# Suicidal No Longer

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Abstract

In this phenomenological study, participants who had been suicidal were interviewed and asked, "What was helpful in suicidal healing?" Participants' stories of healing were analysed thematically. The metaphor of "A Journey Away From the Self" describes the participants' suicidal processes as disconnection from others and from the self: their feelings, their self-worth, and their ability to negotiate their lives. The "Return to the Self" describes their healing as reconnection with others and with the self, developing new perspectives of the self and living, becoming self-accepting, self-advancing, and self-enduring. This investigation of the suicidal person's perspective contributes the voice of those "Suicidal No Longer." The thematic structure identifies processes that have implications for conceptualizing and directing treatment.

Résumé

Dans cette étude phénoménologique, des participants, autrefois suicidaires, ont répondu à la question suivante : "Qu'est-ce qui vous a été utile pendant le processus de votre guérison?" Une analyse thématique de leurs histoires a ensuite été faite. La métaphore "Un voyage loin du soi" décrit les processus qui ont amené les participants à se sentir suicidaires comme une séparation des autres, du soi, de leurs sentiments, de la perception de leur propre valeur et de leurs capacités à gérer leur vie. L'autre métaphore, "Le retour vers le soi," décrit le processus de guérison comme étant le rétablissement de liens significatifs de l'individu avec les autres et avec son soi intérieur. Sa perception, à ce stade, de son soi et de la vie en général change. L'individu s'accepte plus facilement et acquiert la confiance dans ses habiletés à s'affirmer et à gérer les défis quotidiens. Cette recherche sur les perspectives de la personne suicidaire nous permet d'entendre la voix de ceux et de celles qui peuvent être dénommés "suicidaires, plus maintenant." La structure thématique identifie des processsus qui ont des implications quant à la conceptualisation et à la direction des traitements.

What is known about suicidal behaviour and suicide treatment has come from traditional approaches on understanding suicide, suicide treatment, and the efficacy of treatment. Traditional approaches have identified factors associated with suicide, integrated these factors into assessment and treatment models, and evaluated treatment based on these models (Brent, Kupfer, Bromet, & Dew, 1988; Jacobs & Brown, 1989; Litman, 1995; Maris, Berman, Maltsberger, & Yufit, 1992). The majority of suicide literature reporting these developments has emphasized assessment and management rather than treatment. The assessment of suicide risk has had a clear goal, and that is, prediction. To predict who is likely to suicide, from the vulnerability of groups to those who are imminently at risk, is to be able to intervene and save lives. Management of those who are suicidal, once identified, has focused on ensuring survival and providing the optimal environment for treatment. The assumption of management has been that once the precipitating crisis has passed and

individuals are no longer highly suicidal, traditional treatments would follow (Fremouw, de Perczel, & Ellis, 1990). Traditional treatments have been implemented with factors identified as most likely to result in suicide based on the rationale that if those factors were ameliorated, suicide and suicidal behaviour would be prevented.

Disciplines have organized the factors identified with suicide into treatment models according to their different philosophies (Blumenthal & Kupfer, 1990; Fawcett, 1988; Linehan, 1987; Maris et al., 1992; Motto, 1989; Shneidman, 1985, 1987; Weishaar & Beck, 1990). General models (Blumenthal, 1990; Maris et al., 1992) have integrated the myriad of factors into the generic domains of biology, psychiatric disorders, personality traits, family history, and psychosocial stressors and events. The challenge to treatment has been to address the assessment domains, management, and factors that apply across assessment categories.

The predominant treatment strategies that have been utilized are somatic interventions, primarily pharmacological but also ECT, and psychosocial interventions which include psychodynamic therapies and psychological therapies that address behavioural, cognitive, affective and interpersonal factors (Litman, 1995; Brent et al., 1988). The most comprehensive model reviewed in the literature is Linehan's (1987) approach which utilizes a variety of treatment modalities to address biological and social domains.

Somatic treatments have targeted the assessment domains of biology and psychiatric disorders. Pharmacotherapy has been shown to be effective, and important to suicide prevention by studies that support the serotonin hypothesis of suicide risk (Nordstrom & Asberg, 1992), and by the fact that most suicides have occurred during a psychiatric episode, most commonly depression (Brent et al., 1988).

Cognitive, behavioural, and interpersonal therapies, evolved from Beck's (1974) early work on the cognitive aspects of depression in suicide, have focused on how individuals perceive, interpret, and respond affectively and behaviourally to their environments. Based on these processes, treatments have been directed to suicidal individuals identified as having skill deficits and vulnerable cognitive characteristics (Freeman & Reinecke, 1993; Weishaar & Beck, 1990), primarily addressing the assessment domains of family history, personality traits, and psychosocial stressors and events.

