived as unhelpful or even hurtful. This research thus serves to highlight both aspects of current services that are valued by service users and some needs and opportunities for improvement.

Each of the three original studies contributed to the extant literature in one or more ways. Study I yielded insight into the service experiences and preferences of adult suicide attempt survivors in 2020s Finland (more specifically, in the Helsinki metropolitan area). It thereby complemented the handful of qualitative studies that have previously explored Finnish suicide attempt survivors' experiences. In line with previous service user research (e.g., Taylor et al., 2009), the findings of Study I underscored the critical role that service users' perceptions of staff attitudes play in shaping their evaluations of services. The study also highlighted the participants' desire for a thoroughly collaborative relationship with professionals, where both parties contribute and consider each other's input. This included hopes that making sense of the suicidal episode, identifying recovery tasks, and deciding on and implementing a course of action would be joint efforts, rather than dictated by professionals or left entirely to the participant. Importantly, the participants expressed their desire for interventions targeting both the biological, psychological and social aspects of recovery, but had found the latter sorely lacking in current services.

Study II contributed to the small body of qualitative research on service users' experiences of and perspectives on brief suicide-specific interventions (e.g., Latakienė et al., 2019). It found that the participants appreciated ASSIP's suicide-specific program and perceived it to effectively facilitate insight into the suicidal process, a task that they had found to be scarcely supported within healthcare. Importantly, the participants found that the illumination of this process had helped them identify personally meaningful recovery tasks, giving them both experiences of relief and hope of further life-affirming change. However, some reported that a meeting together with loved ones ought to have been 'pushed' more in order for them to be able to take up the opportunity that felt both important and daunting. After ASSIP, the half of participants who felt adequately supported in their work toward their recovery tasks found that they were further building on the gains they had made in ASSIP. However, the other half found their post-ASSIP service path as stagnated during the interview and described this leading to experiences of, e.g., anxiety, worry, and even hopelessness.

Finally, Study III provided a novel perspective on suicide attempt survivors' service interactions by focusing on their recovery-related agency and the perceived role of services in its co-creation during suicidal crises. The main findings of Study III concerned the various ways all participants expressed both agency and non-agency in relation to their recovery process. The participants described the relational context provided by services as highly relevant for their ability to work toward recovery and also for their experience of safety when they found themselves lacking recovery-related intentions and/or power. We found that applying the concept of agency to the participants' accounts helped capture important aspects of their recovery-related efforts and the role they perceived services to have played in facilitating or hindering these efforts. The findings of Study III thus illustrated the value of viewing service users as agents of their recovery process even during suicidal crises, and also the potential costs of ignoring this perspective in designing and delivering services.

In this discussion, I will first make some observations on the complementary role that the current qualitative service user research has in relation to more mainstream perspectives in clinical suicidology and healthcare. I will then discuss in more detail three important themes that emerged in the current research as key areas for service development but have not been frequently highlighted in the extant literature. These include 1) the role of relationship-focused support in services for adult suicide attempt survivors; 2) the interdependent relationship between a brief suicide-specific add-on intervention (i.e., ASSIP) and the services it supplements in supporting recovery; and 3) recognizing service users' agency as a critical resource for and target of intervention during suicidal crises.

## 5.1 Balancing perspectives in suicide research and prevention

Within clinical suicidology, in-depth qualitative explorations of service user perspectives remain relatively rare, and their value has been a topic for some debate (e.g, Goldney, 2002; Hjelmeland & Knizek, 2010; Hjelmeland & Knizek, 2016; Joiner, 2011). This dissertation represents one effort to showcase the kind of practice-relevant knowledge that may be produced through such research efforts. It is my hope that this work may inspire more interest in conducting and using qualitative research also in Finland, and thus serve to balance the research base from which guidance is drawn for service design and practice. To this end, I will briefly discuss some of the recent history and debates pertaining to the value of such research in the relevant fields.

Throughout this discussion, I will argue that the current research serves to highlight some of the challenges that healthcare systems dominated by the logic of evidence-based practice (EBP; Satterfield et al., 2009) and, in particular, evidence-based medicine (EBM; Evidence-Based Medicine Working Group, 1992; Haynes et al., 1996; Sackett et al., 1996) may have in responding to suicidal crises. Thus I will begin with discussing how the dominance of EBM has shaped suicide prevention research and practice, as well as some of the limitations resulting from its foci, to make an argument for a more pluralistic and balanced multidisciplinary approach to service design and delivery. In later chapters of this discussion, I will elaborate on how the findings of the original studies challenge current practices to better incorporate a focus on relationships, the service paths surrounding suicide-specific interventions, and service users' agency.

### 5.1.1 The case for qualitative research in clinical suicidology

Reflecting the dominance of the (post)positivistic paradigms in clinical sciences in general (Park et al, 2020; Young & Ryan, 2020), suicide research has overwhelmingly been conducted using quantitative methods (Hjelmeland & Knizek, 2010; 2016). While the publication policies of the top suicidology journals do not exclude qualitative research in principle, they favor quantitative methods in practice (Hjelmeland & Knizek, 2016). In general, the methodological preferences of suicidology academia align implicitly with those of EBM and/or the more stringent interpretations of relevant evidence within the (internally conflicted) field of psychology (Berg, 2019; Lovasz & Clegg, 2019; Messer, 2004), and there is fairly little explicit discussion on the philosophical underpinnings of these methodological choices. However, in response to criticisms for a lack of methodological pluralism (e.g., Hjelmeland & Knizek, 2010), some important suicidology scholars have also made explicit their view of the (post)positivistic paradigm and an associated methodology as superior in producing knowledge relevant to suicide prevention (e.g., Joiner, 2011).

The place of qualitative methods in suicide research has also been the topic of lively debate amongst teams of experts who identify as proponents of these methods but disagree on their best use (Bantjes & Swartz, 2019; Bantjes & Swartz, 2020; Hjelmeland & Knizek, 2017; Hjelmeland & Knizek, 2020). In a series of influential writings, Hjelmeland and Knizek (2010, 2016, 2017, 2020) have argued that qualitative methods and first-person narratives present a critical avenue to understanding suicidal behavior and thus should be accorded much more emphasis in suicide research. While also advocating the value of qualitative research, Bantjes and Swartz (2019; 2020) have responded to Hjelmeland and Knizek with warnings against making truth claims, especially claims concerning causality, based on such methods. In response, Hjelmeland and Knizek (2020) have denied that they have made or argued for such claims.

While some advocate the superiority of one or the other methodology for practice-relevant knowledge production in suicidology (Hjelmeland & Knizek, 2016; Joiner, 2011), EBM tends to dismiss qualitative evidence altogether (Murad et al., 2016), and a commitment to methodological pluralism is tenuous at best in psychology's interpretation of EBP (Berg, 2019; Lovasz & Clegg, 2019), I argue for valuing the knowledge produced by qualitative methods as complementing that made possible through quantitative methods, and vice versa. As noted by, e.g., Bantjes & Swartz (2019), knowledge claims based on an interpretivist methodology can never concern causality in the realist sense. However, they can and do reveal service users' interpretations of causality as well as the consequences service users understand these interpretations to have had on their experiences and actions. I argue that such knowledge is valuable for both understanding and preventing suicidal behavior, and the current dissertation is an effort to demonstrate this value. However, opportunities to make use of this knowledge in developing healthcare practice is currently limited by the dominant interpretations of what constitutes practice-relevant evidence. While the upcoming Cochrane reviews incorporating also qualitative research signal promising change (Fortune et al., 2021; Scarth et al., 2021), current EBM guidelines make scarce use of qualitative research on service user perspectives.

### 5.1.2 Expanding the foci of current evidence-based practice

When research evidence is emphasised in shaping healthcare policy and clinical decisions, understandings of what are relevant questions to be asked by research as well as what research findings constitute 'evidence' have direct consequences for the opportunities to develop practice (Lovasz & Clegg, 2019). I argue that much of the value of the current and similar qualitative research pertains to its ability to detect, explore and highlight issues that are marginalised by RCT designs and the dominant EBM and related EBP frameworks as they are currently applied in healthcare research and practice.

EBM was introduced in the early 1990s as a new paradigm that would facilitate the replacement of unscientific grounds (e.g., intuition and unsystematic clinical experience) for medical decision-making with a reliance on evidence from clinical research (Evidence-Based Medicine Working Group, 1992). This 'shift in paradigm' was made possible by the recent proliferation of RCTs and thus the mounting of what EBM considered relevant evidence, as well as the emergence of the meta-analysis method for combining the results of individual RCTs (Evidence-Based Medicine Working Group, 1992).

As the current dominant logic of medicine, EBM has been referred to as the 'new' medical model (Fuller, 2017), while a more reductionistic biomedical disease model has been coined the 'old' medical model in different contexts (Engel, 1977; Fuller, 2017). The definitions, role and needs for adjustment of the medical model (as it represents medicine's framing of the scope and method of medical work) have been and continue to be discussed from a multitude of perspectives in medicine and mental health (Barber, 2012; Barnes et al., 2022; Byrne et al., 2015; Engel, 1977; Farre & Rapley, 2017; Fuller, 2017; Hogan, 2019;

Huda, 2021; Shah & Mountain, 2007). Within suicidology, the dominance of the medical paradigm in guiding suicide prevention research and practice has often been critiqued in connection to critiques for the marginalisation of qualitative methodologies (Fitzpatrick & River, 2018; Hjelmeland & Knizek, 2010, 2016; Jobes, 2000; Marsh, 2016; Michel, 2021; Michel et al., 2002; Morrissey et al., 2017; Pompili, 2019). The medical model's usefulness in guiding the development, application and evaluation of psychosocial interventions have also been challenged in the field of psychotherapy research (e.g., Elkins, 2009; Wampold & Imel, 2015).

All that the medical model currently entails in the context of mental health care remains debatable (e.g., Fuller, 2017; Huda, 2021). Critics claim that the guiding model of medical work remains reductionistic and biomedical (e.g., Morrissey et al., 2017; White et al., 2016), while those speaking in its defense view it as holistic and biopsychosocial (e.g, Huda, 2021; Shah & Mountain, 2007). Debates on the nature and value of the medical model for specific purposes are complicated by the recognition that routine practice (in any discipline) is typically affected by a multitude of constrictions resulting from, e.g., limited resources, and may thus not reflect any ideal model it is based on (e.g., Huda, 2021). For example, the biopsychosocial model proposed as a 'new medical model' by Engel (1977) has influenced medicine widely, but has also been critiqued for being impossible to apply in practice (Farre & Rapley, 2017). Models proposed for the guidance of evidence-based practice may also have unintended consequences when they are implemented in the complex socio-political context of healthcare, as was evidenced by the original attempts to define 'empirically validated treatments' in psychology (Lovasz & Clegg, 2019).

While I will argue that the EBM discourse and the associated research and practice emphases currently serve to marginalize issues pertaining to service users' subjective experience and agency as well as the interpersonal process of treatment, it is important to note that the early outlining of EBM in fact gave these aspects much value. In the original article proposing EBM for training purposes, the Evidence-Based Medicine Working Group (1992, p. 2422) underlined that EBM entails integrating the use of research evidence into clinical expertise expressed in, e.g., the ability to assess whether the research evidence generalises to the individual patient and situation at hand. The authors also stated that 'understanding patients' suffering and how that suffering can be ameliorated by the caring and compassionate physician are fundamental requirements for medical practice' and called for 'using the techniques of behavioral science to determine what patients are really looking for from their physicians and how physician and patient behavior affects the outcome of care' (Evidence-Based Medicine Working Group, 1992, p. 2422). In other efforts to emphasise the importance of patients' subjectivity, early critiques of EBM's over-emphasis on nomothetic evidence at the expence of clinical judgement and patient factors were responded to with the Three-Circle Model of Evidence-Based Clinical Decisions, in which clinical expertise, research evidence and patient preferences were given equal weight (Haynes et al., 1996).

However, in the following EBM revolution, some aspects of the proposed model have gained substantially more attention than others, resulting in an overwhelming emphasis on investigating specific intervention contents over the contextual and human interaction aspects of the modern day healing rituals delivered by healthcare (Wampold & Imel, 2015). Specifically, there has been an explosion of RCTs investigating specific diagnosis-matched interventions for medical conditions, including those associated with suicidality, as well as diagnosis-specific clinical guidelines based on this evidence. In clinical suicidology, the emphasis has been on the detection and treatment of medical conditions with evidence of strong associations with risk of suicide (e.g., mood disorders and borderline personality disorder). Recently, evidence of the 'etiological heterogeneity of suicide' (Turecki & Brent, 2016) has resulted in the reframing of suicidal crises as diagnosable conditions of their own to facilitate the development and evaluation of interventions that target suicidality more directly (e.g., Rogers et al., 2023). In contrast, research on *how* treatments should be delivered or what patients desire from healthcare responses is much less prominent in the evidence base reviewed for treatment guidelines.

Even those opposing the dominance of the medical model in shaping suicidology typically conceed that the claiming of suicidal behavior as a concern for medicine has allowed for advances in suicide prevention and practice (e.g., Marsh, 2016). A conceptualization of suicidal behavior as indicative of a health problem has combatted traditional perceptions of suicidality as criminal or evil. It has also brought hopes for a cure. Rigorous research within the EBM frame has produced a vast knowledge base on the risk factors and epidemiology of suicidal behavior. However, there is also relative agreement that the gains from this strand of research for effective clinical practice have been much more limited and even disappointing (e.g., Fox et al., 2020; Franklin et al., 2017). Many leading experts, some psychiatrists among them, agree that the dominance of the EBM-era medical model in understanding suicidal behavior has several disadvantages and should thus be better balanced with other perspectives (e.g., Jobes, 2023; Jobes & Chalker, 2019; Michel, 2023; Michel et al., 2002; Pompili, 2019).

Drawing on the above discussion and the current research, I argue that while applying the logic of medicine to suicidal behavior has its benefits, an unchallenged dominance of this view also has several potentially problematic consequences. First, the focus on diagnosable conditions (to which treatments are matched) sets the stage for a highly individualised view of suicidal behavior, inevitably (even if inadvertently) marginalising questions of contextuality and relationality. Second, framing suicidality as symptomatic of a medical condition promotes a view of the person with suicidal behavior as impaired or incapacitated, and thus risks diminishing the agency of these persons in the eyes of the healthcare system as well as in their own eyes. The tendency of both laypeople and mental health authorities to reificate descriptive psychiatric diagnoses as causal contributors may add to this effect (Kajanoja & Valtonen, 2024). Third, the emphasis on nomothetic knowledge (i.e., the focus on diagnoses as relevant for identifying the appropriate intervention) may lead to a de-emphasis on the idiographic (i.e., hearing the service user's understanding of their predicament and responding to it) (cf., Savander et al., 2019). Fourth, the medical frame and its focus on condition-specific treatments may invite an overemphasis on biological causes and cures for suicidality while underestimating the (non-specific) healing potential of interaction.

Judging by the current participants' accounts, these risks were often realised in current Finnish healthcare services. While the participants emphasised the relational aspects of care as most important to them, they had often found healthcare to overlook the importance of the human interactions associated with prescribing or administering its interventions. Despite placing high hopes on biological cures themselves, many participants found that an overemphasis on this aspect of care had undermined opportunities for healing encounters. Some had also experienced healthcare responses as relying on authoritarian control rather than collaborative efforts, and experiences of objectification were fairly common. Further, the lack of focus on targeting some important contextual factors contributing to the suicidal crisis (e.g., conflicts in couple or family relationships and/or issues such as lack of income or homelessness) was noted by the majority of the current participants. Thus, while many of the fruits of EBM-informed research and practice were highly appreciated by the participants, the associated weaknesses of current services were also made apparent.

### 5.1.3 The value of complementary perspectives in responses to suicidality

In my view, the participants' experiences evidence that current healthcare responses to suicidal behavior do not effectively capitalise on the complementary expertise of different healthcare professions. Healthcare systems are multidisciplinary, but typically also highly hierarchical, with the logic of medicine and EBM-based treatment guidelines profoundly shaping the opportunities for practice in related fields such as nursing, psychology, and social work[3] (Barnes et al., 2017; Noyes, 2022; Satterfield et al., 2009). Both healthcare legislation and cultural tradition grant medicine the ultimate responsibility for and superior authority in shaping and directing healthcare, and the level of independent authority available for other professions at both macro and micro-levels of decision-making is directly affected by this power hierarchy (e.g., Barnes et al., 2022; Noyes, 2022). The hierarchical culture and structure of healthcare organisations may also produce a sort of learned helplessness in non-medical team members, leading them to expect direction or sanctioning from medical professionals even when it is not required by organizational protocols (e.g., Barnes et al., 2022; Noyes, 2022). In current Finnish healthcare, medical

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[3] In Finland, healthcare and social services have undergone a complex integration process in recent years (Tynkkynen, 2023), aimed at minimizing barriers between these services. Thus for brevity, I will refer to professionals in social work also as 'healthcare professionals' in the current context, i.e., when considering the needs for social work in suicide attempt surviving healthcare service users. However, I note that this terming does not do full justice to the unique contribution of social workers' expertise.

professionals hold much power and responsibility as the formal and informal gatekeepers to many interventions provided by other professionals (e.g., psychotherapy).

In addition to practice-level power dynamics, the shaping effect of EBM on the neighboring fields in healthcare is mediated by these fields' own attempts to adjust to or even converge with the key assumptions of EBM to stay relevant in EBM-dominated contexts (Lovasz & Clegg, 2019; Satterfield et al., 2009). Psychology is a field with a 'dual heritage', and a tension between its (simplistically put) scientific and humanistic roots in many ways defines the field (Messer, 2004). The emergence of EBM gave weight to pre-existing pursuits of a more scientocentric basis for practice in psychology, as concerns arose that psychological treatments needed to be legitimized within the same paradigm as medicine in order to be recognised in healthcare policies (Berg, 2019; Lovasz & Clegg, 2019). In the U.S., early attempts at this legitimization through the compilation of lists of 'empirically validated treatments' in psychology had backfired; while the intended purpose of these efforts was to counteract the trend toward considering medications more effective than psychological interventions, they led instead to policies that rejected funding for any psychological intervention that was not specified on the list (Lovasz & Clegg, 2019).

EBP in psychology (EBPP) thus emerged amidst both genuine philosophical diagreements among the field and more practical concerns that if there was no criteria for establishing the scientific legitimacy of psychological treatments, these treatments may be marginalised within healthcare altogether, but that any criteria formed for this purpose may also result in an unintended narrowing of psychologists' opportunities to use their expertise to service users' benefit (Lovasz & Clegg, 2019). To date, these concerns and controversies have hardly been resolved (Berg, 2019; Lovasz & Clegg, 2019). However, as the relatively vague and general documents produced by the APA Task Force on EBPP have been put to practice by, e.g., institutionalized guidelines, reimbursement policies, and funding policies, these reinterpretations have endorsed a hierarchical rather than pluralistic view of 'evidence', although the documents do not suggest any such hierarchy (Lovasz & Clegg, 2019).

The emergence of EBM, as well as the same socio-political influences that EBM stemmed from (i.e., concerns over rising costs and inconsistencies of healthcare delivery), put pressure on each of the healthcare professions to define evidence-based practice in their respective fields (Lovasz & Clegg, 2019; Satterfield et al., 2009). Arguably, the emergence of EBM and its dominance of the systems within which psychologists practice has fertilized psychology's scientific roots while thwarting the humanistic, as particular interpretations of evidence (i.e., those converging with EBM) have protected or promoted the profession's standing within its socio-political context, while others would or could threaten it (Lovasz & Clegg, 2019). Currently, those in psychology arguing for more pluralistic interpretations of relevant evidence represent a minority in positions of power, although practitioners seem to mostly reject a scientocentric and hierarchical-evidence view of evidence-based practice (Berg, 2019; Lovasz &

Clegg, 2019). EPB in nursing and social work have also been developed in close relation to EBM, but managed to hold a somewhat more pluralistic standard for evidence than EBP in psychology (Satterfield et al., 2009).

While medicine's frameworks for understanding and responding to suicidal suffering dominate in healthcare contexts, psychology has long had a prominent voice alongside it in the field of suicidology. Each of the current evidence-based psychosocial interventions in suicide prevention is centrally informed by models focusing on the psychology, phenomenology and relationality of suicidal behavior; some seminal works of psychologists in this field include those by Gregory Brown (Brown et al., 2005; Stanley & Brown, 2012; Wenzel, Brown et al., 2009), Craig Bryan (Bryan, 2021; Bryan & Rudd, 2018), David Jobes (Jobes 2000; Jobes & Chalker, 2019; Jobes, 2023), Marsha Linehan (Linehan et al., 1991; Linehan, 1993) and David Rudd (Rudd et al., 1999; Rudd, 2001). In fact, ASSIP is the only one of these interventions prominently developed by a psychiatrist, Konrad Michel, in close collaboration with the psychologists Ladislav Valach and Anja Gysin-Maillart (Michel & Valach, 1997; Michel et al., 2002; Michel & Gysin-Maillart, 2015; Michel, 2023). Recent important developments in understanding suicidal behavior include the emergence of intent-to-action models of suicide, also developed by psychologists and focused on understanding the psychological processes involved in developing suicidal ideation and proceeding (or not) to more severe ideation and action (Klonsky & May, 2015; O'Connor et al., 2011; Van Orden et al., 2010).

Psychology is thus a dominant force alongside medicine in the multidisciplinary field of suicidology. However, it is arguably those contributions of psychology converging with EBM's paradigmatic expectations that gain traction in suicide research and prevention programs, while a misalignment with EBM's key presumptions may prevent other, potentially more diversifying contributions from affecting practice. It is also interesting to note that while the contributions of psychology have been central to advancing the international field of suicidology in the last hundred years, Finnish psychologists' involvement in suicide research and practice development has been surprisingly scarce. This lack of involvement may have further emphasized the domestic role of EBM in, e.g., shaping the foci of suicide research and training for healthcare professionals on suicide topics. Furthermore, it appears that both domestically and internationally, the integration of social perspectives with psychological and medical frameworks in indicated suicide prevention lags behind the integration between psychology and medicine (Rodríguez-Otero et al., 2022).

In summary, as suicidality is a complex phenomenon, it is imperative that medical understandings of and responses to suicidal behavior are complemented by understandings and responses informed by the psychological and social sciences throughout the healthcare system, including but not limited to specialized mental health services. However, the current dominance of EBM in healthcare also shapes the work of neighboring fields, arguably hampering their potential to provide complementary rather than convergent contributions. The current findings highlight the need to make more effective use of the expertise of each relevant profession in service design, so as to create more balanced service responses to suicidal crises. In the following, I will draw on the original studies to highlight three potential foci for such balancing efforts: a focus on relationships, contexts, and agency.

## 5.2 The role of relationship-focused support in responding to adults' suicidal crises

The current research indicates the need for increased efforts to provide relationship-focused support in response to adults' suicidal crises. The critical role of attachment relationships for humans was first recognized and described in the context of child development (Bowlby, 1977). However, the need for relationships that serve both as a secure base and as a safe haven in life's many challenges is not contingent on age, but is rather a basic human need (e.g., Feeney & Collins, 2019; Price-Robertson et al., 2017; Ryan & Deci, 2017). While early experiences affect the individual's capacity to effectively balance needs for autonomy and relatedness in close relationships (i.e., attachment style), this capacity is amenable to change through healing experiences across the lifespan (Bowlby, 1977; Fraley et al., 2021).

Findings from psychology and neuroscience demonstrate that humans are profoundly social beings (e.g., Mizen & Hook, 2020). However, the individualistic culture of contemporary Western societies idealizes autonomy, self-sufficiency and independence and de-emphasizes (or even pathologizes) the interdependence inherent in human existence (e.g., Marsh, 2016; Price-Robertson et al., 2017). A recent study comparing rates of parental burnout (a risk factor for, e.g., suicidal ideation, substance use and child abuse) in 42 countries across five continents illustrated the hazards of these ideals, finding that parental burnout was significantly more common in individualistic cultures, with Finnish culture being ranked amongst the more individualistic and Finnish parents amongst the most burnt out (Roskam et al., 2023). The wider individualistic culture is also reflected in Western understandings and responses to mental health problems (including suicidality), with both suffering and recovery framed as residing firmly within the individual rather than in relationships (e.g., Bergström, 2023; Marsh, 2016; Price-Robertson et al., 2017).

The problems arising from a de-emphasis on the relational context of suicidal suffering were evident in the current participants' accounts of their service experiences. In analyzing the participants' experiences of and perspectives on health care services (Study I), accounting for the service user's relationship context (e.g., their loneliness, loss of social roles, relationship conflicts and/or worries about loved ones) emerged as the desired aspect of services most consistently found lacking. In analyzing the participants' experiences of ASSIP (Study II), we found that lack of adequate support for including loved ones was the only suggestion for improvement made by more than one participant. Finally, in analyzing the participants' expressions of recovery-related agency we found that they had many relationship-focused intentions, but often found themselves lacking both the power and support needed for their accomplishment. In line with our findings, Miettinen (2022) found that those with suicidal behavior in adolescence, along with their parents, wished for help for the whole family, but had experienced various barriers to receiving such help.

A plethora of research has shown that relationship troubles are a main contributor to suicide attempts across age groups and cultures (e.g., Beniwal et al., 2022; Burón et al., 2016; Järventie, 1993; Stulz et al., 2018; Zortea et al., 2019). In turn, those with lived experience of suicidal crises have systematically described positive relationships as key to their recovery (e.g., Bostik & Everall, 2007; Crona et al., 2017; Lakeman & Fitgerald, 2008; Ridge et al., 2020; Zortea et al., 2019). Support from family and friends has also been cited as a critical facilitator of help-seeking and treatment engagement (e.g., Hom et al., 2015). The current and previous research has also observed how a suicidal crisis in itself often puts strain on the suicidal individual's close relationships and may result in further conflicts or rejections that contribute to the complication of the crisis (e.g., Frey et al., 2017). Thus, the need for relationship-focused support during these crises is evident. Further research documents how being overlooked by professionals often adds to the distress of those caring for a suicidal family member (e.g., Hennipman-Herweijer et al., 2023). By alleviating this distress, relationship-focused support for suicide attempt survivors' and their loved ones could serve both indicated and selective suicide prevention.

Contemporary intent-to-action theories of suicidal behavior (Klonsky & May, 2014; O'Connor et al., 2011; Van Orden et al., 2010) also conceptualize interpersonal relationships as having a critical effect on an individual's risk of suicide. Based on empirical findings, each of these theories suggests that the perceived lack or loss of and/or strain on valued relationships increase susceptibility to suicidality, while experiences of connection and perceived social support are expected to protect from suicidal ideation and/or action (for a summary and comparison of the intent-to-action theories, see Klonsky et al., 2018). However, the commonly recognized importance of relationships for suicidal behavior is poorly reflected in the contents of contemporary suicide-specific interventions and healthcare practices.

For adolescents, family-based interventions have been found more effective in reducing suicidal ideation than individually-focused interventions (e.g., Meza et al., 2023; Turecki & Brent, 2016; Waraan et al., 2023). Several recent studies on attachment-based family therapy (ABFT; Guy et al., 2021) for suicidal adolescents have yielded promising results (Russon et al., 2023). Cognitive-behavioral family therapy has also been investigated as a treatment for suicidal adolescents (Asarnow et al., 2017). Changes in adolescent suicidality have been found to be mediated by changes in family functioning (Pineda et al., 2013), suggesting a causal connection between a relationship-focused intervention and suicide-related outcomes. In a qualitative analysis of family dynamics for self-harming adults, Buckmaster et al. (2021) found that the whole family unit could be impacted by the self-harming behavior and suggested that interventions targeting family dynamics and providing family members with resources to understand and cope with the relational effects of self-harm may be beneficial. However, recent systematic reviews of published studies on family-based interventions for suicidality have found none targeting the relationships of suicidal adults (Frey & Hunt, 2018; Frey et al., 2022).

Since the most recent review (Frey et al., 2022), interest in addressing suicidal adults' family relationships with systemic interventions seems to have been growing, albeit slowly and in the margins of suicide research and prevention efforts. Recently, several studies have piloted couples-based interventions for adults with suicidality. Khalifian, Chalker et al. (2022) explored suicidal veterans' interest in addressing suicidality in a couples-based intervention and found generally positive attitudes. Khalifian, Leifker et al. (2022) piloted a couples-based intervention for veterans with suicidal ideation, finding high feasibility and client satisfaction as well as improvement in variables associated with suicidal behavior in their small sample of five couples. Crasta et al. (2023) reported similar results for another brief relationship-focused intervention (the Relationship Checkup) in twenty couples with a veteran spouse. Hales-Ho and Timm (2023) proposed a couples' intervention for perinatal suicidal thoughts based on CAMS, ABFT and Emotionally Focused Therapy. In a rare proposal allowing the inclusion of family members (not only spouses), Ellis (2022) proposed an integration of narrative therapy and dialectical behavior therapy to provide a critical, relational approach for addressing suicidality in family therapy.

While interventions designed specifically for suicide prevention after a suicide attempt have focused on the individual rather than on their relationships, the Finnish implementation of ASSIP was modified to include an additional session with loved ones. However, none of the participants had made use of this opportunity, and several of them stated that they would have needed more support for doing so. Many of the participants worried about the effect of their crisis on their loved ones, about their loved ones' resources to support them, and/or felt that their loved ones did not understand the situation. The participants who reported hesitation in approaching their loved ones with the suggestion of a meeting also expressed a wish that services had taken more initiative to accomplish this. The perceived lack of an adequate 'push' towards including loved ones may reflect the location of these services – and the professionals working within them – in the wider individualistic context of Finnish society, possibly leading to a tendency toward over-sensitivity to the risks of including loved ones in the therapeutic process. On the other hand, some of the young participants stated that they would not have wanted to include family members owing to the need to protect themselves from a parent they perceived as intrusive or even abusive. Both sensitivity and courage are thus needed in exploring the relationships of those in suicidal crises as well as the needs and opportunities for supporting these relationships and/or addressing abusive patterns in routine practice.

In addition to support for relationships in suicidal individuals' natural network, including those with family and other loved ones, peer support has been suggested by those with lived experience as an avenue for enhancing social belonging and experiences of connectedness (e.g., Hom et al., 2021). Peer support was also discussed by some of the current participants as a potentially valuable resource; however, several participants also had experiences of the ineffective use of peer support (in the context of group formats guided by professionals in ways that did not seem helpful to the participants). Some had found informal peer support (e.g., from other in-patients) valuable. While there is growing interest in different forms of interventions making use of peer support in the context of suicide prevention, evidence for best forms of implementation and delivery remains limited (Chalker et al., 2023; Schlichthorst et al., 2020).

In summary, while the idea of focusing interventions on relationships rather than on individuals shows a somewhat awkward fit with the medical model on which current healthcare services are primarily organized, it is imperative to find ways to integrate more relationally-minded and relationship-focused practices into healthcare as well as other services. This includes training and encouraging professionals to, e.g., ask about relationships and invite those important to the suicidal individual to be included in conversations about the best ways of navigating the crisis; provide information and opportunities for couples' and family therapy in addition to individual and group interventions; provide a linkage to peer support; and inform service users and their loved ones on NGO resources for support that is not available through healthcare (e.g., support for those supporting a family member in crisis). Recognizing the value of these aspects of care also highlights the critical need for securing sufficient funding for NGOs that provide this essential supplementary support.

## 5.3 The interdependence of ASSIP and its service context in providing meaningful outcomes

The current research underscores the importance of integrating (ultra)brief suicide-specific interventions into adequately continuous service paths. The design of these interventions has been inspired by the extremely high short-term risk of suicidal behavior detected in certain groups (e.g., those with a recent suicide attempt and/or recently discharged after admittance for suicidality; Nordentoft et al., 2022) as well as observations on the large proportion of suicidal service users lost to follow-up after emergency room visits (Lizardi & Stanley, 2010). Brief interventions in suicide prevention aim to both immediately reduce risk in highly vulnerable periods and enhance engagement in follow-up care. A recent review found that even interventions provided in one encounter have potential for accomplishing both tasks (Doupnik et al., 2020).

Like other brief suicide-specific interventions, ASSIP is designed to be an add-on to rather than replacement for other necessary services (Michel & Gysin-Maillart, 2015). This makes the context of its implementation a likely key variable in its outcomes. In the original Swiss effectiveness study, ASSIP was integrated into psychiatric services that typically also included, e.g., access to psychotherapy. A substantial decline in the follow-up rate of suicide attempts was observed (8.3 % for ASSIP + TAU vs. 26.7% for TAU alone; Gysin-Maillart et al., 2016). These promising figures contrast with a recent Finnish clinical trial, which reported a 29.2% re-attempt rate for TAU augmented with ASSIP, showing a non-significant difference from the 35.2% re-attempt rate for crisis counseling (CC) augmenting TAU (Arvilommi et al., 2022a). Both intervention groups received the brief intervention as an add-on to treatment as usual, and the trial did not have a control group receiving only TAU. The Arvilommi et al. (2022a) trial therefore provided no estimate of the effectiveness of the two add-on interventions per se, but instead rates of re-attempts for suicide attempt survivors receiving 'services as usual'.

Arvilommi et al. (2022a) hypothesized that those randomized to ASSIP (a suicide-specific intervention) would show fewer re-attempts during the two-year follow-up than those randomized to CC (a non-specific intervention). This hypothesis was not supported, and the intervention groups were pooled in subsequent analyses (Arvilommi et al., 2022b). For the whole study group (160 participants) a re-attempt rate of 32 % was observed, with 57 % of those re-attempting making more than one suicide attempt during the two-year follow-up (Arvilommi et al., 2022b). Comparison of these rates to those observed in other studies (e.g., Gysin-Maillart et al., 2016; Irigoyen et al., 2019) is complicated by the exceptionally stringent data collection method used by Arvilommi et al., which included both patient records and self-reports, likely resulting in above-average comprehensiveness in the detection of re-attempts during follow-up. Differences in study populations (e.g., previous suicide attempts, severity of symptomology) are also expected to affect the proportion of participants re-attempting. Nevertheless, the observed rates leave clear room for improvement in current Finnish suicide prevention practices.

The Arvilommi et al. (2022a) trial observed ASSIP clients receiving services in the same Helsinki metropolitan area as the current study. In both studies, ASSIP was provided outside the healthcare system by the NGO MIELI. All ASSIP therapists had been trained as healthcare professionals (as nurses, psychologists and/or psychotherapists), but employed in the context of crisis work. This context had direct implications for the goals of their work (i.e., to provide crisis support rather than to treat medical conditions) as well as the applicable laws (e.g., healthcare services have an obligation to identify patients and make records of all service interactions, while crisis work allows even anonymous participation). In line with a recent review (Uddin et al., 2023), most of the current participants perceived the non-clinical setting of MIELI more positively than the clinical contexts they had experienced. Clients can contact ASSIP themselves or, if they so wish, healthcare professionals can give their contact information to the

ASSIP team that will then contact the client; the latter was the preferred route for the majority of the current participants. This low threshold to entry was greatly appreciated by the participants and seemed to facilitate engagement with the program. Participants perceived interactions at MIELI as consistently kind and welcoming, citing also small interactions with lobby personnel and/or employees they passed in a hallway as contributing to this perception. The physical setting and procedures at MIELI were often credited for being ‘not so institution-like’ and more approachable than those in healthcare settings.

While participants typically resented having to use several different services and form alliances with many different professionals, none were directly critical of ASSIP’s implementation outside the healthcare services they were simultaneously receiving. However, some reported that this division of labor had led to some confusion or pondered that ASSIP might just as well have been integrated into their psychiatric care, and others (specifically participants who found their treatment to be at a current dead-end) said that although the ASSIP process seemed ‘whole’ and gave them a sense of closure, they would not have objected to having more sessions with their ASSIP therapist. Thus, the current participants valued MIELI as the setting for ASSIP, and the review by Uddin et al. (2023) suggests that non-clinical contexts of therapeutic contact for suicide prevention are also preferred by clients more generally. However, questions may be raised as to whether the closer integration of ASSIP into other services might enhance the effectiveness of service paths for suicide attempt survivors (see also Nordentoft et al., 2022).

To date, there is scarce research to evaluate how (ultra)brief suicide-specific interventions perform in specific subgroups of suicide attempt survivors. A further analysis on the trial data by Arvilommi et al. (2022b) explored the predictors of outcome in the whole sample and revealed that younger age, a diagnosis of personality disorder (especially borderline personality disorder), a history of recent hospitalization and a history of multiple suicide attempts predicted follow-up re-attempts. For patients with none of these characteristics, the re-attempt rate was 13%, in contrast to 65% for those with a diagnosis of borderline personality disorder (Arvilommi et al., 2022b). These findings were interpreted to suggest the differential effectiveness of brief interventions for subgroups of suicide attempt survivors (Arvilommi et al., 2022b). However, the current findings suggest that a re-focus on suicide attempt survivors’ service paths as wholes rather than on individual interventions or the characteristics of individual service users might also help to explain why services succeed or fail in preventing repeat suicide attempts in specific contexts or for specific service users.

RCTs may provide convincing evidence that the target intervention is more effective than the comparator in producing the desired outcome(s) in the context studied. However, a variety of contextual conditions typically apply as prerequisites of this superior effectiveness and may be lost in the subsequent real-world implementations of evidence-based interventions in new service systems (Kemp et al., 2019). The current findings revealed that in the participants’ view, ASSIP was highly effective in, e.g., clarifying recovery tasks, inspiring hopefulness, and enhancing further service engagement. In the current small but diverse sample, these gains were not exclusive to any subgroup, but rather reported also by those presenting with the predictors of poor outcome identified by Arvilommi et al., 2022b (i.e., the young as well as those reporting a diagnosis of personality disorder, a history of hospitalizations and/or multiple previous suicide attempts). However, gains such as a clarified understanding of recovery tasks and willingness to engage in working on them may lose their meaningfulness if further support is not available to the service users after ASSIP.

The interviews used as data in the current study were conducted 4-10 weeks after the last ASSIP session. At that time, half of the participants were fairly confident that they would receive the support they needed to take the next steps in their recovery. The other half found themselves at a confusing crossroads, unsure as to whether or how their path to recovery would be supported after the completion of ASSIP. For example, most participants desired some form of psychotherapeutic support to continue working on recovery tasks and goals identified in ASSIP, but many were worried that this would be impossible due to barriers such as lack of service providers and high out-of-pocket costs. The observations made by Arvilommi et al. (2022b) suggest that these worries were warranted: over the two-year follow-up, only 9.4% of the suicide attempt survivors in the clinical trial had received psychotherapy as part of their mental health treatment.

These findings highlight the importance of considering and also evaluating the service paths of suicide attempt survivors as wholes. This would include a focus on the appropriateness of treatment contents as well as the (psychological) predictability and continuity of individuals' treatment paths as they are built from the various components typically necessary in addressing complex psychosocial problems such as suicidality (see also Nordentoft et al., 2022; O'Connor & Portzky, 2018). The specific contents of the suicide-specific intervention delivered are likely to be much less influential in terms of outcomes than the service context (i.e., chain of care) in which the intervention is delivered. Recent reviews support such a view: Doupnik et al. (2020) found similar effects for a variety of very brief interventions; Sobanski et al. (2021) found that a variety of longer-term psychotherapeutic interventions were effective; and Rudd et al. (2022) proposed clinical strategies based on the common themes of a variety of effective suicide-specific interventions.

In summary, service interventions after a suicide attempt should focus both on providing suicide-specific support, i.e., facilitating an understanding of the suicidal process and acquiring safe means to both cope with and pursue change in suffering, and on making sure that the variety of biological, psychological and social factors driving suicidal behavior for a particular individual are recognized and responded to. Importantly, both service and research design should account for the fact that many of the common drivers of suicidal behavior (e.g., relationship issues, trauma-related suffering, somatic pain, or untenable living arrangements) are rarely *resolved* in an ultra-brief intervention, even when they may be successfully targeted by further interventions (e.g., relationship- or trauma-focused therapy, somatic medicine or social work). The identification of these drivers and possible interventions may be a powerfully hope-evoking intervention, but if no further help in addressing them is provided, hopelessness is likely to re-emerge.

## 5.4 Service users' agency as a target and resource for intervention

There is surprisingly scarce research describing in detail how those in suicidal crises actively pursue recovery through their interactions with services. The current research provides some novel insight into these processes using the concept of agency. In Study III, we proposed a definition of recovery-related agency as the coupling of recovery-related intentionality and power. Operationalising this concept as the participants' narrated ability or inability to act toward their self-identified recovery tasks allowed us to observe the many ways that the participants deliberately sought life-affirming change and safety. Focusing on service encounters further illuminated the many ways that service interactions were perceived to facilitate or hinder these pursuits. Importantly, these analyses revealed the situationality and contextuality of the participants' ability to act toward recovery and/or stay safe in the space between suicide-related and recovery-related intentions. The key finding of Study III thus concerned the co-created nature of recovery-related agency in suicidal crises.