The significance of emotion in assessment and in treatment varies according to the philosophy of treatment. Behavioural and interpersonal therapies have intervened directly with affect to teach skills to manage emotional expression and regulation (Linehan, 1987) and to develop strategies for self-soothing (Buie & Maltsberger, 1989). Few psychosocial therapies have attended to affect directly even though psychological pain has been identified as central to suicide (Fawcett, 1988; Motto, 1991;

Shneidman, 1987) and empathy, the key element in therapy successfully dealing with despair (Havens, 1989).

While outcome studies have shown treatment efficacy for pharmacological and psychosocial therapies, alone and in combination (Brent et al., 1988; Fremouw et al., 1990), the confidence required to guide the selection of treatment interventions has been undermined by the singularity of factors treated and evaluated, and by methodological problems. Few studies were prospective, compared treatments, had random design, or used control groups. With the lack of methodological rigour and inconsistent results, uncertainty remains about the efficacy of treatments. The question of a particular treatment's efficacy is further compounded by treatment errors that have contributed to suicidal acts. The absence of adequate risk assessment has been identified as an error of omission, the failure to prevent suicide when events could have been foreseen. Errors of commission have been determined to result from direct harm or inappropriate therapy (Bongar, 1991). These errors cut across assessment domains and treatment modalities. Imbedded in the query of a specific treatment's efficacy is the challenge to evaluation of truncated treatment. Treatment has frequently ended with crisis intervention and the management of suicidal behaviour and has not progressed through the stages of resolving the issues surrounding the precipitating event or the underlying suicidal process. Repetitive crises (Fremouw et al., 1990) and suicidal chronicity have followed when the originating issues have not been resolved (Roth,1989).

The common factors of suicide, the models of suicide treatment, and the errors of treatment have contributed to the accumulated knowledge of the elements involved for the effective treatment of suicidal behaviours. Despite the knowledge of the preponderance, complexity, and interaction of factors involved with suicide risk, reported treatments have remained fragmented and the research unidimensional, with both contributing to the paucity in the research of which treatments really work. Overall, the research findings indicate, on the one hand, the efficacy of interventions, and on the other, that suicide treatments have not consistently or significantly reduced suicidal behaviour or suicide mortality rates (Dorwart & Chartock, 1989). Ultimately, research has shown that suicide intervention and treatment has failed many: those who have communicated their intent (Fawcett, 1988), those who have sought help, and those who have received treatment and then died by suicide (Coombs, Miller, Alarcon, Herlihy, Lee, & Morrison, 1992; Fawcett, Clark, & Sheftner, 1991; Isometsa, Henriksson, & Aro, 1994).

The knowledge that traditional approaches to suicide treatment have failed many and have not significantly reduced suicidal behaviours raises the question of what more do we need to know and to understand to increase treatment effectiveness and promote healing. Beyond the per-

spectives of theorist, therapist, and observer, another perspective on what is helpful in resolving suicidal behaviour is available from those who have been suicidal and are no longer. Although a body of literature exists on being suicidal from the suicidal person's perspective, consisting of clinical interviews (Havens, 1989), biographies (Lester, 1991), and suicide notes (Leenaars, 1991), there is virtually nothing written on what suicidal individuals have experienced as helpful in their healing. Their voices are absent. Individuals' descriptions of their healing experiences can illuminate the process of healing. Their experience of what made a difference to their healing would contribute a hitherto unheard view to existing perspectives on suicidal healing.

### METHOD

The purpose of this research required a method focused on discovery and understanding rather than the natural science pursuit of cause and effect relationships (Dilthey, 1977). Phenomenology explores individuals' experience in consciousness. It considers phenomena, such as suicidal healing, as being available to discovery through dialogue, a discourse that is believed to reflect a person's experience as a synthesis of their internal and external worlds (Colaizzi, 1978). The premise of phenomenology and this study is that individuals can faithfully describe what was helpful in their healing, and that a systematic thematic analysis of participant dialogues can illuminate the phenomenon of suicidal healing.

*Participants*

The full illumination of a phenomenon's structure flows from the range of factual variation provided by diverse subjects (Wertz, 1984). The goal was to draw on a variety of experience and not circumscribe respondents in any way, either by their specific suicidal behaviour, or by their particular healing experience or healing setting. To this end participants were solicited through a newspaper advertisement inviting them to tell their stories of healing. Those who participated constitute a purposive sample, not a random sample, of individuals who were once, but were no longer suicidal, and who wished to share their stories. Self-report of suicidal intent and behaviour, along with the requirement that no attempt(s) had occurred in the last two years, served as screening criteria. Two were screened out due to recent attempts. No remuneration was offered.