While the concept of agency has a variety of definitions and uses within psychology and psychotherapy research, its essence pertains to the (bounded) human ability to affect ourselves, our environments and other people in line with our intentions (e.g., Bandura, 2006; Coleman & Neimeyer, 2015; Mackrill, 2018). Both this capacity and the experience of it is highly relevant for mental health in general and suicidal behavior in particular. A lack of agency in relation to solving or coping with problems that cause suffering is a common denominator of the conditions that mental health interventions are sought for and designed to address (e.g., Coleman & Neimeyer, 2015; Wahlström & Seilonen, 2016). The concept of agency is also relevant to such predictors of suicidal ideation as entrapment (Höller et al., 2022) and hopelessness (Qiu et al., 2017), both implying an experienced inability to affect an unacceptable and unbearable reality. While the concept of agency has seldom been used to explore or elaborate on suicidal behavior (for exceptions see Benson et al., 2013; Byng et al., 2015; Johnston et al., 2022), several qualitative studies have identified the pursuit, lack and/or exercise of control over one's self and one's circumstances as relevant in suicidal crises (e.g., Benson et al., 2013; Pavulans et al., 2012; Ridge et al., 2020). These findings may easily be reinterpreted in terms of lacking, pursuing and/or exercising agency related to life-goals and/or recovery from suicidality.

In qualitative research, suicide attempts have been described both in terms of a loss of agency/control and as an attempt at exerting agency/control (e.g., Crocker et al., 2006; Johnston et al., 2022; Lakeman & Fitzgerald, 2008). A complete loss of (subjective) agency in relation to critical life-goals is typically described as a precipitant to suicidal ideation and action. In these conceptualisations, suicidal action is then conceived of as a means to regain agency, i.e., as ‘taking control’ by ending suffering in death when it feels impossible to solve it in life (e.g., Järventie, 1993; Pavulans et al., 2012). For example, Järventie (1993) described suicidal processes as a sequence of efforts to cope with a (subjective) reality of waning options in life, even if the result of these processes could be ‘surviving to death’. Like Järventie (1993), Valach et al. (2006) have drawn on action theory to underline the goal-directed and thus agentic nature of suicidal behavior. Valach et al. (2006) demonstrated how life-directed and suicide-directed processes are often intertwined in sequences of suicidal behavior, with sometimes very abrupt switches between the life-goal directed and suicide-goal directed systems. From the perspective of the current research, the late stages of the suicidal process might be viewed as a cumulating loss of recovery-related agency leading to the activation of suicide-related intentions and, if coupled with suicide-related power, potentially leading to suicidal action.

The regaining of agency in relation to one’s life-goals (or ‘taking control over one’s life’), in turn, has been described as key to overcoming suicidality (Crona et al., 2017; Espeland et al., 2023; Sellin et al., 2017; Sinclair et al., 2005). This regaining of agency/control is typically described as resulting from a combination of external support and changes in circumstances as well as internal meaning-making processes that reframe the individual as capable of affecting their circumstances and/or their relationship to those circumstances in meaningful ways (e.g., Crona et al., 2017). An important contribution of the current research, and especially Study III, was the illumination of the co-existence of recovery-related agency and non-agency in the participants’ accounts of the suicidal crisis. Earlier research has sometimes framed the protective agency related to life-goals or recovery as somewhat dichotomous, i.e., as lacking during the crisis and present once recovered, and especially quantitative research on agency tends to view the sense of agency as a relatively stable characteristic of the individual with consequences for mental health or suicidality (e.g., Bryan et al., 2014). However, the current research highlighted the context-dependent nature of this agency and the many ways it was expressed even during the participants’ most vulnerable periods.

In these participants’ accounts, different forms of help-seeking were a typical expression of recovery-related agency during high-risk periods, as were different ways of delaying the suicidal act. Interestingly, the rejection of offered services was also sometimes framed as an exertion of recovery-related agency: when the offered services provided a poor fit with the participant’s recovery-related intentions or even seemed to sabotage them, participants could choose to pursue the relevant recovery tasks on their own. This was the case, for example, in the young participant who ended their in-patient stay against professionals’ recommendation. The participant was losing their apartment and found that avoiding homelessness was the most urgent recovery task for them, but that they were both unable to search for a new apartment and unsupported in this task during the hospital stay. Similar exertions of what Study III coined 'strained agency' could also concern, e.g., repeated efforts to attain more appropriate support. These episodes illustrated the agentic resources the participants had and deployed in their pursuit of recovery. However, such unsupported recovery-related efforts were also associated with cumulating depletion and exhaustion that could contribute to the re-emergence or reinforcement of suicidal impulses (cf., Benson et al., 2016; Pavulans et al., 2012), underlining the necessity to recognise service users' exertions of recovery-related agency and provide support for these efforts. When designing services in a world of limited resources, it is important to note that in some cases, participants reported that the mere recognition of their agentic efforts accompanied by a verbal gesture of encouragement could make the difference between experiencing their efforts as strained or sustained.

It is also worth noting the connection of the current conceptualisation of agency to the intent-to-action theories conceptualising suicidal desire (intentionality) and the ability to act in line with these intentions (power) as distinct components of suicidality, both of which are necessary for suicidal action (Klonsky et al., 2014; O'Connor et al., 2011; Van Orden et al., 2010). It has proven an exceedingly difficult task to predict an individual's progression from suicidal ideation to suicide attempts (e.g., Klonsky & May, 2014). While much less attention has been paid to predicting recovery from suicidal states (Bryan et al., 2021; Dubruel et al., 2023), this would likely prove just as difficult.

The current participants' accounts illustrate how, e.g., a protective connection may be formed or broken even in small interactions. If it is accepted that contextual factors play an important (even critical) part in the formation, sustainment and erosion of recovery-related agency, as Study III suggested, the observation that any characteristic(s) of the individual cannot adequately predict their movements between suicidal ideation, attempts and recovery is unsurprising (cf., Price-Robertson et al., 2017). However, risk factor research (i.e., research concerned with predicting movements from one category to another) tends to view the formation and dissolution of suicidal urges and actions as a relatively decontextualised and intrapersonal process (Marsh, 2016). A more systemic and relational approach to investigating the moment-to-moment movements from and toward suicidal action might thus be useful in moving clinical research and practice forward.

Based on the current research, I argue that facilitating suicide attempt survivors' recovery-related agency should be understood as the core task of services in indicated prevention. Further, I argue that an understanding of this agency as profoundly co-constructed is critical for providing high quality care in suicidal crises. That is, professionals and services need to be able to both value the service users' expressions of intentionality and power related to keeping safe and pursuing change, and accept that their own interventions carry significant weight in facilitating or hindering the emergence and sustenance of this agency. The three original studies each provided direct and specific guidance for professionals and services based on the participants' expressed preferences. Here, I will translate the key findings of this research into three principles to guide the facilitation of suicide attempt survivors' recovery-related agency in any service context. I will finish by considering the need to support professionals' agency (i.e., intentionality and power) in meeting these needs.

First, the participants' accounts made it clear that it is exhausting or impossible to sustain recovery-related agency if one is not recognised as an agent by the services designed to help or the professionals one is interacting with. An agent is necessarily a subject; objects do not have agency. Practices that objectify the service user invite non-agency and/or resistance, both of which may put the suicidal service user at further risk. It is thus of utmost importance that services and professionals recognise, appreciate and make use of the various ways that suicidal individuals express recovery-related agency even amidst their suicidal crises, while also remaining responsive to expressions of lacking agency and needs for support. Relevant practices include, e.g., letting service users tell their story, not only answer closed questions; including the service user in all decisions concerning their care; and small gestures that communicate genuine interest in the service user as a person. It is also imperative that treatment plans consider service users' personal recovery tasks, i.e., their subjective frame of reference and intentionality, rather than only matching interventions to diagnoses.

Second, the participants emphasised that without a thorough processing of the suicidal act it is difficult or impossible to formulate meaningful recovery tasks. Making sense of the suicide attempt is thus critical for (re)gaining recovery-related agency. A collaborative deconstruction of the suicide attempt is a shared component of evidence-based suicide-specific interventions, and should be integrated into any service response to suicidal action. For the current participants, ASSIP served as an effective facilitator of this task, while adequate exploration of the suicidal episode was often reported to be overlooked within healthcare, including specialized psychiatric services. Professionals in the relevant services thus need to be trained to recognise and appreciate the need for such deconstruction as well as to facilitate it.

Third, the participants' accounts demonstrated that the identification of personal recovery tasks inspires hope, but it is not alone enough to sustain it. Planning for safety may be perceived as a universally important recovery task after a suicide attempt (e.g., Rudd et al., 2022), and its accomplishment in ASSIP was appreciated by the current participants. However, effective services should also offer support in addressing the drivers of suicidal behavior, not only suppressing suicidal action. Gaining the power to act toward recovery-related intentions is facilitated by a collaborative plan to address these tasks with sufficiently continuous and predictable support. Suicide attempt survivors' self-identified recovery tasks typically include targets for both biological, psychological and social interventions. Services should thus be prepared to provide assistance in each of these domains. Making better use of the multidisciplinary expertise of health and social service organisations may contribute to better meeting service users' needs despite inevitably limited resources. In the current Finnish context, this might entail service design that produces less gatekeeping duties for medical professionals and more effective utilisation of the expertise of other professions as well as currently underused resources, such as systemic therapies and peer support.

Finally, providing adequate care requires that professionals are able to respond to suicidal service users with respect and empathy. However, attempting to help persons in suicidal crises while holding (inevitably) limited power to do so is an emotionally highly challenging task. This challenge may promote ineffective or even harmful service responses, including cynical, rejecting and coercive actions (e.g., Ellis et al., 2018), as was sometimes reported also by the current participants. Questions of responsibility, liability and guilt are prominent in suicidal crises (e.g., Ellis et al. 2018; Jobes, 2000; Rudd et al., 1999). This may emotionally complicate embracing a view of recovery-related agency as co-created, yet I argue that such a view is imperative for effective service responses. The provision of high-quality services thus requires professionals to be provided with adequate training and ongoing support focusing on the relational and emotional aspects of responding to suicidal crises, not only on, e.g., risk assessment or intervention techniques.

## 5.5 Implications for practice

This research project arose from my desire to both better understand and more effectively accomplish my clinical work. It was thus designed specifically to inform practice. This aim has affected the research questions and design as well as the choices made in reporting the findings. Specifically, each study aimed to provide enough concrete detail to allow practical use of the findings. Study I provided a list of seven key aspects of services that the participants found meaningful and that should thus be taken into account in service delivery and development. Study II illuminated the subjective impact of ASSIP and the participants' views on how its components facilitated these impacts, and called attention to its more effective implementation to fully capitalize on the gains it provided. Study III suggested that conceptualizing suicidal service users' recovery-related agency as the coupling of recovery-related intentionality and power may assist professionals in assessing both the available resources for and obstacles to recovery. Further, it called for professionals to acknowledge that both recovery-related intentionality and power is co-created in service interactions, thereby emphasizing the need to appreciate both the weight and the limits of the power held by professionals.

In this summary, I have combined the learnings from the original studies to allow for a practice-relevant contribution to understanding how current services might be strengthened through greater appreciation for the complementary perspectives provided by both qualitative and quantitative research as well as the professions working together to intervene in suicidal crises. The practical implications of the current research thus include guidance for both individual practitioners interacting with service users in suicidal crises, those involved in service design, and policy makers. Further, these findings may be, and already have been, used for teaching purposes in training healthcare professionals.

## 5.6 Limitations and future research

The current findings have value in informing more meaningful interventions during suicidal crises and after a suicide attempt. However, the populations of those who attempt suicide and those who complete it only partially overlap (e.g., Nordentoft, 2011). Thus, insights gained from investigating suicide attempt survivors cannot be directly generalized to those who die by suicide, and even when interventions effectively address the needs of suicide attempt survivors, there is no guarantee for a reduction in suicides. However, alleviating the suffering of suicide attempt survivors is a worthwhile task for services in itself, and higher quality care for this vulnerable group is likely also cost-effective (Dyvesether et al., 2022; Krysinska et al., 2024; Park et al., 2018; Solin et al., 2022).

The main limitation of the current research involves its use of retrospective interviews to explore participants' experiences of their service interactions. Recollections and personal narratives of previous experiences have implications for interpretations and actions in the present. Narratives are thus of relevance in seeking to understand the narrator's experiences and behavior despite their inevitable inaccuracy in depicting past events. However, as retrospective accounts are filtered through a variety of heuristics affecting human memory recall, the degree to which they may be considered informative on actual past experiences and processes is limited (Bantjes & Swartz, 2019). Hence, while the current data illuminated the meaning of past events as perceived and interpreted by the participants at the time of the interview, it must be accepted that these perceptions and interpretations may have differed, even widely, from the participants' real-time meaning-making during the past episodes they described. In future studies, data collection methods allowing for more real-time tracking of experiences and meaning-making processes would yield a richer picture of the ways in which service users' perceptions of service interactions and their choices for action, for example, are related.

The heterogeneity of the study sample in terms of demographics and history of suicidality, mental health and service use may be considered as both a limitation and a strength of this research. As the aim of the current research was to investigate services available to the heterogeneous population of suicide attempt survivors and not to give specific recommendations for specific subgroups, I argue that this heterogeneity is primarily a strength. The diversity of the sample meant that we received assessments of services from complementary perspectives (e.g., from both first-time service users and those with a long history of service engagement). This enabled the identification of experiences and perspectives that were shared within this heterogeneous group (e.g., an emphasis on professionals' caring attitude and collaborative exploration of the suicidal episode) and that should thus be considered to have high transferrability to service interactions with suicide attempt survivors. The uniform appreciation for ASSIP in this heterogeneous sample also suggested that the brief manualised intervention may be suitable as an add-on to a variety of subpopulations of suicide attempt survivors. However, it was also highlighted that the services ASSIP supplements should reflect the heterogeneity of this population; in the current sample, the intensity of service users' self-identified post-ASSIP needs ranged from finding ASSIP's follow-up sufficient to hopes for intensive intervention through a combination of psychotropic medication, psychotherapy, occupational rehabilitation and social work. Importantly, while some of the variety in needs and preferences was illustrated in this small sample of participants, it is obvious that the current research could not systematically identify the more specific needs of service user subgroups. Rather, the current findings underline the importance of professionals taking an interest in understanding each service user's idiographic reality and the associated needs and preferences. Future studies may focus on the needs of vulnerable subgroups.

Finland is not ethnically or regionally homogeneous, and the current findings thus have more direct relevance in some groups and areas than others. As ethnic identity is not recorded in health or social databases in Finland, there is little understanding of the epidemiology of suicidal behavior in Finnish ethnic minorities, with the exception of some data on the higher suicide rate of the Sami people (Young et al., 2015). Based on findings from other Nordic countries it is likely that other minority groups also have distinct patterns of suicidality (e.g., Erlangsen et al., 2024; Niederkrotenthaler et al., 2020). Research into suicidal behavior and related service use and needs in ethnic minorities would be valuable in the future. The prevalence of ill health and suicidality as well as the structuring, resourcing, availability and contents of mental health services and the related outcomes in terms of, e.g., rates of suicide (Pirkola et al., 2009) and use of disability pensions (Karolaakso, 2024) vary across the country. While the populations and service systems of some of the larger Finnish cities share features with the Helsinki metropolitan area explored in the current study, other cities and areas that are more rural may have less in common with it. In addition, the small but significant areas in Western Lapland that operate outside the predominance of the medical model, relying instead on the open dialogue approach (Mosse et al., 2022) will likely have a different set of strengths and weaknesses in suicide prevention as compared to the service system described by the current participants (Bergström et al., 2023), and further investigation of these differences would be of interest.

Finally, the current research called attention to the need to better understand how service users' agency and the opportunities and barriers presented by service systems interact to provide recovery outcomes. To achieve this, longitudinal mixed-method studies focusing on the construction of recovery (not only risk) would be a highly valuable future pursuit. Such studies would need to follow service users through their service paths, documenting their experiences and interpretations of any services used and also those desired but found inaccessible. Incorporating psychometric and behavioral outcome measures would enable a meaningful integration of qualitative and quantitative data, providing further insight into the facilitators and barriers to recovery for suicide attempt survivors within real-life service systems.

## 5.7 Conclusions

This research illuminated both the opportunities and current challenges of providing meaningful help to suicide attempt survivors within the context of Finnish healthcare and crisis services. The main findings concerned the co-created nature of movements toward recovery and the significant impact of professionals' actions in either facilitating or hindering this process during suicidal crises. Building on the findings of the three original studies, I have suggested complementing existing suicide prevention practices by 1) prioritizing relationship-focused support, 2) optimizing the integration of diverse service components, including suicide-specific brief interventions, to more effectively facilitate the recovery process, and 3) recognizing the agency of the service user as both a primary target and a valuable resource for intervention. It is my hope that, if implemented, these recommendations will contribute to the improvement of services, ensuring that those in suicidal crises – as well as their loved ones – more consistently receive the support they need and deserve.

# YHTEENVETO (SUMMARY)

## Itsemurhakriisistä toipuminen yhteisen työn kohteena: itsemurhaa yrittäneiden näkökulmia terveys- ja kriisipalveluista saatuun apuun

Tässä tutkimuksessa selvitettiin itsemurhayrityksestä selviytyneiden aikuisten näkökulmia palveluihin, joita he olivat saaneet ja toivoneet itsemurhakriisinsä aikana. Itsemurhayritys on merkittävä toteutuneen itsemurhan ennustetekijä (Bostwick ym., 2016). Itsemurha on kuitenkin kaikkea muuta kuin väistämätön lopputulema toistuvienkaan itsemurhayritysten jälkeen; päinvastoin, suurin osa itsemurhaa yrittäneistä ei kuole itsemurhan kautta (esim. Carroll ym., 2014; Suominen ym., 2004).

Kohtaamisilla terveydenhuollon ja kriisipalveluiden kanssa voi olla itsemurhakriisin purkamisessa ratkaiseva merkitys, mutta palveluilla on usein myös vaikeuksia vastata avuntarpeeseen tavoilla, jotka tuntuisivat itsemurhavaarassa olevista merkityksellisiltä ja auttavilta (esim. Taylor ym., 2009). Palvelunkäyttäjien näkemykset voisivat auttaa kehittämään paremmin tarkoitustaan palvelevia terveys- ja kriisipalveluita, mutta Suomessa on harvoin tutkittu itsetuhoisuudesta kärsineiden kokemuksia ja näkökulmia liittyen itsetuhoisuuden yhteydessä saatuihin tai toivottuihin palveluihin. Tämän väitöstutkimuksen tarkoituksena oli tuottaa käytännönläheistä tietoa itsemurhaa yrittäneiden suomalaisten palvelunkäyttäjien näkemyksistä ammattilaisten työn ja palveluiden kehittämisen tueksi.

Tutkimus toteutettiin yhteistyössä MIELI Suomen Mielenterveys ry:n, Helsingin kaupungin sekä Helsingin ja Uudenmaan sairaanhoitopiirin kanssa. Kaikissa kolmessa osatutkimuksessa aineistona olivat neljäntoista itsemurhayrityksestä selviytyneen aikuisen syvähaastattelut. Viimeisimmän itsemurhayrityksensä jälkeen jokainen haastateltava oli osallistunut MIELI ry:n tarjoamaan Lyhytinterventioon itsemurhaa yrittäneille (Linity; Michel & Gysin-Maillart, 2015). Jokainen osallistuja oli käyttänyt myös terveydenhuollon palveluita itsemurhakriisin yhteydessä. Haastattelut toteutuivat 4-10 viikkoa Linityn viimeisen käynnin jälkeen, jolloin Linityyn johtaneesta itsemurhayrityksestä oli kulunut 3-6 kuukautta. Aineistoa tarkasteltiin laadullisesti. Tutkimuksissa I-II sovellettiin tavanomaista sisällönanalyysiä, ja tutkimuksessa III sovellettiin kohdennettua sisällönanalyysiä. Tutkimushaastattelujen lisäksi tutkijoiden käytettävissä olivat osallistujien Linityn ensimmäisellä käynnillä kertomat tarinat itsemurhayrityksestään sellaisina, kuin ne oli Linityssä dokumentoitu. Näitä tarinoita käytettiin tutkimuksessa taustoittamaan osallistujien haastatteluissa kertomaa.