There were nine Canadian and European participants, seven women and two men, ranging in age from 27 to 57. At the time of the study, five participants were single and four were married, three had divorced, and one was remarried. Five had children. Four were Catholic and five Protestant. Participants' education and/or occupation included clerical, technical, and university educated professionals. Most of the individuals who

participated had experienced more than one suicidal crisis, and their healing had occurred over many years with many changes. Six had experienced repeated suicidal behaviour starting in childhood. Three had experienced suicidal crises only as adults. The participants included individuals who did not receive treatment in a formal sense or setting as well as those who did. The interview dialogue was the opportunity for the phenomenon of healing to show itself.

## Procedure

Preparation for the study included a number of tasks: to prepare materials to solicit and to screen respondents, to obtain informed consent for participation and for the release of information, to guide interviews, and to satisfy ethical concerns. The study came alive when individuals responded to the newspaper advertisement. Respondents were screened, the purpose and nature of the study was outlined, and a date was set for the personal interview. The interview began with an open inquiry, "What was helpful in your healing?" Care was taken to establish rapport and to follow, not lead, the participants' stories. The format imposed minimal structure, allowing the participants' experience to present itself as spontaneously as possible. Prompts were initiated when participants came to closure on their story. Each interview took approximately two hours, and was audiotaped and transcribed.

## Data Analysis

Each participant's written transcript, or protocol, was read and reread in order to acquire a feeling for the data and to become immersed in the description of the participant's life world. Each protocol was considered statement by statement with respect to its significance to suicidal and healing processes. Significant phrases, sentences, or paragraphs were extracted and recorded in a table format. Then, corresponding to each significant statement in the table, a paraphrase was made for each statement in an attempt to elicit the meaning of the statement.

Going beyond what was in the statement, to what was given with it allowed for the emergence of themes, which were named and recorded beside the paraphrase and the significant statement in the table. These themes were the first level of abstraction. This process, illustrated with the following example, was repeated for each of the protocols, and represents a within-persons analysis.

| Significant Statement | Psychological Paraphrase | Theme |
| --- | --- | --- |
| I never did that action. I've held knives in my hand ready to cut my wrists. We had a big pine tree, on our land and I'd been in that tree ready to jump out. . . . I was eleven. | Was poised with knives to cut and in the tree ready to jump at age 11. | Collected suicide options. Rehearsed suicidal behaviour. |

The themes from all the protocols were pooled and grouped. The groupings were named, a second level of abstraction, forming first order themes which were then grouped and named, forming second order themes. This process, illustrated in table 1, of grouping and naming the pooled themes represents a between-persons analysis.

The movement from descriptive instances of surface meanings to the second-order themes of immanent meanings is a movement through successive levels of abstraction. It is a process that unites factual variability through abstract themes with common meaning. The factual variability and frequency of themes were all accounted for in this process. The closing phases of analysis compared the second-order themes with the interview transcripts and with the extracted significant statements. Along with this comparative review, the participants and invited others were asked to review the levels of themes to validate the naming, grouping, and meaning of the themes. The thematic structure was present in all protocols for all participants and for other reviewers. The culminating structure of second-order themes is considered to be internally cohesive, fully illuminating the phenomenon of healing as expressed explicitly or implicitly in the participants' descriptions.

The validity of the method resides in the premise that phenomena may be described and may be understood through a thematic structure. The validity of the data analysis rests on faithfully following procedural steps of handling the data throughout the analysis process, from data collection to the final thematic structure. In this study this included articulating the procedure and validating the culminating thematic structure with the original protocols, with participants, and with unique experiences (Shapiro, 1986; Wertz, 1984). This process, modelled on the work of Colaizzi (1978) and Osborne (1990), followed a systematic step-by-step analysis, from extracting significant statements of descriptive instances through successive levels of abstraction to the final structure. When the thematic structural understanding is present and resonant in the experience of others, empathic generalization occurs. This validates the structure and provides the basis of reliability and credibility. Reliability exists in the sameness of meaning across individuals and across factual variability (Shapiro, 1986; Wertz, 1984).

## RESULTS

The final thematic structure provides an understanding of becoming suicidal and suicidal healing as processes of disconnection and reconnection. The metaphor of "A Journey Away From the Self" resonates with the process of disconnecting from feelings, self-worth, experience, and the ability to negotiate life. The metaphor of "A Return to Self" describes the processes of healing as a reconnection, with the de-

velopment of a new relationship to the self and new perspectives on living. The thematic structure is presented linearly in Table 1, described with participant quotations, and then summarized in a synthesis.

TABLE 1.

*Suicidal No Longer Phenomenological Thematic Structure*

| *Second Order Themes* | *First Order Themes* |
|---|---|
| *The Journey Away From the Self* | *Disconnection* |
| I. Context: Learning What is Lived | 1. Loss |
| | 2. Negative Interaction |
| | 3. Invalidation |
| II. Coping: Living What is Learned | 1. Silencing |
| | 2. Withdrawal |
| | 3. Constriction |
| | 4. Accepting Responsibility |
| | 5. Acting Out |
| III. Worthlessness | Self-Judgements |
| IV. Awareness of Suicidality | 1. Function |
| | 2. Recognition |
| V. Deterrents to Suicidality | Types |
| VI. Suicidal Behaviour | Types |
| *The Return to the Self* | *Reconnection* |
| VII. Crisis | Crisis |
| VIII. Reaching Out: Connecting With Others | 1. Connecting |
| | 2. Misconnecting |
| IX. Reaching In: Connecting With Self | 1. Opening to Feelings |
| | 2. Connecting Feelings |
| | 3. Connecting Suicidality |
| | 4. Identifying Patterns |
| X. Breaking Patterns | 1. Awareness vs. Denial |
| | 2. Listening to Self |
| | 3. Maintaining Connections |
| | 4. Determining Needs, Limits |
| XI. Evaluating | 1. Confronting Experience |
| | 2. Identifying Goals, Boundaries |
| XII. New Patterns: Trusting and Honouring Self | 1. Self-Accepting |
| | 2. Self-Advancing |
| | 3. Self-Enduring |

*The Journey Away From the Self: Disconnection*

*Context.* Participants' "Journeys Away From the Self" were set in the context of their learning environments. Participants experienced loss and disrupted attachments through death and through emotional and/or physical separation in relation to others, goals, or health. Their particular loss contributed to their isolation and to their lack of structure and direction. Participants' interpersonal interactions were negative and stressful. They experienced physical abuse, sexual abuse, or emotional abuse in the form of criticism, blaming, or discounting. Forms of emotional abuse were experienced with helpers. Invalidation was experienced blatantly and overtly, and more subtly through colluding alliances, in families, with friends, and in treatment. The context of loss, negative interaction, and invalidation in which participants lived and learned about life and themselves was described by one participant this way:

> I saw a lot of abuse, I saw a lot of people yelling at each other . . . my brothers punching each other until the blood come out of their lips and their eyes would be black and I would get picked on because of my size . . . parents fighting . . . the yelling stuff and withdrawing from each other, walking away in a rage. And, I remember that I always wanted out. I did not want to be in that environment. I hated who I was, I hated what I did, I hated the fact that I violated another human being the same way I was violated, and the thing that I was, I wanted to kill him . . . just end it.

*Coping.* Participants described utilizing multiple strategies of disconnection to cope with situations, events, and feelings. They disconnected from others and from activities through a lack of contact, and from themselves through a lack of awareness and/or deliberate actions. They learned ways to live and survive physically and emotionally. Accepting responsibility and accepting blame were vehicles for accepting invalidation which was frequently accompanied by self-injury behaviour, as described by this participant.

> I started to become very self-abusive. . . . Bit myself, punched myself, hit myself, stood in front of the mirror, slapped my face, and then I'd go, "You stupid puke of God." And I reasoned I was puke of God because if I was diarrhoea of God at least I would have gone through the system, but puke wouldn't even go through the system. . . . God wouldn't want me in the system.

Instead of accepting responsibility or blame, others acted out. Responsibility was redirected and misdirected through anger with violence towards others, animals, or the self, and with addictions to activity, alcohol, drugs, eating, or sex. Acting out was described by one participant this way:

> When I was younger, for acceptance, I joined a gang. I was a bad kid. . . . I beat up kids, slashed tires, stole cars, but it's for acceptance again, looking for support, looking for security. . . . I'd do anything to get acceptance so I had to, and after a while I got so hard I just didn't think about it.

And by another participant, this way:

> I got very promiscuous, really promiscuous, because I just felt so bad about my-
> self, so I thought well, this is all I'm going to get, so I'll just sleep with him. It was
> never for the sex. I never really enjoyed it or anything but . . . to be loved.

Participants were silenced in body and voice as they accepted invalida-
tion, denying their feelings and reactions and becoming unable to speak
for themselves. They experienced a numbing and a sense of unreality. As
they disconnected they began to lose a sense of their self as described by
this participant.

> It felt like I was having all these masks that I wore, and I didn't have one for me.
> It was just masks, and I felt like a shadow and I was fading away, and fading away,
> and fading away more, and if you put your hand on me you'd go through me. I
> didn't feel real, I didn't feel like a person.