Tutkimuksessa I tarkasteltiin sitä, miten osallistujat olivat kokeneet vuorovaikutuksen terveydenhuollon kanssa edesauttaneen tai haitanneen toipumistaan itsemurhakriisin aikana. Lähes kaikilla osallistujilla oli sekä myönteisiä että kielteisiä kokemuksia kohtaamisista terveydenhuollossa. Osallistujat arvioivat palveluiden auttavuutta ennen kaikkea suhteessa siihen, miten hyvin niiden oli koettu tukevan osallistujien itse merkityksellisiksi arvioimien toipumisen tehtävien (eli toipumista edesauttavien toimien) toteuttamista. Seitsemän palveluiden ominaisuutta nousi haastatteluissa keskeisiksi. Osallistujat toivoivat 1) tulevansa kohdatuksi avun arvoisina, 2) saavansa tukea itselleen merkityksellisten teemojen tutkimiseen, 3) saavansa tukea itsemurhayrityksen ja siihen johtaneen prosessin läpikäymiseen ja ymmärtämiseen, 4) hoitopolun psykologista jatkuvuutta ja ennakoitavuutta, 5) tarpeenmukaista tukea omien toipumisen tehtäviensä toteuttamisessa, 6) tilaisuuksia osallistua lääkehoitoaan koskeviin päätöksiin ja 7) ihmissuhdekontekstinsa huomioimista.

Osatutkimuksessa I korostui yhtenevästi aiemman tutkimuksen kanssa se, miten ratkaiseva merkitys palvelunkäyttäjien henkilökunnan asenteista tekemillä havainnoilla oli heidän palvelukokemustensa muotoutumisessa (esim. Taylor ym., 2009). Lähes kaikilla osallistujilla oli kokemuksia vuorovaikutustilanteista sekä empaattisiksi, kunnioittaviksi ja välittäviksi että vihamielisiksi, torjuviksi ja/tai välinpitämättömiksi koettujen ammattilaisten kanssa. Osallistujat kuvasivat, miten ensimmäisen kaltaiset kohtaamiset olivat edistäneet toivon, itsearvostuksen ja kuulumisen tunteita, kun taas jälkimmäiset olivat luoneet esteitä hoitoon hakeutumiselle tai sen hyödyntämiselle ja usein myös vahvistaneet yllykkeitä itsetuhoiseen toimintaan. Osallistujat korostivat, että tuki itsetuhoiseen tekoon johtaneen prosessin ymmärtämiseen sekä palveluiden riittävä ennustettavuus ja jatkuvuus olivat ratkaisevan tärkeitä toipumisen kannalta. Lisäksi he ilmaisivat toivovansa niin itsetuhoisuuden biologisiin, psykologisiin kuin sosiaalisiinkin taustasyihin kohdistuvaa apua, mutta viimeisen ulottuvuuden oli koettu jääneen pääosin huomiotta heidän saamissaan palveluissa.

Osatutkimuksessa II selvitettiin sitä, miten osallistujat olivat kokeneet Linityyn osallistumisen vaikuttaneen itseensä. Linity (Michel & Gysin-Maillart, 2015) on MIELI ry:n kriisipalveluiden tarjoama lyhyt, itsetuhoiseen käyttäytymiseen kohdennettu interventio, joka on tarkoitettu täydentämään muita tarpeenmukaisia palveluita itsemurhayrityksen jälkeen. Linity painottaa varhaiseen terapeuttiseen allianssiin panostamista ja kollaboratiivista työotetta. Kolmen käynnin interventiossa lähtökohtana on itsemurhaa yrittäneen oma tarina. Asiakkaan itsemurhayrityksestään ja sen taustasta kertoma tarina videoidaan ensikäynnillä ja sitä tarkastellaan yhdessä videolta toisella käynnillä, minkä jälkeen Linityn työntekijä koostaa tarinasta tiivistelmän edelleen yhdessä tarkasteltavaksi. Tarinan tarkastelu ja itsetuhoiseen tilaan liittyvä yleinen psykoedukaatio ovat lähtökohtana yksilöllisen tapausjäsennyksen, toipumistavoitteiden ja turvasuunnitelman rakentamiselle kolmannella käynnillä. Tapaamisten jälkeen asiakkaalle lähetetään kahden vuoden ajan seurantakirjeitä (ensimmäisenä vuonna kolmen kuukauden välein ja toisena puolen vuoden välein). Seuranta-aikana asiakkaalla on mahdollisuus vastata kirjeisiin ja/tai olla yhteydessä Linity-työntekijäänsä kriisitilanteessa. Linity on alun perin suunniteltu yksilöinterventioksi, mutta Suomessa siihen on liitetty mahdollisuus neljänteen istuntoon yhdessä itsemurhaa yrittäneen läheisten kanssa.

Osatutkimuksessa II havaittiin, että kaikilla osallistujilla oli pääosin myönteinen kokemus Linitystä. Arviot sen vaikutusten henkilökohtaisesta merkityksestä vaihtelivat: jotkut osallistujat kuvasivat Linityn olleen täysin ratkaiseva tekijä toiveikkaiden tulevaisuudennäkymien (uudelleen)rakentamisessa, kun taas toiset arvioivat sen tuottaneen joitakin hyötyjä, mutta tilanteensa pysyneen kuitenkin pääosin muuttumattomana. Kaikki osallistujat arvioivat Linityn tuottaneen toipumista tukevaa muutosta ainakin kahdella neljästä heidän kertomuksissaan tunnistetusta muutoksen osa-alueesta. Osallistujien kertomuksissa muutoksia kuvattiin parempana olona (esim. helpottuneisuutena tai toiveikkuutena), uusina näkökulmina (yleisimmin kirkkaampana ymmärryksenä itsetuhoisesta prosessista), uusina käyttäymismalleina (esim. rohkaistumisena puhumaan omista asioista tai tekemään vähemmän, kun on uupunut) sekä uusina resursseina (esim. osallistujalle itselleen uskottavana turvasuunnitelmana ja yhteydenottomahdollisuutena). Suurin osa osallistujista koki Linityn tuottaneen myös sivuvaikutuksia. Näitä kuvattiin kahdella osa-alueella: hankalina tunteina (esim. videointiin tai käsiteltyihin teemoihin liittyvänä ahdistuksena tai huolena työntekijän kuormittumisesta) ja tiedonkäsittelyn ylikuormittumisena (joka näyttäytyi esim. unohteluna tai dissosiatiivisina oireina). Kukaan osallistuja ei kuitenkaan kuvannut sivuvaikutuksia erityisen ongelmallisina, vaan pikemmin väistämättömänä osana toipumista kohti työskentelyä. Työntekijöiden huomaavaiseksi koetun suhtautumisen kuvattiin edesauttaneen sivuvaikutusten sietämistä ja/tai väistymistä. Kolmanneksi havaittiin, että kaikki osallistujat kuvasivat Linityssä syntynyttä muutosta jollakin tavalla keskeneräisenä. Vaikka moni koki Linityn aikana tapahtuneen muutoksen olleen erittäin merkittävä, yhtä lukuunottamatta kaikki osallistujat korostivat tarvitsevansa jatkossa Linityyn kuuluvaa kirjeseurantaa ja yhteydenottomahdollisuutta tukevampaa tukea saadakseen työstettyä keskeneräisiä toipumisen tehtäviä tai pidettyä yllä tapahtunutta muutosta. Lisätukea toivovista osallistujista seitsemän arvioi haastatteluhetkellä, että toivotun kaltaista tukea oli heille saatavilla; loput kuusi olivat epätietoisia ja huolissaan siitä, miten tarvittava tuki jatkossa järjestyisi. Kukaan tutkimuksen osallistujista ei ollut hyödyntänyt Linityn osana tarjottua mahdollisuutta tapaamiseen läheisten kanssa, vaikka useampi arvioi, että se olisi ollut tarpeen tai hyödyllistä.

Osatutkimuksessa III tarkasteltiin osallistujien kuvauksia toipumiseen liittyvästä toimijuudestaan ja palveluiden roolista tämän toimijuuden syntymisessä, ylläpitämisessä ja sammuttamisessa. Toipumista koskeva toimijuus operationalisoitiin osallistujien kuvauksiksi itsestään kykenevinä toimimaan toipumisen tehtäviensä eteen. Se koostui siis kahdesta osa-alueesta: 1) toipumista koskevista intentioista (joita edusti osallistujien ilmaisema oma ymmärrys toipumisen tehtävistään eli siitä, mikä vahvistaisi tunnetta elämästä elämisen arvoisena ja/tai edesauttaisi turvassa pysymistä myös itsetuhoisten yllykkeiden jatkuessa tai palatessa) ja 2) osallistujien ilmaisemasta kyvystä toimia näiden intentioiden mukaisesti. Tarkastelimme näitä ilmauksia erityisesti yhteydessä osallistujien kuvauksiin vuorovaikutuksestaan terveys- ja kriisipalveluiden kanssa.

Osatutkimuksessa III havaittiin, että kaikki osallistujat ilmaisivat sekä toimijuutta että ei-toimijuutta liittyen toipumisen prosessiin. Palveluiden tarjoama tuki kuvatui hyvin merkityksellisenä sen kannalta, miten osallistujat kokivat pystyvänsä saavuttamaan tai ylläpitämään toipumista koskevaa toimijuutta tai toisaalta pysymään turvassa silloin, kun kokivat toipumista koskevan toimijuutensa puutteelliseksi. Toimijuuskokemusten ja suhdekontekstin ristiintaulukointi tuotti neljä erilaista toimijuuskuvausta, jotka nimettiin vahvistetuksi toimijuudeksi, kuluttavaksi toimijuudeksi, ankkuroiduksi ei-toimijuudeksi ja ajelehtivaksi ei-toimijuudeksi. Vahvistettu toimijuus viittasi osallistujien kokemuksiin tilanteista, joissa he kokivat palveluiden auttaneen luomaan ja/tai ylläpitämään heidän omia toipumiseen liittyviä intentioitaan ja/tai kyvykkyyttään toimia intentioidensa mukaan. Vahvistettua toimijuutta he kuvasivat ikään kuin itseään uudistavaksi tai ruokkivaksi. Vastaavasti kuluttavaa toimijuutta ilmeni tilanteissa, joissa osallistujat kokivat jäävänsä toipumisen tavoitteidensa kanssa yksin tai palveluiden jopa haittaavan heidän omien toipumiseen liittyvien intentioidensa muodostumista ja/tai ylläpitämistä ja/tai niiden mukaan toimimista, mutta löysivät tapoja toimia itsenäisesti tavoitteidensa eteen. Vaikka osallistujat kuvasivat kyenneensä toimimaan näissä tilanteissa toipumista kohti, he myös arvioivat käytettävissään olevien toimijuusresurssien kuluneen tai vähentyneen näiden ponnistusten myötä. Ankkuroiduksi ei-toimijuudeksi kutsuimme tilanteita, joissa osallistujat kuvasivat toipumiseen liittyvän intentionaalisuutensa ja/tai kyvykkyytensä olleen puutteellista, mutta ammattilaisten tuen auttaneen pitämään heidät turvassa ja olleen osaltaan vahvistamassa toimijuuden edellytysten syntymistä. Ajelehtivalla ei-toimijuudella taas kuvattiin tilanteita, joissa osallistujat kokivat oman toipumiseen liittyvän toimijuutensa puutteelliseksi tai kokonaan puuttuvaksi, ja samalla jäävänsä ilman tukea, joka voisi loiventaa tämän tilan vaarallisuutta. Ajelehtivaan ei-toimijuuteen liittyi osallistujien tarinoissa usein itselle vaaralliseen toimintaan ajautumista tai turvautumista.

Toimijuuden käsitteen soveltaminen osallistujien kertomusten tarkasteluun auttoi kuvaamaan uudesta näkökulmasta heidän toipumiseen liittyviä ponnisteluitaan ja sitä, millainen rooli palveluilla oli heidän näkökulmastaan ollut näiden ponnistelujen helpottamisessa tai estämisessä. Osatutkimuksen III tuloksissa korostuivat ne mahdollisuudet, joita palvelunkäyttäjien näkeminen toipumisprosessin toimijoina myös itsemurhakriisin aikana voi hoidolliseen vuorovaikutukseen tuottaa, ja toisaalta ne riskit, joita heidän toimijuutensa ohittaviin käytänteisiin liittyy.

Tämän väitöstutkimuksen tulokset täydentävät itsemurhatutkimuksen kenttää hallitsevan määrällisen tutkimuksen antia tarjoamalla pääsyn palvelunkäyttäjien tulkintoihin, jotka ilman laadullisten menetelmien hyödyntämistä jäävät piiloon. Tarjoamalla näkymän itsemurhayrityksestä selviytyneiden subjektiivisiin merkityksenantoihin tutkimus kokonaisuudessaan valotti sitä, miten itsemurhakriisistä toipumisen tai kriisin pitkittymisen polku rakentuu palvelunkäyttäjien ja palveluiden vuorovaikutuksessa. Tutkimuksen tulokset havainnollistivat, miten jokainen kohtaaminen palvelujen kanssa voi edistää tai estää itsemurhaa yrittäneiden palvelunkäyttäjien toipumiseen liittyvää toimijuutta. Kolme osatutkimusta tarjosivat kukin palvelunkäyttäjien kokemuksiin perustuvaa käytännönläheistä opastusta ammattilaisille ja palveluiden kehittämisen parissa työskenteleville ammattilaisille. Kokonaisuutena tämä väitöskirjatutkimus auttoi havainnollistamaan itsetuhoisuutta monimutkaisena ilmiönä, johon vastaamisessa terveydenhuoltojärjestelmä nykyisellään nojaa palvelunkäyttäjien arvioimana liiaksi yksilökeskeiseen ja lääketieteelliseen näkökulmaan. Tutkimuksen havaintojen pohjalta väitän, että paremmin palvelunkäyttäjien tarpeisiin vastaavien palveluiden kehittämiseksi olisi tarpeen vahvistaa sekä itsemurhatutkimuksen moniäänisyyttä ja -menetelmäisyyttä että sosiaali- ja terveydenhuollon eri ammattiryhmien toisiaan täydentävän asiantuntemuksen hyödyntämistä palveluiden suunnittelemisessa ja toteuttamisessa.

Yhdessä tarkasteltuina osatutkimusten tuloksissa huomionarvoisiksi nousi kolme nykyisissä palveluissa liian vähäiselle huomiolle jäävää näkökulmaa. Ensinnäkin keskiöön nousi osallistujien tarve ihmissuhteisiinsa (ei vain heihin yksilöinä) kohdentuville interventioille. Ihmissuhteisiin liittyvä kuormitus on itsetuhoisuuden tavallinen taustatekijä ja seuraus, mutta sen enempää aikuisten itsetuhoisuuden hoitoon suunnitelluissa interventioissa (Frey ym., 2022) kuin näiden osallistujien osakseen saamassa tavanomaisessa hoidossa tätä ei ole juuri huomioitu. Osallistujat toivoivat enemmän tukea läheistensä mukaan ottamiseen hoitopolulla ja sen kautta myös itsetuhoisen teon näihin suhteisiin synnyttämien huolten ja jännitteiden käsittelyyn. Yksinäisyydestä kärsivät osallistujat toivoivat suorempaa tukea ihmissuhdeverkostonsa vahvistamiseen. Myös toive vertaistuen vahvemmasta hyödyntämisestä nousi esiin. Kaiken kaikkiaan siis nykyisten palveluiden puutteena esiin nousi korostuneen yksilökeskeinen fokus, jossa suhteisiin ja osallistujille tärkeisiin sosiaalisiin rooleihin kohdistuva tuki jäi olemattomaksi. Jatkokehittämisen tarpeeksi nousivat siten sekä itsetuhoisuuteen kohdennetut interventiot, joissa suhdefokus olisi sisäänrakennettuna, että tavanomaisen hoidon kehittäminen paremmin suhdenäkökulman huomioivaan suuntaan.

Toiseksi tämän tutkimuksen tulosten tarkastelu yhteydessä Linityn vaikuttavuudesta erilaisten palvelupolkujen osana kertyneeseen aiempaan näyttöön (Arvilommi ym., 2022a; Arvilommi ym. 2022b; Gysin-Maillart ym., 2016) nosti esille tarpeen tarkastella itsemurhaa yrittäneiden palvelupolkuja kokonaisuuksina niiden vaikuttavuuden lisäämiseksi. Osallistujien kertomukset valaisivat sekä epäjatkuville palvelupoluille hukattuja mahdollisuuksia että niitä kertautuvia hyötyjä, joita syntyi, kun itsetuhoisuuteen kohdennettu lyhytinterventio (Linity) yhdistyi riittävän ennakoitavalla ja jatkuvalla tavalla muihin tarpeenmukaisiin palveluihin. Osallistujat arvostivat MIELI ry:n kriisipalveluiden alla tarjottuun Linityyn hakeutumisen matalaa kynnystä, ja tuoreen katsauksen (Uddin ym., 2023) havaintoja mukaellen osallistujat pitivät myös muutoin MIELI ry:n ei-kliinistä ympäristöä terveydenhuollon ympäristöjä miellyttävämpänä. Nykyisellään Linity ei kuitenkaan näytä nivoutuvan riittävän ennakoitavalla ja johdonmukaisella tavalla osaksi terveydenhuollon hoitopolkuja, jotta Linityssä rakennettua ymmärrystä itsetuhoisuuden taustasyistä ja motivaatiota niiden työstämiseen päästäisiin optimaalisesti hyödyntämään.

Kolmanneksi osatutkimusten tulokset tekivät näkyväksi, miksi palvelunkäyttäjien toimijuus on tärkeää ottaa auttamispyrkimysten keskiöön. Kokemus omaa elämää koskevan toimijuuden menetyksestä on tavallinen itsetuhoisten yllykkeiden laukaisija (esim. Järventie, 1993; Pavulans ym., 2012) ja toisaalta toimijuuden palautumista on kuvattu keskeisenä toipumiselle (Crona ym., 2017;

Sinclair ym., 2005). Osallistujien kuvaukset tarjosivat käytännönläheistä opastusta siihen, millaisilla toimilla ammattilaiset ja palvelut voivat vahvistaa tai toisaalta haitata heidän toipumista koskevaa toimijuuttaan. Monilla osallistujista oli kokemusta vuorovaikutustilanteista, joissa he olivat kokeneet tulevansa kohdelluiksi objekteina pikemmin kuin osallisina omassa hoidossaan. Näiden kokemusten osallistujat kuvasivat heikentäneen toimijuuden kokemustaan ja/tai synnyttäneen vastustusta, ja molemmissa tapauksissa haitanneen heidän hyvinvointiaan ja turvallisuuttaan. Toisaalta osallistujat kuvasivat, että kun he tulivat kohdelluiksi subjekteina, joiden näkökulmasta oltiin hoidossa kiinnostuneita, he kokivat itsekin paremmin sekä ymmärtävänsä itseään että kykenevänsä toimimaan omaa hyvinvointiaan palvelevalla tavalla.

Osallistujat tekivät myös selväksi, että ilman itsemurhayrityksen perusteellista käsittelyä heidän olisi ollut vaikeaa tai mahdotonta tunnistaa itselleen mielekkäitä toipumisen tehtäviä. Itsemurhayritykseen johtaneen prosessin ymmärtäminen oli siis heidän näkökulmastaan ratkaisevan tärkeää toipumiseen liittyvän toimijuuden kannalta. Tällaisen ymmärryksen rakentaminen on osa kaikkia näyttöön perustuvia itsetuhoiseen käyttäytymiseen kohdennettuja interventioita, ja myös suomalainen Käypä hoito -suositus korostaa, että itsemurhaa yrittäneen kanssa on tärkeää käydä läpi koko yritykseen johtanut tapahtumaketju (Itsemurhien ehkäisy ja itsemurhaa yrittäneen hoito: Käypä hoito -suositus, 2022). Omalla kohdallaan osallistujat kuvasivat Linityn palvelleen hyvin itsetuhoisen prosessin ymmärtämistä, kun taas terveydenhuollossa moni koki itsemurhayrityksen läpikäymisen jääneen vähälle huomiolle tai jopa kokonaan huomiotta. Itsemurhaa yrittäneitä potilaita kohtaavien terveydenhuollon ammattilaisten valmiuksia tukea tässä tärkeässä tehtävässä on siis tarpeen vahvistaa.

Lisäksi osallistujat korostivat, että palveluiden olisi tärkeää tarjota tukea myös itsetuhoisten yllykkeiden taustalla oleviin tekijöihin puuttumisessa, ei pelkästään itsetuhoisten tekojen hillitsemisessä. Henkilökohtaisten toipumisen tehtävien tunnistaminen lisäsi toiveikkuutta, mutta jos osallistujat olivat jääneet niiden toteuttamisen kanssa yksin, toivottomuus usein palasi. Osallistujien itse määrittelemiin toipumisen tehtäviin sisältyi tyypillisesti tavoitteita sekä biologisille, psykologisille että sosiaalisille interventioille, ja palveluiden toivottiin tarjoavan apua kaikilla näillä osa-alueilla. Nykytilanteessa osallistujat kokivat erityisen puutteelliseksi toisaalta psykoterapian ja toisaalta kaikkiin toipumisen sosiaalisiin ulottuvuuksiin (esim. ihmissuhdekonflikteihin tai itselleen merkityksellisten sosiaalisten roolien puuttumiseen tai menettämiseen) kohdentuvan tuen saatavuuden.