*Worthlessness.* Participants drew conclusions about themselves and their
lives. They described conflicts between their inside and outside selves.
The perception of looking good and doing it right on the outside and
feeling bad on the inside meant they were wrong. They described them-
selves as "feeling bad and being bad, no good, dirty, and ugly." They
blamed and rejected the self for being and for hurting. They believed
they were helpless and worthless, deserving nothing. In the moments
when they believed they deserved better, they did not believe anything
could change or be different.

*Awareness of Suicide.* Participants moved between times of wanting to
die and not wanting to die. Thoughts of death and suicidal behaviours
were precipitated by distressing situations, demands, and memories. The
connection between these triggers and becoming suicidal was clear for
some and not recognized by others. Some participants recognized their
behaviour as suicidal, and attributed their impulses to forces beyond their
control. Others recognized they were experiencing a crisis while remain-
ing unaware that they were suicidal. Several were shocked to discover
they were "suicidal."

> In the dark of one night, in the ruminations about what I could do . . . it was
> actually what I could not do . . . there was no way out, things could not change,
> there was nothing to change. . . . I gave up trying. It was somewhere in the midst
> of how I could hook up the exhaust that I realized what I was doing. The realiza-
> tion I had was that I was in the midst of killing myself . . . that I was doing this
> because he didn't approve of me, that his opinion and right to life were more
> valid than my own, that he had a right to live and that I didn't because he was
> right and I was wrong. Wrong according to whom? It seems incredible in this
> moment of telling, the thinking I had, and the power of the realization in the
> darkness of that moment.

*Deterrents to Suicide.* A variety of beliefs, behaviours, and events deterred
suicide.Descriptions included participants' religious beliefs, their need
to care for children, not knowing how to complete suicide, searching for

the perfect plan, interruptions, altered perspectives, shifts from help-lessness to anger, bereavement, dissociation, and the determination to resist powerful impulses. Dissociation, which deterred suicide, was con-fusing for one participant. He said,

> I don't know. I don't know. I just came to the edge and then, I don't know. It was the same way with the tree, it's like, the time on the bridge seemed to pass and I end up not there.

*Suicidal Behaviour.* Methods of suicide and lethality were not a focus of the interviews, but, rather, that participants had acted with intent and had engaged in suicidal behaviour. These behaviours included ideation, expression, and action. Participants had thought about dying; they wished to die and they prayed to die. They persevered with their suicidal thoughts, threatened suicide, engaged in high risk behaviour, and wagered with God. They collected plans for killing themselves, rehearsed their plans, attempted suicide, and repeated their attempts.

### The Return to Self: Reconnection

*Crisis.* Crisis provided the opportunity for change and with it came the potential to reconnect. For some participants, a singular crisis was a piv-otal turning point, for others there were many crises on their journeys. For all participants, a crisis began the reconnecting process to the self through internal shifts and altered perspectives, and/or through their contact and involvement with others.

*Reaching Out: Connecting With Others.* Contact with others during crisis frequently marked the beginning of supportive emotional connections. Participants experienced support when others respected their experi-ence: listened, dialogued, and encouraged self-understanding and help seeking. Participants also recognized support when others set limits, held them accountable, and wouldn't let them withdraw. One participant's initial supportive connection occurred this way.

> What started me in therapy, I was really angry at (partner) for something. I had gone to the dentist in the morning and I had a chiropractor's appointment in the afternoon, and I walked out of the dentist's and he was supposed to be there to drive me back and he wasn't there, and it was like I couldn't count on him for anything and it was, if I can't count on him there's no sense having him around, so by the time I took a bus . . . to my chiropractic appointment, I was so upset and so tense and so everything that when he walked in and said "Hi, how are you today?" I just burst . . . everything just burst, so he talked to me, I was a mess for about an hour. And he said, "Look, I know this person. Would you go and see her?"

Alternately, contact that was not supportive represented a misconnection. The lack of support resonated with the participants' experiences of feeling bad, which they interpreted as being bad them-selves, which, in turn, validated their experience of being helpless

and worthless. The potential for contact to begin the process of reconnection was lost through misconnection. Participants continued to cope with their strategies of disconnection. One participant described it this way:

> I went there and he said, "Describe your life." Then he said, "Well, you're coping really well considering all you've got on your plate. I don't see a problem here." And he sent me home. He said, "I have patients with problems." Because I felt so bad I thought I didn't do it right, there was something wrong with me, that I was bad. . . . I was scared, I was angry at myself for feeling like this, I was self-abusive.