Tämä ja aiempi tutkimus (esim. Taylor ym., 2009) on osoittanut, miten keskeistä on, että ammattilaiset pystyvät vastaamaan itsemurhakriisissä apua hakeville palvelunkäyttäjille kunnioittavasti ja empaattisesti. Itsetuhoisuuden hoito on kuitenkin emotionaalisesti vaativa tehtävä. Ammattilaisten vaikeudet sietää tähän tehtävään liittyviä jännitteitä voivat näyttäytyä palveluissa esimerkiksi kyynisinä, torjuvina tai pakottavina toimina (esim. Ellis ym., 2018), joista myös tämän tutkimuksen osallistujilla oli kokemuksia. Laadukkaat palvelut rakentuvat syvälliselle ymmärrykselle vuorovaikutuksen merkityksestä itsetuhoisesta kriisistä toipumiselle. Siksi ne edellyttävät, että ammattilaisille tarjotaan asianmukaista koulutusta ja tukea myös itsetuhoisiin kriiseihin vastaamisen relationaalisiin ja emotionaalisiin näkökohtiin keskittyen, ei pelkästään riskiarvioinnin tai interventiotekniikoiden näkökulmasta.

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# ORIGINAL PAPERS

## I

## HOW DO HEALTH CARE SERVICES HELP AND HINDER RECOVERY AFTER A SUICIDE ATTEMPT? A QUALITATIVE ANALYSIS OF FINNISH SERVICE USER PERSPECTIVES

by

Selma Gaily-Luoma, Jukka Valkonen, Juha Holma & Aarno Laitila, 2022

*International Journal of Mental Health Systems,16*, 52

https://doi.org/10.1186/s13033-022-00563-6

Gaily-Luoma *et al.*
*International Journal of Mental Health Systems* (2022) 16:52
https://doi.org/10.1186/s13033-022-00563-6

International Journal of
Mental Health Systems

**RESEARCH** **Open Access**

# How do health care services help and hinder recovery after a suicide attempt? A qualitative analysis of Finnish service user perspectives

Selma Gaily-Luoma[1*], Jukka Valkonen[2], Juha Holma[1] and Aarno Laitila[1]

**Abstract**

**Background:** Suicide attempt survivors are at high risk of re-attempts and suicide death. Previous research has shown that service users' experiences of post-attempt care are related to future treatment engagement and re-attempts. In-depth understanding of how current services meet service users' needs in the period immediately following a suicide attempt is thus imperative for the development of more effective tertiary prevention practices in real-life health care systems.

**Method:** In this qualitative study, Finnish suicide attempt survivors' experiences of and perspectives on mental health services were explored through a semi-structured interview. Participants were seven female and seven male service users interviewed 3–6 months after the index suicide attempt. A conventional content analysis of these service user interviews is presented.

**Results:** Participants' experiences of care ranged from helping to hindering recovery. Seven key aspects of services were described as helpful when present and hindering when absent. These included (1) meeting the service user as worthy of help, (2) supporting the exploration of personal meanings, (3) supporting the exploration of suicidality, (4) psychological continuity and predictability, (5) offering a responsive partnership in navigating recovery, (6) inviting service user involvement in medication decisions, and (7) accounting for service users' relational context.

**Conclusions:** Current health care services are inconsistent in meeting suicide attempt survivors' subjective needs, leaving clear room for improvement in tertiary suicide prevention. To be perceived as meaningful by service users, services should strive to offer opportunities for both biomedical, psychological, and social interventions, with responsivity to individual needs and preferences. A focus on the social aspects of recovery (e.g., offering support to loved ones affected by the suicidal incident; facilitating peer support and social belonging) was most often found to be lacking in current services.

**Keywords:** Suicide attempt, Self-harm, Health care, Service user, Experience, Mental health, Psychiatry, Emergency services, Qualitative, Recovery

## Background

A history of attempted suicide is the most significant predictor of suicide death [1], making suicide attempt survivors' care a priority in suicide prevention. Tertiary prevention research aims at supporting improvement in practices. However, transforming research evidence into more effective real-life health care systems presents an ongoing challenge [2, 3]. Previous research has shown

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that suicide attempt survivors' subjective experiences of care are related to, e.g., treatment outcome and future engagement with services [4, 5]. In-depth understanding of service user perspectives is thus needed to inform the development of approachable, high-quality services [6, 7].

Historically, Finland has pioneered suicide prevention efforts [8]. The Finnish National Suicide Prevention Project of 1986–1996 [9] was the first comprehensive, research-based suicide prevention program in the world. Its quantitative and qualitative results were published in over 100 articles [8, 10]. Prominent findings included a high incidence of untreated psychiatric disorders in individuals who had died by suicide and inadequacies in the treatment of suicide-related psychiatric disorders. National policies were implemented to improve identification rates and quality of treatment of these disorders.

The National Suicide Prevention Project was a success [9, 10]. Finland's previously rising suicide rates began to decline in 1990 and have since halved [11]. However, the current age-standardized suicide rate of 13.4/100,000 remains above the average for high-income countries [12]. In 2020, the Finnish Ministry of Social Affairs and Health launched a new Mental Health Strategy and National Suicide Prevention Program for the decade 2020–2030 [13]. Measures detailed in the program include raising public awareness to reduce stigmatizing attitudes, restricting access to means of suicide, enhancing access to low-threshold crisis support and health care, supporting those bereaved by suicide, attending to substance-abuse-related suicide risk, improving responsible media coverage, developing EU legislation for suicide-related social media content, and strengthening research.

Since the completion of the National Suicide Prevention Project, Finnish suicide research has continued to yield results of value for tertiary prevention. The most recent publications include a clinical trial [14] and longitudinal observations on prospective study cohorts [15]. However, qualitative research efforts have been scarce, and suicide attempt survivors' experiences of services remain unexplored.

### Finnish mental health services for suicide attempt survivors

Finland has universal health care that includes the promise of need-based psychiatric services for all residents, with recently published Current Care Guidelines [16] for suicide prevention and intervention after attempted suicide. However, treatment delays and the limited availability of evidence-based psychosocial interventions have been identified as barriers to appropriate care, with an ongoing national debate on possible solutions [17]. Despite prioritizing efforts, these barriers also affect individuals presenting with suicidal behavior [18].

While private-sector providers offer treatment options for those with private insurance or the ability to pay out of pocket, several non-governmental organizations (NGOs) supplement public health care with free-of-charge services. The NGO most prominently involved in suicide prevention, MIELI Mental Health Finland, provides crisis support services, a national crisis helpline, and the Attempted Suicide Short Intervention Program (ASSIP) [19]. ASSIP is a three-session manualized intervention for suicide attempt survivors, with follow-up letters and the possibility for crisis contact over the next 2 years. ASSIP is designed to be auxiliary to any health care interventions assessed as appropriate (i.e., treatment as usual) after a suicide attempt and is recommended as such in the Current Care Guidelines [16].

### Aims of the study

We investigated service users' experiences of health care services after a recent suicide attempt. The present article focuses on service users' experiences of services provided by the Finnish public health care system. These service users' experiences of ASSIP will be presented elsewhere. We aimed for in-depth understanding of service users' personal views on whether and how services had facilitated or could facilitate their recovery. Our data-driven definition of recovery emphasizes the present service users' own understandings of its goals and process and resembles the concept of 'psychological recovery' proposed by Andresen et al. [20].

## Methods

This study applied an exploratory qualitative design in a naturalistic setting. Participants were suicide attempt survivors with recent experience of both health care services and the Attempted Suicide Short Intervention Program (ASSIP). Here, we report our findings on participants' experiences with the health care system, i.e., "treatment as usual". This includes experiences with, e.g., primary health care services, emergency services and psychiatric in-patient and out-patient services. Findings on participants' experiences of ASSIP, provided by an NGO outside the health care system and designed as an adjunct to treatment as usual, are to be published separately.

Our primary data consist of in-depth service user interviews focusing on experiences of care. Additional data include written summaries of participants' narratives of their index suicide attempt (documented as part of ASSIP). These summaries were reviewed in this study solely to enhance contextual understanding.

This study received ethical approval from the Helsinki University Hospital Ethics Committee. As per Finnish and EU regulations, participants were given a detailed description of the procedures for ensuring the confidentiality and protection of their personal data both during and after the study. All participants gave their written consent to use of their recorded interview and the written summary of their suicide attempt for the purposes of this study.

### Study recruitment

Participants were recruited through the MIELI Suicide Prevention Center (MIELI) in Helsinki. Eligible participants included all persons entering ASSIP at MIELI, excluding only those under age 18 and/or resident outside the Hospital District of Helsinki and Uusimaa. Through MIELI, ASSIP is available to Finnish-speaking adolescents and adults with a recent suicide attempt, excluding those whose suicide attempt occurred during a psychotic episode, those with a current substance abuse disorder serious enough to impede engagement with the intervention, and those with habitual serious self-harm. In the ASSIP context, a suicide attempt is defined as either a completed or interrupted action that, in the person's own understanding, was aimed at taking their own life.

ASSIP therapists informed eligible clients of the study at beginning of the first ASSIP session and at the end of the last session asked for their consent to participate. Consent was confirmed by the interviewer at the end of the study interview.

### Participants

Of the 104 eligible service users informed of the study, 18 gave their initial consent and 14 participated in the research interview (one could not be interviewed due to COVID pandemic restrictions and three withdrew before the interview). The most common reason given for consenting was a desire to be of help in service development and/or increase public awareness of suicidal behavior. Reported reasons for non-consent included privacy concerns and/or an expectation that participation would be overwhelming. Participant characteristics are presented in Table 1. Participants represented diverse socio-demographic backgrounds and current life circumstances. Highest education varied from high school diploma to master's degree. Thirteen participants were white, and one was of mixed ethnicity.

**Table 1** Participant characteristics

| | n | % |
|---|---|---|
| Registered sex | | |
| Male | 7 | 50 |
| Female | 7 | 50 |
| Age | | |
| 18–29 | 5 | 36 |
| 30–45 | 4 | 29 |
| 46–59 | 3 | 21 |
| 60+ | 2 | 14 |
| Current occupation | | |
| Employed | 7 | 50 |
| Student | 3 | 21 |
| Pensioner | 2 | 14 |
| Unemployed | 2 | 14 |
| Living arrangement | | |
| With spouse | 4 | 29 |
| With other adult family member(s) | 3 | 21 |
| Alone or with roommate | 6 | 43 |
| No fixed abode | 1 | 7 |

The physical severity of the index suicide attempts ranged from requiring emergency medical intervention to interrupted with no physical injury (e.g., climbing to a height but deciding not to jump). Planned or used methods included intoxication (9), self-cutting (2), leaping from a height (2), motor vehicle collision (3) and electrocution (1); some participants combined means. In addition to the index attempt, eight participants reported at least one previous suicide attempt either in recent years or decades earlier. Seven had received psychiatric treatment in relation to suicidality before the current episode. During the current episode, all had experience of emergency services, 12 had received outpatient psychiatric services, four had been inpatients, and two had received psychotherapy.

The participants' narratives of their suicide attempt showed diversity in the routes to suicidal action. Two participants reported psychological well-being well into middle age and attributed their suicide attempt solely or primarily to a specific current stressor (e.g., chronic pain due to a somatic condition). Three participants narrated a previous suicidal episode, followed by a lengthy period of well-being before the current episode. The majority of the participants narrated the suicidal process as having its roots in early childhood, many reporting traumatic life histories of early abuse and/or bereavement.

### Service user interviews

All participants took part in a semi-structured research interview conducted by the first author. The interviews took place at the MIELI Suicide Prevention Center 3–6 months after the index suicide attempt and 4–10 weeks after the last ASSIP session. Interviews lasted 45–120 min and were video recorded. Following the interview topic guide (see Additional file 1), experiences of ASSIP were investigated first, then those of any other services received by the participant. Participants were asked about aspects of services they perceived as helpful, unhelpful, or even hurtful, any surprising elements, suggestions for improvement, and their subjective assessment of whether each service received had been helpful to them. The primary focus was on the most recent suicidal episode, but accounts of previous episodes were explored when initiated by participants. While all the participants answered all the questions in the topic guide, the interviewer followed the participants' narrative lead, and thus the order of the questions varied. A reflective journal was kept to document initial impressions, insights and questions elicited by each interview.

### Data analysis

We performed a conventional content analysis [21] of the interview data, since our aim was to describe the phenomenon under study (i.e., suicide attempt survivors' perspectives on services) and this method allows data-driven insights to emerge from the data. Interviews were transcribed verbatim and read/listened to multiple times to enable immersion in the data. Data excerpts relevant to the research question (i.e., all meaning units in which participants expressed some kind of personal view on health care services) were then systematically identified and open-coded. Open-coded units of similar content were organized into clusters and the clusters tentatively conceptualized as themes. Data excerpts not yet belonging to established clusters/themes were reviewed in a cyclical process, resulting in the refinement of existing conceptualizations (incorporation of variations of closely related thematic content) and the formation of new clusters (when data did not fit with existing clusters/themes). A record was kept of the evolving coding and clustering of data and conceptualization of themes. The analytical process was led by the first author and reviewed and refined in data sessions with the fourth author. All authors contributed to refining the final themes and their wordings during the writing process.

## Results

The participants provided rich accounts of their personal experiences of and views on services they had received. In narrating their experiences, participants mentioned a variety of personally meaningful recovery goals, i.e., changes they wished for and/or understood to be a personal marker of "getting better". Such goals included, for example, ridding oneself of the wish to die, not being overwhelmed by negative feelings, finding hope, (re)discovering an interest in working or the ability to work, and being able to meet the demands of daily life. Participants also spoke of a variety of recovery tasks, i.e., activities they understood as a route to achieving their personal goals. These tasks included, for example, learning to talk about what was bothering them, strengthening their sense of self-worth, getting traumatic experiences "off their chest", finding the right medication, learning to manage recurrent suicidal impulses without acting on them, and finding or returning to meaningful activities and/or relationships.

When participants were asked about the helpfulness of services they had received, they seemed primarily to make these evaluations in relation to their personally meaningful recovery goals and tasks. Thus, services were found helpful when experienced as providing help in achieving personal recovery goals and/or working on personal recovery tasks and unhelpful or even hurtful when experienced as not supporting personal goals/tasks and/or promoting goals/tasks that the participant did not find personally meaningful.

Seven key themes emerged in the participants' accounts of what helped or hindered their recovery. Themes 1–5 were found in all the participants' accounts and themes 6–7 in most of them. We present these key themes as dimensions that incorporate the whole range of helpful to hindering experiences reported by participants.

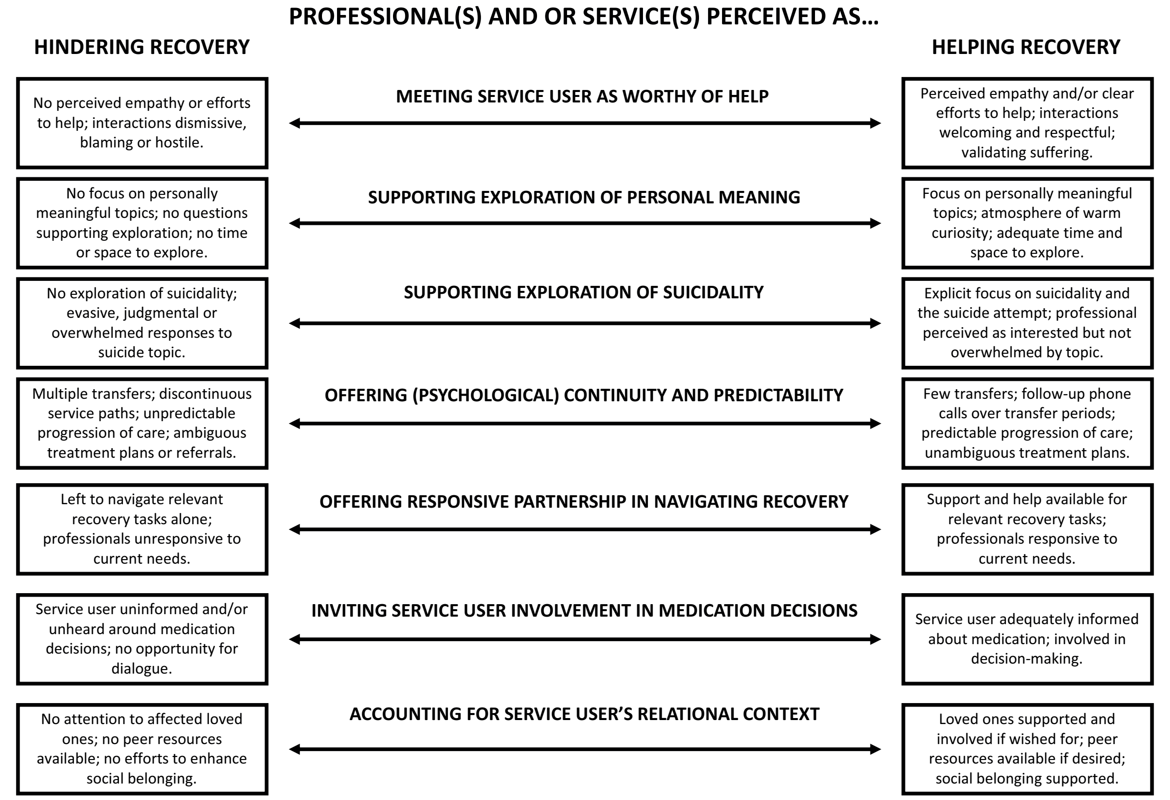
### Key aspects of services perceived as helpful after a suicide attempt

The key aspects of services perceived by service users as helpful to recovery included *meeting the service user as worthy of help, supporting the exploration of personal meaning, supporting the exploration of suicidality, offering (psychological) continuity and predictability, offering a responsive partnership in navigating recovery, inviting service user involvement in medication decisions* and *accounting for service users' relational context* (see Fig. 1).

#### *Meeting the service user as worthy of help*

This theme refers to how professionals were perceived to communicate that the service user was (or was not) deserving of help. The participants most often described the professionals they had encountered as well-meaning. They spoke appreciatively of "understanding", "empathetic" or "decent" professionals expressing genuine concern, working to arrange for their continued care, and giving them information about their options and encouragement about the possibility of recovery. Such actions were experienced as validating service users' worth as human beings, reducing shame and evoking hopefulness. Participants who had hesitated to disclose their suicide attempt cited professionals' empathetic style as making disclosure possible and/or worthwhile.

Participants mostly described professionals' actions as understandable (e.g., caused by an overwhelming



PROFESSIONAL(S) AND OR SERVICE(S) PERCEIVED AS…

| HINDERING RECOVERY | | HELPING RECOVERY |
|---|---|---|
| No perceived empathy or efforts to help; interactions dismissive, blaming or hostile. | MEETING SERVICE USER AS WORTHY OF HELP | Perceived empathy and/or clear efforts to help; interactions welcoming and respectful; validating suffering. |
| No focus on personally meaningful topics; no questions supporting exploration; no time or space to explore. | SUPPORTING EXPLORATION OF PERSONAL MEANING | Focus on personally meaningful topics; atmosphere of warm curiosity; adequate time and space to explore. |
| No exploration of suicidality; evasive, judgmental or overwhelmed responses to suicide topic. | SUPPORTING EXPLORATION OF SUICIDALITY | Explicit focus on suicidality and the suicide attempt; professional perceived as interested but not overwhelmed by topic. |
| Multiple transfers; discontinuous service paths; unpredictable progression of care; ambiguous treatment plans or referrals. | OFFERING (PSYCHOLOGICAL) CONTINUITY AND PREDICTABILITY | Few transfers; follow-up phone calls over transfer periods; predictable progression of care; unambiguous treatment plans. |
| Left to navigate relevant recovery tasks alone; professionals unresponsive to current needs. | OFFERING RESPONSIVE PARTNERSHIP IN NAVIGATING RECOVERY | Support and help available for relevant recovery tasks; professionals responsive to current needs. |
| Service user uninformed and/or unheard around medication decisions; no opportunity for dialogue. | INVITING SERVICE USER INVOLVEMENT IN MEDICATION DECISIONS | Service user adequately informed about medication; involved in decision-making. |
| No attention to affected loved ones; no peer resources available; no efforts to enhance social belonging. | ACCOUNTING FOR SERVICE USER'S RELATIONAL CONTEXT | Loved ones supported and involved if wished for; peer resources available if desired; social belonging supported. |

**Fig. 1** Key aspects of services perceived as helpful

workload) even when they felt hurt or disappointed in some way by those actions. There were, however, exceptions. Some participants read staff unresponsiveness to their individual circumstances as a cue that their treatment was being performed "for the organization, not for me" or "as a routine", resulting in a feeling of being dismissed or not deemed worthy of individualized care. Many also reported of a professional acting in ways that felt intentionally punitive and/or blaming, such as aggressively commanding "a grown-up" to "stop playing around". These incidents were described as hurtful, but they did not seem to hinder participants from having subsequent good experiences with other professionals. However, several participants described learning to fear and/or avoid a specific treatment context (most often the emergency room) due to hostile or humiliating interactions with staff that they had experienced themselves or witnessed peers experiencing. Some reported this as a personal barrier to care and as accelerating self-harm behaviors.