Another, this way:

> One Dr. I talked to about my unhappiness and not liking sex. He instructed me to draw up a scale to measure my anxiety in relation to a male body, clothed, naked, at a distance, closer and certain body parts. I understand this as desensitizing to a phobia. This encounter fills me with anger as I look back . . . I could not have labelled it then, I had no idea, but I can say now that this Dr. had no idea of what was going on with me, and no idea of women, nor did he make any effort to find out.

*Reaching In: Connecting with Self.* With supportive connections and sufficient safety, participants allowed themselves to risk, to explore, and to confront differences, anger, old wounds, and unfinished business. They opened to their ability to feel, experienced their feelings, connected their feelings to events with meaning, and developed an understanding of their experience. They began to identify their life patterns, and, in particular, the triggering events which precipitated suicidal behaviour. One participant described becoming aware of his patterns when his attention was drawn to his bodily feelings and their historical associations and meanings.

> I had my stomach massaged and had a memory come up about, great hate, the bully who used to punch me in the stomach when I'd come out of the bathroom. He used to get a big laugh out of it because I wouldn't flinch. It didn't hurt. I'd go out into a corner and gasp for air, but it didn't hurt, I was tough. And when she massaged my stomach, it was like these cloud bursts of feeling came. And I didn't know where it come from and I said to the masseuse, "Go back and hit that again." I told her what was happening. The muscles, the memories. The feelings that I wanted to kill myself.

*Breaking Patterns.* Participants struggled with awareness and denial. Their struggle was between maintaining their new connections, with awareness, and retreating into their old patterns of disconnection. They moved back and forth between a new pattern of believing that they had the worth, the right, and the ability to negotiate their lives and the old pattern of believing they were helpless and worthless, becoming suicidal. Breaking their old patterns involved learning to listen to the self and their feelings, and to determine their needs and limits rather than automatically plummeting into feeling bad, powerless and helpless, and wanting to die when they experienced distress. Movement into the new pattern

occurred through sudden acceptance in crisis or gradual acceptance through expanding awareness. One said,

> I learned what was important to me, a little at a time by noticing what was important in the moment. I learned to listen and trust myself. And as important, I learned to say that out loud. It was learning emotional honesty. . . . I guess one thing I've learned over the years is the part that I played in making my own pain. I had waited for my husband to make it right for me, rather than learning to do it for myself. . . . And we couldn't, didn't know how or what was going on to do it differently.

*Evaluating.* Through their willingness to explore and to confront their feelings and life experience, participants became able to evaluate their own experience and patterns in comparison to others' patterns and, more importantly, in comparison to their own patterns. This was often expressed with humour.

> There's two people on the street, we both walk out at seven in the morning, both got flat tires, and we look at each other and go back into the house. My neighbour goes in, gets on the phone, calls AMA, "I've got a flat tire, please come down and fix it." I just call suicide prevention. You know, I'm just going to die. I've got a flat tire. Something happens and my life is screwed. You know, and that's the thought process: it just kicks in, bang, negative, negative, and I'm just going to die.

*New Patterns: Trusting and Honouring the Self.* Through the trials of breaking through the barriers of disconnection participants came to believe in and to trust the self, discarding old patterns and developing new ones. One participant described reaching back to infancy and reconnecting with that early experience in order to make sense of her adult life. This reconnection allowed a new perspective to evolve. She described the process of reconnecting with her experience this way:

> I could see myself as being a little baby in a crib and afraid to cry or do anything because I would be hurt, you know, you'd be . . . and my thing was that I was going to protect this baby so it didn't get killed and then it started, you know all my life I'd been doing that, trying to protect myself, and then the next minute I'd want to kill myself and like I couldn't understand it. . . . I started crying, and crying and crying and thinking you know, like I won't, at times I thought they would kill me and then, you know, I'd fight, I didn't want to die. But then when things would happen to me, then I'd want to die and so I had to just go back in my mind and think, you know, they can't hurt me any more. Like, there's nothing they can do to hurt me. . . . My parents. There's nothing they can do. I'm grown up, you know. They can't hurt any more and I don't need to kill myself. It was like I needed to kill myself to get out of these situations or to get out of something that was hurting me.

Old patterns were dissolved and new patterns evolved through the process of connecting with their own lives, managing their fears and feelings without becoming suicidal. Reconnecting led the "Return to the Self" and to the development of new perspectives on the self and living. Participants became self-accepting, self-advancing, and self-enduring, the antitheses of worthlessness, helplessness, and hopelessness. They chose to trust the self, to act for the self, and to live.

*Summary and Synthesis of "The Journey Away and The Return to the Self"*

Participants' disconnections and their "Journeys Away From the Self" began in the context of what they lived and the coping responses they learned in order to survive. When their strategies, evolved for protection, functioned to disconnect them from the self, from their experience, and from others, they experienced despair. When they were not delivered from their difficult situations or from their despair, participants became suicidal and experienced crises.

The "Journey Back to the Self" began with a crisis providing the opportunity for reconnection to the self through internal shifts, and/or through contact with others. As they reached out to others and shared themselves, they experienced support and the validation of the self, their experiences, and their painful feelings. Not every crisis or contact brought supportive connections. With connection, they experienced permission to be with the self, to feel, and to understand their experience and themselves.

As they experienced their feelings and connected their feelings to the events, interactions, and patterns they had learned as a response to living, they broke old patterns of disconnection. Significant connections were discovering their patterns of coping and becoming suicidal. Through opening to feeling, participants processed their experience, identified their fears, clarified unfinished business, and articulated their anger. They struggled with denial and awareness, staying with the pain of feeling, owning and accepting what they felt, and dealing with what it meant. Their awareness developed as they remained connected with others ,as they listened to the self, stayed present and connected to their own feelings. In turn, they determined and communicated their feelings, needs, and boundaries, and received validating feedback.

When participants were believed and valued, they began to believe in themselves and their own experience. They began to act on their own needs and to believe in their right and their ability to do so, discarding their old patterns of despair and helplessness along the way. Throughout this process of reconnecting, participants developed new patterns and perspectives on the self and on living which became their healing. They opened to knowing themselves, becoming known, and knowing others. They learned self-trust, self-agency, and they opened to life, accepting the journey of the self.

## DISCUSSION

Driven by the gap between suicide treatments and the efficacy of those treatments, this study sought new perspectives on suicidal healing. The study accessed the experience of those who had healed to explore and to understand their process of healing. Participant's stories began with when

they were suicidal, first identifying their disconnections. Only then were they able to describe their healing and their processes to reconnection. Participants described a "Journey Away From the Self and the Return to the Self". This metaphor emerged from their descriptions and their conveyed sense of movement through a process. Their experiences were analyzed phenomenologically yielding a thematic structure illuminating the phenomena of suicidal behaviour and suicidal healing.

Participants' disconnections evolved through living and responding to life. Their life contexts (Maris, et al., 1992), coping strategies (Brent et al., 1988), and despair (Beck, Steer, Beck, & Newman, 1993; Dahlsgaard, Beck, & Brown, 1998; Farber, 1977) concur with previous findings. Participants learned what they lived and lived what they learned, the despair of worthlessness, helplessness, and hopelessness. The importance of despair for participants is consistent with the view that to understand despair is to understand the psychology of suicide (Maltsberger, 1986; Motto, 1991; Shneidman, 1987).

The thematic structure describes the processes leading to despair as disconnection, with the self becoming disenfranchised. The loss of a sense of self has been identified by a number of researchers (Maltsberger, 1997; Rudestam, 1986; Weiner & White, 1982). Suicide models identify suicidal despair as resulting from the inability to negotiate life and to realize satisfactory life goals due to the influence of cognitive distortions, errors of processing (Freeman & Reinecke,1993; Weishaar & Beck, 1990), and the inability to utilize one's processing, specifically the inability to feel or to follow one's feelings to anything other than despair (Shapiro, 1985). The thematic structure concurs with this understanding and illuminates the process leading to despair.

Participants despair and disconnection emerged from their cognitive and emotional processing and the conclusions they drew about themselves. They attributed worthlessness and hopelessness to the self, rather than to the situation or to the way they were treated, and without relief, they believed they were helpless. These conclusions, in the initial early construction of meaning, were experientially and developmentally appropriate according to the stages of Piaget's cognitive development and Kohlberg's moral development (Crain, 1980). With continued exposure to invalidation and negative interactions their developmental learning was maintained. They continued to believe as if they were trapped children and could not, as adults, act on their own behalf. These initial constructions of meaning are discussed in the literature as cognitive distortions and errors of processing. The processing error is holding these conclusions, valid developmentally when drawn in one's past, through time into the present.

Participants' descriptions of self-injury provide a deeper understanding of this coping strategy and affirm this behaviour as a defence against

dissonance, anxiety, and dissociation and as a deterrent to suicide (Grunebaum & Klerman, 1967; Himmelhoch, 1988). For participants, self-injury transferred their emotional pain into physical pain, functioning as a validation of 'their sense of self in the world' creating a sense of stability and an equilibrium between their inner and outer experience.

The themes of the "Journey Away From the Self" describe the process of disconnection to the self, to emotional and cognitive processing, to experience, to others, and ultimately to despair and the loss of a sense of self. A paradox of this process is that disconnection evolved through coping strategies to provide safety, survival, and an equilibrium which functioned to sever connections to the self, to the ability to process, and to experience.