### *Supporting the exploration of personal meaning*

This theme included accounts of professionals' perceived support (or lack thereof) in the exploration of themes and experiences that the participants found meaningful in relation to their suffering, including relationship issues, unresolved life experiences and questions of identity. Such exploration was desired by all participants and cited by many as the most important aspect of care. However, several participants felt that issues such as medication, diagnoses, sick leave, and/or management of anxiety had been over-emphasized in their care, while little or no attention was paid to understanding the roots of their subjectively experienced suffering. Participants expressed wishes of "[professionals] really getting to know me", "going deeper", "focusing on root causes" and "more therapy-type sessions".

The participants made it clear that although they were motivated to explore difficult topics, they needed help in doing so. Several participants emphasized that without the support of questions they would be or had been unable to express themselves. One participant stated, "if they didn't ask me anything, I wouldn't say anything" and another reported sitting in anxious silence and eventually dropping out of appointments in which professionals "seemed to expect I could just open up" with very little help from questions.

When exploring personally meaningful topics with an engaged professional, the participants described gaining new insights and feeling less shame and more compassion for themselves. However, opportunities for such exploration seemed to be inconsistent across services. While some participants reported appreciatively on such exploration with their psychologist or nurse, others felt there had been no room for this in their health care contacts. This seemed to lead several participants to wish for psychotherapy, which they expected would offer them an opportunity for the kind of joint exploration they longed for. In fact, this opportunity seemed to represent the most significant line of hope for several participants. In some, these hopes had a desperate tone, since either costs or difficulties in finding a service provider made psychotherapy seem like it was “not an option” or “just a pipe dream”.

#### *Supporting the exploration of suicidality*

This theme comprised accounts of professionals’ perceived support (or lack thereof) in the exploration of the participants’ suicidality. All participants viewed careful examination of the suicide attempt as important or even crucial for formulating meaningful recovery goals or treatment plans. However, many felt that there had been little or no opportunity for this in their health care. Some participants reported that they had only been asked about suicidality through standard questionnaires, and that their answers were not subsequently discussed with any professional, one participant stating, “I felt like I was filling in forms all the time—I have no idea where they went”. Another reported a nurse in a psychiatric ward telling her not to talk about her suicide attempt, as “it’s time to move on now”. Several others also felt that the topic of suicidality seemed to be avoided by professionals, sometimes creating a severe obstacle to collaboration. The exploration of suicidality was thus raised as an issue separate from (although parallel to) the exploration of personally meaningful topics in general.

Participants also reflected on their personal struggle with the topic of suicidality, acknowledging it as “difficult to talk about” and “not something you want to repeat every time to a new professional”. Some had hesitated over the disclosure of suicidal intent or a suicide attempt due to hopelessness about treatment and wanting to retain the option of completed suicide. One participant reported that despite her hesitation she would have disclosed her intent before the attempt, had she been asked directly about suicidality by her psychiatrist. She reported being surprised at not being asked.

Several participants reported hesitating over discussing suicide topics due to worry about the effects on professionals. Many had anticipated or perceived professionals to be emotionally burdened by their accounts of suffering and/or suicidality, one participant stating, “I kind of feel bad going through all this with [professionals], like, how can they take it—I’m making them feel bad, too”. On the other hand, participants expressed appreciation for situations in which they felt talking about suicidality was “allowed” and professionals did not become, for example, “overwhelmed”, “either overly concerned or withdrawn” or “judgmental” around this topic.

#### *Offering (psychological) continuity and predictability*

This theme included accounts of the perceived (dis)continuity and/or (un)predictability of services. Most participants expressed a wish for more continuity of treatment. Many had felt demoralized by being repeatedly transferred from one professional to another. Several stated that starting with a new professional felt like “going back to the beginning” and disrupted their progress. Some constantly feared news of another transfer, having previously lost a meaningful treatment relationship due to, e.g., staff changes.

Participants reported feeling that to avoid being prematurely discharged they needed to be rather proactive in their engagement with services. This led to much unease, as many recognized that hopelessness and/or fears of being burdensome could dissuade them from using services. Follow-up contact with suicide attempt survivors was a common suggestion for service improvement, with several participants emphasizing the importance of professionals checking on the outcomes of emergency room referrals.

Participants’ sense of service continuity was sometimes challenged by confusing or unclear treatment plans. Many were pleasantly surprised at receiving their first psychiatric appointment within just days of referral. However, they also reported professionals emphasizing that treatment would be of limited (but unspecified) duration, leaving them in uncertainty about the availability of care in the near future. Some reported being left in confusion during a transfer period about whether, how or where their treatment might continue. On the other hand, a supportive phone call during a transfer period could greatly improve participants’ satisfaction with the continuity of their treatment paths. The participants’ emphasis was thus on the psychological or experienced continuity of care rather than the number of transfers per se.

Some participants’ sense of psychological continuity was further undermined by cognitive dysfunction during the most acute phase of their suicidal crisis. They had noticed with frustration that even helpful interactions and insights soon became unretrievable from memory during this phase. Several participants wished for more written notes (on both practical information and insights during treatment sessions) and text message reminders.

### *Offering a responsive partnership in navigating recovery*

This theme included participants' perceptions of the responsivity (or lack thereof) of professionals to their individual circumstances, needs and preferences in the recovery process and the collaboration offered by professionals in navigating it. While they wished for therapeutic conversation, the participants rejected an exclusive focus on this or any other form of intervention. Instead, they wished for need-based support to be available for a variety of personally meaningful recovery tasks. These included, e.g., arranging for basic needs (e.g., applying for benefits, finding an apartment), organizing meaningful day-to-day activities (especially during sick leave) and finding peer support. In tackling current issues, participants emphasized their wish for partnership or collaboration with, rather than simple direction from, professionals. Such collaborative interactions had been experienced by most participants at least some of the time. These experiences were described as, e.g., "empowering", hope-evoking and encouraging further engagement with services.

However, collaboration or responsivity to service users' expressed needs was not a given. Some participants felt that professionals' views on relevant recovery tasks had differed widely from their own and that reconciling these differences had proven difficult. One participant felt her hopelessness was currently largely due to the interruption of her studies, making resuming these studies her prioritized recovery task. Completing this task would have required making a phone call to the school, a "simple" task greatly complicated by her anxiety. Thus, she wished that "someone would [make the call] with me, since I can't do it alone". However, she felt that when she spoke about this issue, "[professionals] told me that kind of stuff is easy to fix". Yet she felt no help was offered in fixing it, thereby exacerbating her hopelessness.

Several participants perceived the organizational context (policies, workloads etc.) as restricting professionals' responsivity to service users' individual circumstances. This seemed to result in experiences of objectification, with some participants describing treatment as "something that's done *to* me" or as moving along an "assembly line" rather than a collaborative process. Doctors' (including psychiatrists') roles were often perceived as disappointingly restricted to such topics as diagnoses, medication, and sick leave. Organizational protocols, culture or constraints were also the perceived cause of many unsatisfactory interactions with other professionals. One participant reported attempting to initiate dialogue on treatment tasks and goals by asking his psychologist about "the point of these sessions". The reply, "you are entitled to these specialized psychiatric services", seemed to him confirmation that his treatment was performed primarily as an organizational routine, with individual needs and recovery tasks deemed irrelevant.

### *Inviting service user involvement in medication decisions*

This theme included accounts of participants' experiences with psychotropic medication and professionals' perceived efforts (or failures) to collaboratively engage participants in dialogue about it. Thirteen participants reported receiving some kind of psychotropic medication in relation to their recent suicidal crisis. Twelve reported having experienced adverse side-effects and/or withdrawal symptoms (e.g., extreme fatigue, "feeling drunk", nausea and heart palpitations). Two were certain of the helpful effects of medication and two others assumed this, reporting that medication "can't be ruled out as a cause for feeling better" or "I don't remember how I felt without it, but I assume it's helpful". The remaining nine had to date no personal experience of the benefits of medication. However, almost all participants reported being at least somewhat hopeful about the potential of medication being helpful, and even those who were not hopeful, reported compliance.

In fact, several participants stated that medication is an important—"even the most important"—element in treatment, despite having no personal experience of its helpful effects. However, even participants with high hopes for medication expressed dismay at situations in which it seemed the primary focus of their care. As one participant stated:

> *"Even though [medication] is the most vital part of treatment, it felt a bit much once when I came in and the first thing I'm asked is 'how's the medication, have you taken it?'. I mean, I felt like they could at least ask how I'm doing and not the meds [small laugh]. But that's just me, I mean the meds are an important part of it and that's how it should be."*

Most participants also expressed frustration in receiving little or even no information on the medication prescribed for them, the difficulty of "finding the right drug", and/or doctors being "unable to explain how or why [the medicine] should work". Many participants expressed a wish for genuine dialogue with their doctor about medication, possible adjustments to it and/or its eventual termination.

### *Accounting for service users' relational context*

This theme included participants' perceptions of professionals accounting (or not) for their social and relationship context. All participants with a spouse or involved adult children expressed concern about their family members being affected by the suicidal incident and receiving too little or no support. They wished for "a system for this" and that it would not be left up to family members and/or service users alone to decide if, when and how they might need support or want to join the treatment process. Some participants also reported conflicts in close relationships that contributed to their suffering but remained unaddressed in their treatment.

Most participants described support from family members and/or friends' as a valuable resource in their recovery. However, this resource did not seem to receive much attention in their health care contacts. In addition to loved ones not being offered support and not being invited to join treatment processes, participants expressed dismay at experiences such as having no private place to go with visitors during an inpatient stay or being discharged from the emergency room without a family member being informed, despite requests both from themselves and family members. Some participants, however, considered it important that family members were *not* involved in their treatment.

Those with scarce natural networks called for their lack of close relationships or thwarted social belonging (e.g., during sick leave) to be better taken into account in treatment planning and practices, including more active checking-in by professionals "to keep track that I'm alive". They also expressed appreciation for efforts to provide "human contact" through services even if they were unhappy with other aspects of their health care contacts.

Some participants felt group interventions better suited "less grave situations and more outgoing people" or feared their own reactions to peers' difficult emotions, while others had found or expected to find both formal and informal peer interactions highly valuable. Some participants emphasized the importance of both peer relationships and written narratives by recovered peers as resources providing experiences of social belonging, hope and destigmatization. However, they had found professionals to be mostly unaware of such resources and unable to give guidance on finding them even when asked.

## Discussion

This article reports on service user experiences of health care services after a recent suicide attempt, focusing on both helpful and hindering aspects of care. All the participants had received the Attempted Suicide Short Intervention Program (ASSIP) [19], provided by a non-governmental organization outside the health care system and designed as an adjunct to treatment as usual. Findings on users' experiences of ASSIP will be published elsewhere and are discussed here only briefly as context for the present findings.

A recent Finnish randomized controlled trial [14] comparing ASSIP and crisis counseling as usual (CC) as adjuncts to treatment as usual provided by the health care system found a non-significant difference in effectiveness between these interventions in preventing repeat suicide attempts. The high re-attempt rate in both groups (29.2% for ASSIP and 35.2% for CC at 2-year follow-up) indicated an urgent need for the development of the whole service system. We believe the present in-depth qualitative exploration of recent service user experiences has provided information useful for improving services.

As in earlier studies, e.g., [22, 23], the present service users had ample experience of both helpful and hindering (or even hurtful) interactions with services. Key aspects of services perceived as helpful in their pursuit of recovery included *meeting the service user as worthy of help, supporting the exploration of personal meaning, supporting the exploration of suicidality, (psychological) continuity and predictability, offering a responsive partnership in navigating recovery, inviting service user involvement in medication decisions* and *accounting for service users' relational context.*

Our findings are both congruent with and complement previous research. Irrespective of context, suicide attempt survivors wish for collaborative professionals and continuity of care, including more follow-up efforts and fewer transfers during treatment processes, e.g., [5, 23, 24]. More attention to peer and natural network resources have also been requested by suicide attempt survivors in previous studies, e.g., [22, 25]. Service users also frequently perceive some professionals as unprepared to discuss suicidality, e.g., [22, 25, 26]. The service users in this study emphasized the importance of early and consistent opportunities for both the therapeutic exploration of meaningful topics and biomedical interventions to alleviate suffering, the one not being seen as a substitute for the other. Similar appreciative and critical views on psychotropic medication have also been reported in previous studies, e.g., [22].

Suicide attempt survivors' appraisals of helpful aspects of care mostly coincide with those presented by other psychiatric service users, e.g., [27]. However, careful exploration of the suicidal act may be considered as a need specific to this service user population. While not systematically highlighted in previous qualitative studies, this need was emphasized by the present participants. In short, these service users join those in earlier studies who have called for patient-centered care with need-based opportunities for a variety of interventions, e.g., [23, 24].

### Reflections on the Medical Model

The frustrations users report with current services may be seen as reflecting Medical Model-related issues previously addressed in the literature [6, 7, 28–31]. The Medical Model is the paradigm favored by Western modern medicine. Despite controversy, it also dominates both research and practice in the fields of psychiatry and suicidology. In the Medical Model, suicidal behavior is understood as symptomatic of an underlying illness or disorder of the individual (e.g., depression) for which curative or symptom-reducing treatment is seen as the primary route to preventing further suicidal behavior. Acceptable interventions posit targeting a specific cause of this illness or disorder with an effective specific ingredient, whether biological (e.g., psychotropic medication targeting a neurochemical imbalance) or psychological (e.g., a specified therapeutic intervention targeting suicidal cognitions). As cures are understood to be disorder-specific, standardized assessment methods (e.g., symptom inventories) are preferred to ensure accurate diagnosis. With mounting quantitative evidence [4], such common factors as the therapeutic alliance are increasingly recognized as relevant, but their value is seen as indirect or instrumental (e.g., enhancing adherence to treatments delivering specific ingredients) rather than healing per se.

While the Medical Model may be credited with many advances in modern psychiatry and suicide prevention, its challenges in alone informing effective responses to mental health issues in general and suicidal behavior in particular have been repeatedly addressed in the literature (e.g. [6, 7, 27, 28]). The present findings may be seen as reflecting these challenges. The Finnish Current Care Guidelines [16] for suicide prevention and intervention after attempted suicide acknowledge the existence of alternative models of suicidal behavior, i.e., that suicidal behavior may be understood as at least partly independent of any illness or disorder. However, these guidelines rest firmly on the Medical Model, as do the health care practices informed by them. In their appraisal of these practices, the present service users echoed criticisms of the Medical Model in reporting frustration with what they perceived as an overly individual focus in care, an over-emphasis on medication, diagnoses and standardized procedures, an inadequate focus on the underlying interpersonal or social causes of suicidality, and treatment discontinuity caused by the structuring of services. These practices were often perceived as objectifying and contributing to a sense of not being seen or valued as one's unique self. On the other hand, when professionals' general stance was perceived as empathetic and collaborative, Medical Model-informed intervention contents (e.g., psychotropic medication, referral to specialized services) were often highly valued by the participants.

Interestingly, many service users seemed to be caught up in a personal debate about the most efficacious model of responding to suicidality. In their accounts, they argued consecutively for the primacy of medication and the primacy of psychological or social interventions in suicide prevention. These service user reflections presented an interesting parallel to the controversy and debate among professionals, communicating a similar co-existence (rather than achieved integration) of different paradigms. Echoing Engel's [32] classic proposition of a biopsychosocial model for the treatment of mental health issues, most of the service users offered framings of suicidality as *both* (1) symptomatic of an illness with biological causes and thus curable with medication, (2) expressive of psychological vulnerabilities and thus suitable for psychological interventions, *and* (3) as rooted in their social context and thus best alleviated by interventions targeting their relationship with this context.

The Finnish Current Care Guidelines [16] also state that biological, psychological, and social factors all contribute to the pathway to suicidal behavior. However, social factors seem to be largely overlooked in current health care practices, perhaps due to their awkward fit with the Medical Model (see also: [33]). In the present study, all the participants had been offered biological remedies and at least some form of psychological support or intervention, as laid down in the Finnish Current Care Guidelines. But while these guidelines cite, e.g., community support as a protective factor, they do not suggest possible interventions targeted at social or interpersonal aspects of recovery. In keeping with these non-specific guidelines, few service users in the current study reported receiving support focusing on the social aspects of recovery.

The present service users seemed, however, to find such recovery tasks highly relevant. They called attention to their social context in expressing worry about affected loved ones or sorrow over their lack of close relationships. Those who had been assigned sick leave often described being thrown further off balance by loss of the social roles associated with work or study and needing (but rarely receiving) help in adjusting to, or compensating for, this. Many saw relationships with peers as potentially highly meaningful and wished for (but rarely received) help in finding such resources. The conclusion Kerkhof ([10], p 63) reached two decades ago in an evaluation of the Finnish Suicide Prevention Program has not yet lost its relevance: "[t]here still appears to be a gap between medical paradigms and sociocultural paradigms in understanding and preventing suicidal behavior". Our results, like those of earlier qualitative studies, underline the importance of finding ways to close this gap in order to provide effective, need-based interventions for those at greatest risk of suicide.

### Ethical considerations

While the value of service user participation in suicide research is evident, study designs require careful ethical consideration to prevent any adverse consequences for participants in this highly vulnerable population, e.g. [34]. Hence the present effort to address key ethical issues included procedures to ensure genuinely voluntary participation, safety in the event of heightened distress during or after the interviews, and protection of the participants' data and identity. These procedures seemed to ensure safe and meaningful participation: all the service users reported satisfaction with their participation, even when they acknowledged feeling somewhat fatigued after the interview. Several participants described participation as a deeply meaningful experience and many spontaneously expressed their willingness to further participate in similar efforts. One participant described the experience:

> *"I find it really valuable to be able to put these experiences in words and know that someone is interested in this side of things...the view of someone navigating these processes and their perspective, in a deep sense, on the treatment they have received...I mean, I've filled in feedback forms in the past, but they feel kind of faceless...When I was considering participating, I knew I had stories to tell, this is not my first time around, and it feels [valuable] to be able to share my perspective."*

Ethical concerns include recognition of both researcher positioning and procedures enhancing validity [35]. This study was inspired by the first author's wish to understand the experience of those using the psychiatric services she was also engaged in providing. This positioning may be seen as both an advantage and a threat to validity. While the first author's personal engagement with the target service system allowed for a deeper contextual understanding of the participants' accounts, it may also have presented risks through, e.g., preconception bias. The validity-enhancing procedures included a reflective journal (documenting a genuine learning process, including surprises, during the data collection and analysis), data sessions and discussions with other members of the research group, and dialogues with several peer audiences to invite multivoiced challenges to the emerging analyses.

### Strengths and limitations

The service users participating in this study were diverse in age, sex, socioeconomic status, previous service use and history of suicidal action. However, only a minority of those eligible decided to participate. While the uptake rate may be considered good for a qualitative study requiring such deep participant engagement, it is important to note the possibility of self-selection bias in the sample when interpreting the results. Service users with more resources and further along in their recovery are likely over-represented in this sample. The scarcity of minority representation in the sample limits the usefulness of these findings for understanding service experiences in minority groups vulnerable to both negative service experiences and suicide. Future studies could also include thus far understudied groups such as persons for whom a suicide attempt has resulted in permanent physical disability. Themes identified in this study may form a useful starting point (e.g., in brief questionnaire form) for a quantitative investigation of service experiences in a representative sample of service users.

We plan to report findings on participants' experiences of health care services and ASSIP in separate publications to allow for a more detailed exploration and discussion of each. However, service users' experiences of ASSIP have likely affected their appraisals of encounters in the health care system, and vice versa. ASSIP seemed to benchmark some desirable aspects of care, which may have resulted in greater service user frustration with other services. In the first 1–2 months following ASSIP, psychiatric services seemed to fail as often as they succeeded in supporting service users' continued work on recovery tasks that they had identified as personally relevant during ASSIP. Service users left without such support experienced this discontinuance as undermining the gains they had made in ASSIP, while those receiving such support felt they were further building on these gains.