Crisis brought disequilibrium to the processes of disconnection, allowing for the possibility of change and reconnection. Through crisis and supportive validating contact, participants began breaking the barriers of disconnection. Supportive connections were not always established through crisis and contact. The "miss" through contact, or misconnections, concurs with reported errors of treatment (Bongar, 1991). A zeal to instil hope, to increase options, to problem solve, or to medicate misses validating the individual's experience. This automatically invalidates participants' feelings, constructions of meaning, and efforts at coping with participants returning to their patterns of disconnection.

When supportive connections were established, participants opened to themselves, to their processing, and to their experience. They began reconnecting to themselves. Repeatedly, participants described the revision of their patterns coming about when their feelings, precipitated in experience, were understood and validated, thereby allowing them to shift their attributions of "wrongness" and "badness" out of themselves and attribute them to situational, contextual, and coping dimensions. This changed the automatic relationship between feeling bad and being suicidal, and altered their sense of helplessness as well. The focus on accepting the self, one's feelings, and one's developmental processing allowed for the emergence of self-trust. This resulted in a reorganization of the self, processing, and experience. The power of experiential validation and a relationship to provide the context and catalyst for change clearly concurs with empathic methods of treatment (Havens, 1989; Rogers, 1959) and with descriptions of self-validation forming a sense of self and identity through relational and validating contexts (Ishiyama, 1995). The significance of emotional knowing as a path to change and integral to one's beliefs about the self has been articulated by Mahoney (1991):

> A developmental or constructivist perspective considers emotions to be primitively powerful knowing processes that are integral to the lifespan organisation of

the individual. From this view, emotions are still associated with episodes of discomfort and disorganisation, but the latter are seen as (1) natural expressions of an individual's current realities, and (2) necessary (and often facilitating) elements in the reorganisation of that person's tacit assumptions about self and the world.    (p. 208)

According to the thematic structure, the pathways to reconnection were experiential validation and emotional knowing. When participants were believed and valued, they began to believe in themselves and to believe in their own experience allowing them to become open to the process of reconnecting.

### Implications for Suicide Prevention and Treatment

*Conceptualizing Treatment.* The major implication of the thematic structure is its conceptualization of suicidal behaviour and suicidal healing as processes of disconnection and reconnection, and how that conceptualization directs treatment. Conceptually, the process of treatment would explore the patterns of disconnection, the precipitating and predisposing vulnerabilities, and the individual's resources. Interwoven with this exploration, and guided by the relevant themes, treatment would facilitate reconnecting individuals with others, with their experience, and with the self. Strategies would be directed towards individuals cognitive and affective processing of experience, past and present, in order to identify, confront, and modify the patterns of disconnection and the suicidal path. This is an implicitly recursive process that weaves its way through breaking old patterns to the development of new perspectives.

*Facilitating Treatment.* The structural understanding implies that treatment facilitates healing when the treatment philosophy recognizes the impact of context, coping styles, and despair to the disconnecting process. Furthermore, it utilizes the pathways of experiential validation and emotional knowing to initiate the dissolve of old patterns and stimulate reconnecting. Participants' descriptions articulated three aspects integral to the reconnecting process.

First, the presence of a validating relationship forms an external anchor and catalyst for reconnection with others, with experience, and with the self, providing the foundation for developing self-trust and self-acceptance. And alternately, contact characterised by a lack of validating support reinforces despair and disconnection. This type of contact, or misconnection, occurs when others lack acceptance for the integrity of persons and their experience and are unable or unwilling to identify suicidal behaviour.

Second, how others handle the cognitions and feelings of despair shift the movement one way or the other between suicidal and healing processes. Distinguishing between emotional experience and the attribu-

tions and conclusions flowing from emotional and cognitive processing encourages individuals to label and to trust their emotions as reflecting interpretations of events, distinct from evaluations of the self.

Third, the breaking of suicidal patterns requires dealing with disconnections related to underlying issues. Discriminating between precipitating and underlying factors is part of the process of developing awareness, making connections, and identifying patterns. Participants described the necessity of recognizing, accepting, and understanding the past experiences that had brought about their disconnection in order for healing to occur, allowing for a process of reconnection and the "Return to the Self."

*Multidimensional Treatment.* Participants described disconnection and reconnection in relation to their external worlds and to their much deeper and complex internal worlds. Their disconnection and reconnection involved their thoughts, feelings, physiologies, behaviours, and life situations. This understanding of suicidal and healing processes directs a shift away from disciplinary reduction, and places the focus on discrete factors and treatments of change that decontextualize affect, cognitions, and behaviour, in time, from each other and from experience.

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