## Conclusion

In this study, we sought in-depth understanding of suicide attempt survivors' perspectives on health care services after a suicide attempt. We believe our findings are useful for both clinicians, service developers and policy makers. In line with previous research, service users reported that being met with empathy and respect fostered a sense of hope, self-worth and belonging, while hostile or dismissive staff attitudes created barriers to care and even accelerated self-harming behaviors. Adequate predictability and continuity of services was perceived as crucial for both making and retaining recovery gains. Service users called for the need-based availability of both (bio)medical remedies, psychological interventions (including an explicit, but not exclusive, focus on exploring suicidality), and interventions targeting their relational context and sense of social belonging. The responsiveness of services to individual needs and preferences was described as key, with service users emphasizing that one valued intervention modality (e.g., psychotropic medication) cannot substitute for another (e.g., therapeutic conversation). Interventions targeting social aspects of recovery (e.g., attention to affected loved ones; facilitation of peer support and social belonging) were most often found to be lacking in current services.

**Abbreviations**

ASSIP: Attempted Suicide Short Intervention Program; CC: Crisis counseling; NGO: Non-governmental organization; MIELI: MIELI Mental Health Finland Suicide Prevention Center.

## Supplementary Information

The online version contains supplementary material available at https://doi.org/10.1186/s13033-022-00563-6.

**Additional file 1.** Interview topic guide. Translated from original Finnish.

**Acknowledgements**
We thank Outi Ruishalme, Frans Horneman, Marena Kukkonen and the MIELI Mental Health Finland Suicide Prevention Center; Henno Ligi and the City of Helsinki; Erkki Isometsä and Helsinki University Hospital for making the data collection for this study possible. We also thank all the participants for sharing their experiences for the purposes of this study.

**Author contributions**

SGL and AL were responsible for the study design. SGL collected the data. The analytical process was led by SGL and reviewed and refined in data sessions with AL. All authors contributed to refining the final themes and their wordings during the writing process. All authors read and approved the final manuscript.

**Funding**
This study was funded by a grant from the Emil Aaltonen Foundation. The funding body has had no role in the execution of the study.

**Availability of data and materials**

The original qualitative data is not available due to participants' right to privacy.

## Declarations

**Ethics approval and consent to participate**

Ethical approval was granted by Helsinki University Hospital Ethics Committee and all participants gave their written consent for participation.

**Consent for publication**

Not applicable.

**Competing interests**

SGL has been employed for clinical work and service development by the two largest health care providers in the study area (2008–2020 City of Helsinki and 2020- Helsinki University Hospital). This research was conducted independently of these contracts and funded by external research grants. JV is employed by MIELI Mental Health Finland, the organization providing the present participants with the Attempted Suicide Short Intervention Program (ASSIP). JV is not directly involved in the provision of ASSIP or other crisis services. AL and JH declare no competing interests.

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Received: 25 May 2022 Accepted: 24 October 2022

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## Publisher's Note

# II

# CLIENT-REPORTED IMPACT OF THE ATTEMPTED SUICIDE SHORT INTERVENTION PROGRAM

by

Selma Gaily-Luoma, Jukka Valkonen, Juha Holma & Aarno Laitila, 2023

*Psychotherapy Research*, *34*(6), pp. 722–735

https://doi.org/10.1080/10503307.2023.2259070

*Psychotherapy Research*, 2023
https://doi.org/10.1080/10503307.2023.2259070

RESEARCH ARTICLE

# Client-reported impact of the Attempted Suicide Short Intervention Program

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*(Received 24 April 2023; revised 6 September 2023; accepted 7 September 2023)*

## 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 relabeling 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.

## Acknowledgements

We wish to thank all the participants for sharing their experiences for the purposes of this study. We thank Outi Ruishalme, Frans Horneman, Marena Kukkonen and the MIELI Mental Health Finland Suicide Prevention Center, Kirsi Suominen, Henno Ligi and the City of Helsinki, and Erkki Isometsä and Helsinki University Hospital for making the data collection for this study possible. We are also grateful to Konrad Michel for valuable comments. Author contributions: SGL and AL were responsible for the study design. SGL collected the data. The analytical process was led by SGL and reviewed and refined by all authors. All authors read and approved the final manuscript.

## Funding

This work was supported by the Emil Aaltonen Foundation.

## Disclosure Statement

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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# III

# SUICIDE ATTEMPT SURVIVORS' RECOVERY-RELATED AGENCY IN THE RELATIONAL CONTEXT OF SERVICES: A QUALITATIVE ANALYSIS

by

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Submitted manuscript

# SUICIDE ATTEMPT SURVIVORS' RECOVERY-RELATED AGENCY IN THE RELATIONAL CONTEXT OF SERVICES: A QUALITATIVE ANALYSIS

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## ABSTRACT

**Background:** Suicidal persons' contacts with services present a key opportunity for suicide prevention. However, interventions by services are not always effective. A deeper understanding of suicidal service users' agency and its implications may facilitate the provision of meaningful responses to help-seeking during suicidal crises. This study explores the recovery-related agency of suicide attempt survivors and the perceived role of interactions with services in facilitating or hindering it.

**Methods:** Fourteen Finnish suicide attempt survivors were interviewed in-depth on their experiences of interacting with services during a recent suicidal episode. An operationalization of recovery-related agency as the expressed ability to take (mental or physical) action in a direction perceived as aiding recovery from suicidality (i.e., the coupling of recovery-related intentionality and power) was used to explore transcribed interviews through directed content analysis. Data were further categorized based on whether the service context was perceived as helpful or unhelpful to recovery efforts.

**Results:** All participants expressed both agency and non-agency in relation to their recovery process. The relational context provided by services was presented as highly relevant for the achievement and sustainability of recovery-related agency as well as for participants' experience of safety in instances when agency was lacking. The results are presented as a typology of recovery-related agency in its perceived relational context, with the categories of *sustained agency*, *strained agency*, *contained non-agency* and *uncontained non-agency*.

**Conclusion:** The concept of agency helped capture important aspects of suicidal individuals' recovery-related efforts and the role of services in facilitating or hindering them. The findings illuminate the value of viewing suicidal service users as agents of their own recovery process as well as the potential costs of ignoring this perspective in service delivery and design.

### Keywords

Suicide prevention; agency; recovery; suicide attempts; service user; qualitative

## BACKGROUND

Suicidal persons' contacts with services present a key opportunity for suicide prevention. However, finding meaningful ways to respond to service users in suicidal crises presents an ongoing challenge for health services (1–3). The relative scarcity of research on suicide prevention from the perspective of service users and/or as an interpersonal process may contribute to this challenge.

The traditional medical model views the patient as a rather passive target of treatment (4). While this model persists in guiding healthcare responses to suicidality, alternative approaches to conceptualizing and optimizing the role of services have also emerged or been adopted in the field of mental health. These include the self-determination theory (SDT) (5), a theory of human motivation and behavior that is "centrally concerned with the social conditions that facilitate or hinder human flourishing", p. 3. The SDT emphasizes the point of view of individuals (their motivations and experiences of basic need satisfaction) as relevant for the outcomes of any health-promoting interventions and acknowledges the role of social contexts in the formation of this point of view. Empirical findings have supported the SDT's claim that the provision of effective need support predicts treatment engagement and outcomes in healthcare (5,6) and psychotherapy (5,7).

Other models of service-assisted change explicitly acknowledging the role of service users' subjectivity and intentionality include the contextual model of psychotherapy (8) and a variety of recovery-oriented models for mental health services, e.g., (9). These models construe service users as active meaning makers who choose and use different aspects of the help available to them in creative and often unexpected ways, leading to outcomes that reflect the unique relational process of each therapy (4,10,11) or, more broadly, each process of recovery (12,13).

When the service user's meaning making and intentionality are construed as relevant for service outcomes, the concept of agency becomes useful for understanding how individuals in suicidal crises use services and, in turn, how services may be of better use to these individuals. While the concept of agency has received little attention in suicide research, we find it potentially highly useful for understanding recovery-related behavior during suicidal crises. Hence, we will propose a definition of recovery-related agency for the purposes of this study. First, we define what is meant by recovery in the current context.

## Recovery as an idiosyncratic process

Recovery is a concept used widely in the medical, health and psychological sciences. While the traditional medical model defines recovery as the reduction of clinical symptoms below a nomothetical threshold, models of personal recovery as a process of strengthening experiences of agency, hope and meaning irrespective of mental health struggles have begun to gain prominence also in the field of suicidology. Recently, Sokol et al. (12) presented a theoretical model of recovery from a suicidal episode based on a literature review, and Ropaj et al. (2023) (13) put forth a Delphi consensus on what recovery from suicidal behavior entails from the perspective of those with lived experience. Both studies emphasize the idiosyncratic and processual nature of recovery and the importance of service users being able to define recovery for themselves rather than being pressured to meet standards set by services. Drawing on these studies, we define recovery from a suicidal episode as *a transformative process bringing about life-affirming change*. This definition gives center stage to participants' own understanding of a process that would lead them to perceive life as worth living and empower them to keep safe even when suicidal urges resurface or persist.

## A definition of recovery-related agency

Agency is a concept used in all fields of science concerned with humans as intentional beings (e.g., philosophy, social sciences, psychology, and neuroscience). Its specific definitions and their philosophical underpinnings vary widely across scientific contexts, and no single definition of agency can meaningfully be proposed for more than context-specific purposes (14). Our definition is informed by previous conceptualizations and discussions of agency in the context of pursuing (therapeutic) change (4,10,15–17), and aims to summarize the aspects of agency most relevant in the current context.

For purposes of the current study, we defined agency as having four essential attributes. The first is *intentionality*. Although the agent's intentions may be more or less clearly formed, agentic action is necessarily guided by both reasons and goals, i.e., an idea of why a specific action should be taken or actively avoided, e.g., (14,15,18). The second is *power*, i.e., an agent must have the (potential) power to affect other entities, although this potential may not be realized in all (or any) of the ways intended, e.g., (19,20). The exertion of such power may be any action (including an intentional omission of action), either mental or physical, with the potential to move one nearer to achieving one's goal (14). The third is an *object*, i.e., the concept describes a relationship between a subject with intentionality and power and an object of the intentionality that is (potentially) affected by the exercise of power. Again, this object may take the form of a mental, social, or physical “thing”, i.e., agentic action can be directed at objects in one’s own mind, in the social environment, or in the physical world. The object-related nature of agency is typically implicit in its definitions, but it is relevant for the current context and thus included as an attribute here. Fourth, agency is necessarily *bounded*, i.e., agency does not imply or require omnipotence, e.g., (15,20).

In summary, we define service user agency in relation to recovery from a suicidal episode as *having (some) intentionality and (some) power in bringing about a transformative process resulting in life-affirming change*. Below, we explore cases of recovery-related agency as presented in suicide attempt survivors’ accounts of their interactions with services during their suicidal crisis.

## METHODS

This study is part of a qualitative research project exploring suicide attempt survivors’ experiences of services. Our primary data for analysis consist of in-depth research interviews. We also had access to the participants’ narratives of their index suicide attempt as documented in the Attempted Suicide Short Intervention Program (ASSIP) (21), in which all had participated.

### Participants

Participants were recruited through the MIELI Suicide Prevention Center (MIELI), where they had received ASSIP in relation to a recent suicide attempt (i.e., the index attempt). Participants were diverse in their demographics and histories of suicidality and mental health. Participant characteristics are presented in Table 1.

### Services

Here ”services” refers to the variety of service providers reported by participants as intervening in their crisis or considered by participants as potential sources of help. These providers included public and private healthcare providers (e.g., psychiatric inpatient and outpatient services, emergency services, occupational or student health services) and NGOs (all participants had used MIELI services, and some had experience of other NGOs).

**Table 1.** Participant characteristics

| | n | % |
|---|---|---|
| **Registered sex** | | |
| Male | 7 | 50 |
| Female | 7 | 50 |
| **Age** | | |
| 18-29 | 5 | 36 |
| 30-45 | 4 | 29 |
| 46-59 | 3 | 21 |
| 60+ | 2 | 14 |
| **Current occupation** | | |
| Employed | 7 | 50 |
| Student | 3 | 21 |
| Pensioner | 2 | 14 |
| Unemployed | 2 | 14 |
| **Previous suicide attempts (before the index attempt)** | | |
| Yes | 8 | 57 |
| No | 6 | 43 |
| **Services used during current episode** | | |
| ASSIP | 14 | 100 |
| Emergency services | 14 | 100 |
| Outpatient psychiatric care | 12 | 86 |
| Inpatient psychiatric care | 4 | 29 |

## Study interviews

Each participant took part in one semi-structured research interview conducted by the first author. Study interviews took place at the MIELI Suicide Prevention Center (where participants had also received ASSIP) 4-10 weeks after the participants' last ASSIP session and 3-6 months after their index suicide attempt. The interviews lasted 45-120 minutes and were video recorded. Participants were invited to narrate the experiences and interactions they found important in detail. In addition to the participants' general experience of each service they had received, the interview topic guide explored which aspects of these services participants perceived as helpful, unhelpful, or even hurtful, surprising elements, suggestions for improvement, and participants' subjective assessment of whether each service had been helpful to them.

### Data analysis

We applied directed content analysis (22) to explore expressions of recovery-related agency in the current data. In line with the definition presented in the introduction, we operationalized "recovery-related agency" as the participant's expressed ability to take (mental or physical) action in a direction they perceived as aiding recovery, i.e., the coupling of recovery-related intentionality and power. "Recovery-related non-agency" was operationalized as the expressed inability to take such action or being confused as to what such a direction might be, i.e., their expressed lack of recovery-related intentionality and/or power. In our operationalization, we chose to take into account both descriptions of *experiencing* oneself as capable or incapable of taking a desired action (i.e., reported experiences of having recovery-related power) and reported *behavioral expressions* of this capability or lack thereof (i.e., reported exercises of recovery-related power) as expressions of participants' agency. We use the term "expressed agency" to account for both forms of expression.

Because our research question concerned participants' recovery-related agency in the context of interactions with services, we limited our analysis to excerpts in which participants described their agency specifically in relation to the context of services or professionals. We included both reports of actual interactions with professionals (e.g., an emergency room visit) and imagined (anticipated) interactions that participants described as relevant for their agency (e.g., described expectations of what an emergency room visit would be like based on stories from peers or the media or on one's own previous experiences). Further, we focused on recovery-related agency and thus did not explore expressions of agency toward other goals (e.g., intentionality and power directed at taking one's life).

In a previous analysis of the current data, we found that participants evaluated the helpfulness of each service in relation to how well that service recognized and responded to their personal recovery goals and tasks (23). Thus, for the purposes of this research, the helpfulness of each service context was evaluated simply on whether participants reported perceiving it as aiding work on personal recovery task(s) and goal(s) they had found relevant in that specific context at that specific time (helpful relational contexts) or as unsupportive of or even detrimental to such pursuits (unhelpful relational contexts).

In our analysis, we first worked through the transcripts to identify excerpts in which participants discussed their recovery-related agency (i.e., expressed an ability or lack thereof to take action they considered meaningful for their recovery). Once we had identified all such excerpts, we proceeded to sort them into two categories based on our operationalization of recovery-related agency. After this, we re-categorized each excerpt based on the reported helpfulness of the current context, i.e., on whether the relational context was perceived as helpful or unhelpful in relation to the current recovery task/goal. The resulting two-by-two matrix thus represented a typology of expressed recovery-related agency in the perceived relational context of services.

## RESULTS

Participants' accounts varied in the relative frequency of agentic and non-agentic expressions, but each account included examples of both. Within individual accounts, participants' expressed agency varied from task to task (e.g., being able to take steps toward safety planning but at a loss for ways to try repairing a valued relationship) and from situation to situation (e.g., being unable to ask for help in one situation but able to do so in another).

### Personal recovery tasks as expressions of intentionality

Participants' recovery-related intentionality was expressed in their personal recovery goals and tasks (see Table 2). These goals and tasks represented the participants' understanding of what recovery meant for them (goals) and what actions would serve this end (tasks). The identification of relevant recovery tasks was, in itself, a commonly cited recovery task, meaning that participants' recovery-related agency could be directed at clarifying intentions (goals and tasks) as well as at gaining power to act toward an existent intention.

**INSERT TABLE 2 HERE**

While recovery tasks were presented as actions necessary for recovery, they were also typically perceived as being beyond the participant's independent power. Thus, interactions with services were presented as highly relevant for participants' recovery-related agency.

### Services as the context of recovery-related agency

All participants reported interactions with services that had enhanced their ability to identify, pursue and/or complete a recovery task, i.e., supported their recovery-related agency. Most also described interactions that had left them without support or even directly hampered their efforts. The context of a specific service or relationship was often presented as providing resources that had facilitated the pursuit or completion of some recovery tasks, while overlooking others. Thus, the same service or professional could be viewed as providing a helpful context at one moment (when support coincided with the recovery task currently perceived as relevant by the participant) and unhelpful at another moment (when support was not available for another recovery task emerging as relevant).

Professionals' recognition of and support for participants' pursuit of agentic power was appreciated and often also reported as leading to empowerment, whereas the lack of such recognition and support left participants feeling frustrated and often also powerless. Participants resented interactions in which their intentionality was overlooked, and often responded with either covert or direct forms of resignation or rebellion when they felt that these intentions were not recognized or respected. Perceived threats to the participants' autonomy often led to a form of protective retreat, e.g., refusing an offered form of treatment, dropping out, or more subtly disengaging and deciding to withhold information from professionals.

Many participants reported that they had found it very difficult to communicate their struggles with agency, even though they wished for these struggles to be recognized and responded to. Participants associated this lack of power with both situational issues with trust (e.g., fearing an unwanted response from a specific professional) and more general difficulties in displaying vulnerability. One participant described an experience of being seen by professionals as either fully powerless or all-powerful and their lacking in the power required to correct the latter assumption:

> I feel that either it is assumed that you are superhuman, like you can do everything … or then the opposite is assumed, like you can't do anything … it's a bit annoying because you don't really know how you should behave, whether you should behave the way they expect or whether you should behave in a completely different way, so it's difficult… [I've noticed that] it's much easier to show that you're stronger [than they think], harder to show that you're weaker I guess.

Participants' recovery-related agency was thus presented as multifaceted and in complex interplay with the relational context provided by services. Next, we present our categorization of this interplay.

### Recovery-related agency and relational context

In the participants' accounts, both agency and non-agency was reported in both helpful and unhelpful contexts. Thus, we present our results as a two-by-two matrix of recovery-related agency and relational context. The four categories in the matrix are labeled *sustained agency, strained agency, contained non-agency* and *uncontained non-agency* (see Table 3).

**INSERT TABLE 3 HERE**

### *Sustained agency*

All participants reported on instances where they had been able to identify and engage in meaningful recovery tasks and goals and felt supported in this work, experiencing emotional tones of, e.g., confidence, safety, pride, and hopefulness. In these instances, agency was achieved through or nurtured by joint efforts, support received and/or acquisition of new resources. These were labeled as "sustained agency", as the accumulative effect on recovery-related resources (intentionality and power) was implied to be positive.

Sustained agency was often reported in relation to ASSIP's facilitation of thorough cognitive and emotional processing of the suicide attempt, a recovery task that participants generally agreed was important. One participant described it thus:

> It can't really be anything other than ASSIP that, well, it made me process [the suicide attempt], or it made me- it didn't *force* me to do anything but got me do it and that means it really hit the spot.

In some cases of sustained agency, participants had entered into a relational context with agency (e.g., feeling prepared and able to delve into a difficult issue) and found the context to further support it. In other cases, non-agency was transformed into agency by a sustaining context. An example of the latter was given by a participant who entered ASSIP with a very fragmentary understanding of the suicide attempt and cited understanding the suicidal process as a critical recovery task:

> I thought I would look crazy on the video, but it turned out that it was really clear what had led up to the suicide attempt … So it all kind of fell into place, because I hadn't realized what [the suicide attempt] was all about.

Another common case of sustained agency entailed becoming able to complete or work on the recovery task of asking for help in a crisis because the relational context recognized the difficulty of this task and supported overcoming it. One participant gave an example:

> I called [the outpatient clinic] a couple of times when I had questions ... [it's really difficult for me to] bother anybody, so it was good that I learned a little bit, I learned how to contact them ... [it helped] that they showed me that they were worried about

> my wellbeing and we kind of rehearsed it every time that I should stay in contact so I wouldn’t be left on my own to think about things.

When participants perceived the relational context to support their autonomy, they reported being better able to utilize services in a way that effectively aided their recovery (e.g., by being honest about their situation and engaging in treatment). In many cases being explicitly allowed to regulate one’s engagement (e.g., to take breaks, to decide how much to disclose or to not be required to commit long-term) was cited as having made it easier to participate in treatment.

### *Strained agency*

Some participants had been able to pursue or accomplish a recovery task in the perceived absence of any meaningful support or even in the face of straight-out rejection or sabotage of their efforts. In these episodes, agency had been achieved or maintained through lone efforts and self-exertion, resulting in the valued action toward recovery being accompanied by emotional tones of, e.g., struggle, depletion, resentment, disappointment and forced self-reliance. These were labeled as “strained agency”, as the accumulative effect of such agentic efforts on personal recovery-related resources was implied to be negative.

Strained agency efforts were often cases in which participants had been rejected when reaching for help with a recovery task but managed nevertheless to hold on to their intention and continue pursuing the desired outcome, sometimes in explicit defiance of their setback. A young participant narrated their experience of help-seeking during conscript military service:

> I explained [to the army doctor] that I hadn’t been doing so well [since elementary school] and I was depressed … he was really accusatory or- he let me talk, and he asked me some questions, and then I said ‘hey, I want concrete help, I don't have to be discharged, but I would like some help with this’, so he thought for a moment and was just like ‘this should be all cleared up with this talk now’, and I told him ‘no, it’s not okay’, that I would really like to get help, or be told that I will get help, and then he looked really angry and started to tap on the computer saying that I would be discharged, and then he commented like ‘is it fair to the other guys’, that I’m just weaker than the others, how will the others react, if I leave, everyone else would start leaving too, stuff like that, just like you’d expect from an army doctor, and then he- well, it was pretty unpleasant to hear, but I thought I'd turn it into my strength, just to show him I'd go and seek help after I was discharged, so that was useful about it at least.

In another illustrative case of strained agency, a participant described solving their loss of autonomy during an inpatient stay by leaving, contrary to the professionals' recommendation, in order to solve a recovery task they found urgent but which the professionals were not responsive to:

> One of my problems was that I was losing my apartment and had to find a new one. I told [the hospital staff] about it but they were like 'but you can't go out', so I couldn't get a new apartment or do anything to take care of those things, and then when I asked for help they didn't help me with it either, so it was really frustrating. I had like a week to find a new apartment, so it was a terrible stress ... they wanted me to stay [in hospital] longer but I didn't see the point because I couldn't get anything done there.

The same participant described a struggle to be heard with their recovery needs, expressing powerlessness in relation to certain recovery tasks and a wish for support in working towards them:

> I feel like something could have been done about [my problems with school and family], but I needed help with it ... the doctor in the ward, they just told me that stuff is easy to fix, like it's not a good enough reason [to feel suicidal] ... and just last week I saw my [out-patient] psychologist, and they were like 'you can just pick up the phone and call and that will solve it', but they didn't understand how difficult it is for me to call ... [I would need] someone to do these things with me because I can't do them on my own.

This participant described persistent strained agency efforts to acquire the needed support:

> I've tried to make [the psychologist] understand that a phone call to the school, for example, it's such a small thing to them, but to me it's a really big thing. They haven't gotten it yet, but maybe someday.

While not yet giving up on the intention and effort to form a collaborative alliance with the professional, this participant also described a sense of hopelessness ("I feel like my treatment is kind of a dead-end right now."). Similar undertones of disillusionment and emerging hopelessness were typical in cases of strained agency.

### *Contained non-agency*

In some episodes, participants described remaining incapable of recovery-related action even in a context experienced as helpful. In these cases, participants reported their experience of confusion, helplessness, or hesitation being accompanied by a sense of being supported, resulting in a more tolerable emotional state. These were labeled cases of “contained non-agency”, because the helpful context was perceived as providing protection from the most harmful effects of the non-agentic state.

One participant described their experience of being supported in a state of confusion and powerlessness after a devastating loss, and the feelings of safety this brought:

> It was such a relief when I came [to the outpatient clinic], I was not very fit for work and then the doctor was like ‘okay, let's take proper sick leave and defuse this situation’ … when you’re in these healthcare situations or talk about these difficult things you’re in a vulnerable position, so the fact that someone takes the initiative like ‘okay, let's do this’, it's so valuable, like you get to experience that you get a little control over your life when you may not really be in control of yourself … they have handled it really well because my anxiety is specifically related to worries about the future, about whether I’ll be left with nothing to support me ... it has been really effective how they’ve engaged with me and assured me that help is available.

In cases of contained non-agency, participants often communicated a sense of relief, rest and/or hopefulness despite experiencing themselves as powerless and/or confused. One participant described the meaning of being provided with an emergency team during a vulnerable period:

> The positive thing about it was the idea, that okay, if this person can’t get a permanent healthcare contact right now because it’s full everywhere, then that’s a really good idea, to find an unstable person a place they can visit and where someone checks on them that they’re still alive, that’s really great.

Another participant fondly remembered the nurses who had expressed worry and compassion during a vulnerable time:

> [The nurses at the health center] were surprisingly supportive, they asked questions, and when I told them about the time I tried to get help but nothing came of it, they were like ‘oh, you got no help’, and then they asked me if I have any kind of plan for when I get back home, and when I talked to them about it they seemed worried and were like, ‘hey, can you manage these two nights, you’ll get a call then and an appointment will be booked’, and it was just like, for once they took it seriously.

Both participants reported this as an episode in which they had felt unsafe and lacking both the stable intentions and power needed to guide themselves towards recovery. While neither had received the immediate intensive help they wished for, both described the support they had received as making them feel better despite remaining unable to trust themselves to act in their own best interest, i.e., remaining non-agentic in relation to maintaining their safety. By alleviating some of the current emotional burden (driving suicidal behavior), the support they received had made it easier for them to stay safe even if it did not instill any immediate sense of their being able to control or regulate their behavior per se.

### *Uncontained non-agency*

In cases of uncontained non-agency participants found themselves both unable to identify and/or act toward recovery tasks and lacking any meaningful support for so doing. These experiences were accompanied by emotional tones of, e.g., desperation, numbness, resignation, and anger. These were labeled as cases of "uncontained non-agency", because the unhelpful context was described as leaving the participants without any protection from the most harmful effects of their non-agentic state.

The role of a supportive context in making disclosure possible was discussed by many participants. One participant, who cited "opening up" as a critical recovery task, described struggling with this task in meetings with psychiatric services:

> Especially since you were not used to any kind of treatment, you were pretty closed off and feeling a bit of pressure and couldn't really say anything about yourself, but then [the professionals] also didn't know how to ask, so then many times the hour went on so that we were mostly just silent, and it was quite stressful. Somehow [the professionals] seemed to assume that I would be able to open up right from the start, even though the people were strangers and the whole context was completely unfamiliar to me, so that didn't, that didn't do any good at all for [my situation].

This participant eventually dropped out of these sessions. They reported that support provided by subsequent contacts with other services had empowered them to share personal experiences, resulting in both emotional relief and meaningful insights, i.e., experiences of sustained agency.

A high barrier to contacting services and asking for help was commonly associated with cases of uncontained non-agency. One participant described their dilemma when contacting outpatient services to make their next appointment had been left up to their own initiative:

> That worries me a bit, because I would need some continuous support, but I don't have it, not even a scheduled appointment for my outpatient clinic … I have the doctor's number, so I can of course send them an SMS, but I don't know if I dare to do that … I'm not very proactive about these things, so now I'm just waiting for them to maybe call me at some point … I've always felt like I'm a burden to others, that's one of the

> biggest- that I don't want to be a burden, that they have better things to do, that I wouldn’t dare [to bother them].

This participant also described a previous request for help (a strained agency effort toward recovery) being met by an unhelpful context (failure to make a promised referral), resulting in giving up (i.e., a shift to uncontained non-agency):

> Either I wasn't taken seriously or then [the referral] just wasn't processed for some reason, because I was promised that they would make a referral to a psychiatric clinic, but I heard nothing, and then when I asked about it, they were just like ‘yeah, we’ll take care of this for you at some point’, but the referral never came, so I gave up on it.

In cases of uncontained non-agency, participants were sometimes able to hold onto recovery-related intentions despite experiencing a lack of power and support in acting towards realizing them. In these cases, they reported being frustrated with their sense of drifting toward recovery-hampering actions, such as being stuck at home, failing to maintain a reasonable daily rhythm, or failing to show up for appointments, and feeling their recovery goals slipping further away from them.

In some cases, experiencing the lack of both power and support was accompanied by a loss of recovery-related intentionality, with participants describing an emerging sense of indifference toward any recovery goals. These episodes could result in dangerous situations, including suicidal behavior. Some participants reported episodes in which their ambivalent intentionality had prohibited their spontaneous disclosure of suicidal thoughts or intentions. For two participants, a suicide attempt followed such an incident. When asked why they had not disclosed their suicidal intent (after voluntarily seeking help), one participant explained the effect that a direct question might have had on their ability to make the disclosure: “Honestly, at that point I thought I’d do it. But I wouldn't have lied if the psychiatrist had asked. I was actually a bit surprised that they didn't ask.”

## DISCUSSION

This study explored suicide attempt survivors’ accounts of their interactions with services. The findings illustrate the complex interplay between service users’ recovery-related agency and its perceived relational context during a suicidal crisis. The support provided by services was presented as highly relevant for both participants’ recovery-related intentionality and power. In participants’ accounts, perceived support often inspired or sustained empowerment towards the tasks of recovery (*sustained agency*), and even when it did not, it provided safety (*contained* *non-agency*). In turn, while participants could remain agentic in relation to their recovery process even when support was perceived as lacking (*strained agency*), such instances left participants feeling depleted. Further, a lack of perceived support left them feeling unsafe when they also found themselves lacking recovery-related intentionality and/or power (*uncontained non-agency*).

### Coaching behaviors as expressions of recovery-related agency

The participants' agency was expressed both in setting goals for recovery and in coaching services to be more helpful in achieving these goals, cf. (4,11). We find Bandura's (15) constructs of individual, proxy, and collective agency useful for understanding the coaching behaviors the participants described. Individual agency refers to the (limited) control individuals can directly exert on their circumstances. When goals are beyond individual agency (as the participants typically found their recovery goals to be) proxy agency and/or collective agency are needed to attain them (15).

Proxy agency is agentic effort directed at influencing others who may have the necessary resources, knowledge, or other means to act on one's behalf (15). The participants often described regulating their interactions with professionals in complex ways to secure the help they felt they needed to reach their recovery goals. In fact, some of their most tenacious *strained agency* efforts could be viewed as forms of proxy agency, as they were directed at influencing a gate-keeping professional in such a way that critical resources would become available. On the other hand, the participants' (sometimes similarly strained) efforts at forming a collaborative therapeutic alliance reflected an understanding that achieving recovery goals was a matter of interdependent effort rather than something another person could do for them, i.e., in these instances they seemed to pursue collective rather than proxy agency (15). These findings illustrate how the participants' recovery-related efforts took a variety of forms, and how services and professionals played a variety of roles in such efforts.

### A self-determination theory perspective on recovery-related agency

The self-determination theory (SDT) (5) proposes that the satisfaction of three basic psychological needs (autonomy, relatedness, and competence) in service interactions predicts both service user engagement and outcome. Britton et al. (24) discuss the relationship between autonomy and treatment engagement as well as the role of relatedness and competence in the care of suicidal individuals, proposing the SDT as a framework for engagement-promoting care throughout services. Some recent theoretical works have also proposed SDT's tenets as a foundation for effective practices in suicide prevention (25,26), motivating a closer look at the SDT in relation to the current empirical findings.

In the SDT, autonomy is defined as voluntariness, self-endorsement and congruence with one's authentic interests and values (5). In the current study, autonomy support could be conceptualized as recognition of and respect for the participants' intentionality. Such recognition and respect was reported as facilitating engagement in treatment processes, which then helped to further clarify recovery-related intentions and gain power. It also engendered feelings of being heard and thus alleviated emotional pain. When participants' intentionality was not recognized or respected, they reported feeling, e.g., objectified, abandoned, and coerced. Perceived threats to participants' autonomy often led to a shift from pursuing recovery-related goals to protective action, e.g., disengagement by dropping out or withholding information.

Relatedness is defined in the SDT as a sense of social connectedness, i.e., feeling cared for by and significant to others (5). In the current data, support for relatedness was presented as relevant for recovery-related agency in at least two ways. First, participants expressed appreciation for service interactions in which their need for relatedness was met. When an empathetic other was available, participants described empowerment (*sustained agency*) or an experience of being safer even when they continued to feel powerless (*contained non-agency*). Second, participants often critiqued services for not providing enough support for recovery tasks pertaining to needs of relatedness (23,27). Such recovery tasks included forming a safe therapeutic alliance, resolving conflicts in significant relationships and (re-)connecting with loved ones or peers. Perceived lack of recognition and support for these tasks was reported as leaving participants' powerless to progress towards many of their relationship-focused intentions.

The third basic psychological need posited in the SDT is competence, i.e., the experience of effectance and mastery. Appropriate task difficulty, positive feedback and the provision of structure are proposed as facilitating feelings of competence (5). In the current study, support for competence can be conceptualized as support for gaining or maintaining agentic power. Interventions such as dividing goal work into small rehearsable tasks, noticing achievements and providing information were cited as empowering. Perceived lack of structure in interactions with services often left participants confused and powerless. In turn, structure-providing interventions (e.g., ASSIP's program and tasks) were often explicitly cited as making recovery-related action possible (27).

### Recovery-related agency as co-created

From the participants' point of view, recovery-related intentionality and power was co-created moment-to-moment by the individual and their specific context. An understanding of recovery as co-created is in line with both the SDT (5,7) and recovery models of suicidality (12,13). It is also reflected in calls to acknowledge that a collaborative alliance is critical for any helping efforts (1,28). However, the process of this co-creation has rarely been focused on in-depth in suicide research.

We argue that the current study contributes both conceptual tools and empirical findings useful for understanding the co-creation of recovery-related agency in suicidal individuals' interactions with services. Importantly, the conceptualization of recovery-related intentionality and power as distinct but necessary components of recovery-related agency provides a useful perspective on assessing and dealing with obstacles to recovery-related action. It facilitates trouble-shooting when recovery-related action does not seem possible (distinguishing lack of recovery-related intentions from lack of power to act upon intentions) as well as identifying service users' expressions of both recovery-related intentions and power as crucial resources for collaborative helping efforts. The concept of recovery tasks helps identify clients' successes in acting toward their recovery-related intentions even during on-going crises, thereby facilitating encouragement of these efforts and feelings of competence.

The current findings illustrate how each response (or non-response) of services to help-seeking behaviors may significantly affect service users' ability to achieve and sustain recovery-related agency, both directly (through alleviating or exacerbating emotional pain) and indirectly (by affecting willingness and capability to further engage with available support). Evidence-based models of suicide prevention are based on this acknowledgement (3,29). However, health care service design and provision too often relies on practices that ignore or minimize the basic interpersonal aspects of care and thus fail to capitalize on their potential (1,2).

Further, the empirical results demonstrate how offering interactions and resources that facilitate suicidal individuals' recovery-related intentionality and power requires taking an interest in what recovery goals and tasks the person finds relevant, cf. (13). Giving primacy to the service user's frame of reference does not exclude the possibility that services may also contribute in ways as yet unimagined by the service user. On the contrary, the provision of new perspectives and unexpected resources was perceived by service users as a valued aspect of helping efforts (27). However, when professionals take the initiative in providing responses (e.g., suggestions, interventions, or formulations) that do not mesh with the service user's current understanding of relevant recovery tasks, these should be made in a spirit of dialogue instead of being prescriptive, lest they be perceived as coercive or objectifying and thus motivating protective action rather than engagement, cf. (5,24).

Finally, acknowledging service user agency also entails appreciating how any offer of help is inevitably interpreted by and mediated through the subjectivity of the service user. Professionals' well-intended actions do not automatically bring about the intended outcome. Thus, professionals and services need to accept the boundedness of their own helping-related power and remain curious about the real-time effects of their interactions with suicidal individuals. Further, consistent tracking of these effects should also inform corrective responses, i.e., attempts to repair ruptures in the collaborative alliance, cf. (30).

### Strengths and limitations

The main strength of this study is its focus on the contextuality of suicide attempt survivors' agency in navigating recovery. Such explorations are rare in the suicide research literature, yet they serve to inform professionals in valuable ways. We explored participants' expressions of recovery-related agency in relation to the range of services they perceived as (potentially) available to aid their recovery, broadening our scope beyond service-user agency in, e.g., psychotherapy alone. However, the existence or expression of service users' recovery-related agency is not limited to the context of services, but is also in operation in their choosing to use or not to use any potential resources, as well as in their independent recovery-related efforts (4,16). Further, the current analysis focused specifically on participants' agency in relation to their self-identified recovery tasks, excluding expressions of agency or non-agency in other areas (such as agency related to suicidal intentions). Thus, a variety of relevant perspectives on suicidal individuals' agency remain outside the scope of this article and await further research.

The current analysis is based on retrospective accounts, i.e., participants' understandings of their service experiences as re-constructed at the time of the interview. These understandings were inevitably affected by the participants' current situation and emotional state, the interview context and the many heuristics known to affect human memory recall (31). Real-time data collection methods such as ecological momentary assessment (32) could help diminish these issues in future research.

## CONCLUSIONS

The current findings illustrate both the fragility and the renewability of suicidal service users' recovery-related agency and the possibilities that each service encounter presents to facilitate or hinder it. Specifically, service interactions that recognise service users' recovery-related intentionality and power (or lack thereof) were described to facilitate service engagement, empowerment, and safety in suicidal crises. These findings support the implementation of suicide prevention practices that recognise and make use of service users' agency rather than ignore or diminish it.

### List of abbreviations

SDT = Self-Determination Theory
ASSIP = Attempted Suicide Short Intervention Program
MIELI = MIELI Mental Health Finland

### Declarations

*Ethics 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.

*Consent for publication*

Not applicable.

*Availability of data and materials*

The original qualitative data are not available due to participants' right to privacy.

*Competing interests*

The authors declare that they have no competing interests.

*Funding*

This study was funded by grants from the Emil Aaltonen Foundation and the Alfred Kordelin Foundation. The funding bodies had had no role in the execution of the study.

*Authors' contributions*

SGL and AL were responsible for the study design. SGL collected the data. The analytical and writing processes were led by SGL and reviewed and refined by all authors.

*Acknowledgements*

We thank all the participants for sharing their experiences for the purposes of this research. We thank Outi Ruishalme, Frans Horneman, Marena Kukkonen and the MIELI Mental Health Finland Suicide Prevention Center, Kirsi Suominen, Henno Ligi and the City of Helsinki, and Erkki Isometsä and Helsinki University Hospital for making the data collection for this study possible.

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**Table 2.** Examples of participants' recovery tasks and goals

| Examples of personal recovery goals | Examples of personal recovery tasks |
|---|---|
| Ridding myself of the wish to die | Finding an apartment |
| Not being overwhelmed by negative feelings | Re-enrolling in school |
| Having/finding hope | Strengthening my sense of self-worth |
| (Re)discovering an interest in working or the ability to work | Opening up about difficult issues |
| Being able to meet the demands of daily life | Forming an understanding of the suicidal process |
| Having/finding a reason to stay alive | Learning to manage recurrent suicidal impulses without acting on them |
| Getting back to my own life | Asking for help when needed |
| | Finding the right medication |
| | Learning to talk about what's bothering me |
| | Finding or returning to meaningful activities and/or relationships. |
| | Getting traumatic experiences "off my chest" |
| | Identifying personal recovery tasks |
| | Maintaining a reasonable rhythm of daily activities |
| | Getting out of the house and socializing |

**Table 3**. Recovery-related agency in its perceived relational context

| | Context perceived as helpful | Context perceived as unhelpful |
|---|---|---|
| **Expressed agency** | **SUSTAINED AGENCY**<br>The context is experienced as helpful, and the participant is able to work on a recovery task or complete it. Recovery-related action is possible and the accompanying emotional tone is positive. | **STRAINED AGENCY**<br>The context is experienced as unhelpful, but the participant takes it upon him- or herself to work on a recovery task or complete it. Recovery-related action is possible, but the accompanying emotional tone is negative. |
| **Expressed non-agency** | **CONTAINED NON-AGENCY**<br>The context is experienced as helpful, but the participant is not able to work on a recovery task. Recovery-related action is not possible, but the accompanying emotional tone is positive. | **UNCONTAINED NON-AGENCY**<br>The context is experienced as unhelpful, and the participant is not able to work on a recovery task. Recovery-related action is not possible, and the accompanying emotional tone is negative. |