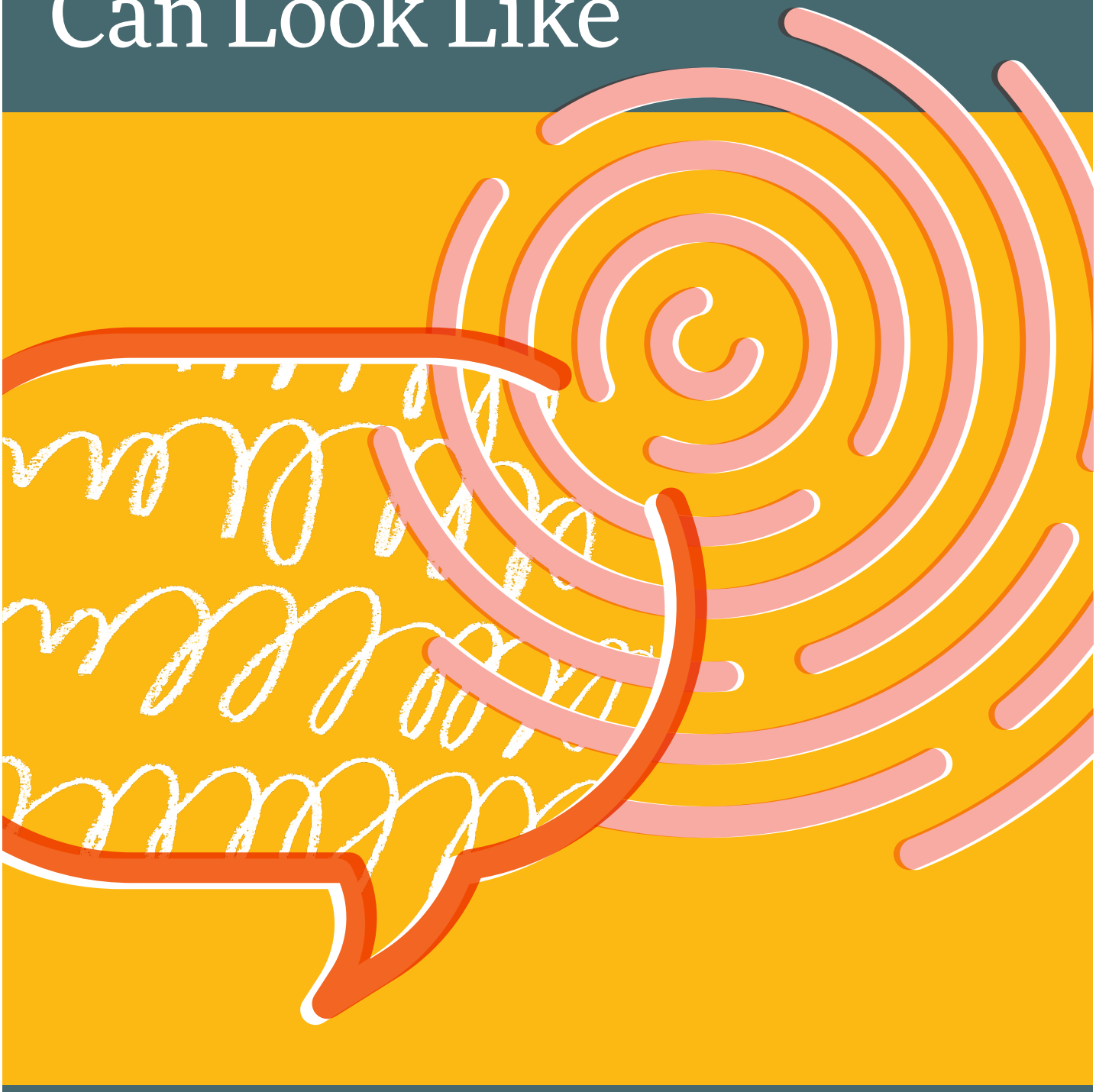
iE:24

INFO EXCHANGE
ARTICLE #24

A CARING CONVERSATION

A Caring Conversation: What Suicide Prevention Can Look Like



centre *for*
suicide prevention

Robert Olson
BA, MLIS, Librarian & Writer
Centre for Suicide Prevention

"I was officially diagnosed bipolar when I was thirty years old. It was at that breakdown, when I was thirty and ended up in the hospital that I truly felt so disconnected and in so much pain like looking out the window and seeing the life out there and not feeling that, just feeling empty. I didn't want to be here anymore, I thought it would be better somewhere else. And I've always heard people saying that people who take their own life are selfish and that's so not true. Unless you've been in the moment where you can feel that absolute darkness, hopelessness, pain, it has nothing to do with anyone else, it's just wanting to like remove myself from a situation and stop that pain."

"Yeah, I honestly thought my life was over, like if this was the new normal for me, I didn't want it thank-you-very-much. I'm checking out, like I'd rather do something else than suffer and not know what's happening every minute. And because I had already been predisposed for thirteen years of thinking about suicidal ideation, this was like 'oh this is the opportune time' because this was pretty bad, this was a good reason to say I had enough. So, it just goes to show how difficult it can be to understand what's happening with someone and the fear is so great, obviously just recently with one other celebrity, the fear of figuring out the struggle is so great that they are willing to die."

IN THIS ARTICLE *Suicidal Behaviours / "The Caring Conversation" / Attitudes Toward Suicide / Strengths Over Deficiencies / Connections*

The idea of killing oneself is baffling and abhorrent to the majority of us. We cannot fathom what goes through the mind of someone who decides to end it all. Some may wonder how much pain and anguish people must feel to push themselves to that extreme. Others may think that they are selfish and only thinking of themselves. And many more don't want to know what is going on at all, believing matters like suicide - and what drives people to it - are better left unsaid. As a society, most of us just don't get it.

The quotations on the page opposite are recollections of 'attempt survivors', people who have attempted suicide and lived, relating how they felt when they were on the verge of killing themselves. I spoke with a group of people who had attempted suicide and lived, and they described that point where their decision to die had been made or was closely approaching. These quotes belong to two of those individuals. Of course, their words cannot even begin to fully relate how horrible that point was for them, but they give us a retrospective glimpse into what they were thinking at the time of acute crisis.

The overwhelming majority of people who die by suicide do not want to die, nor do they kill themselves on a whim. Suicide is rarely an act of impulsivity: rather, it has been mulled over for a long time. People considering suicide are in extreme psychological pain and they want that pain to end. This pain causes their vision to become so narrow that the only way out of it they can see is killing themselves. This process is gradual – people rarely come to a point of suicidal crisis over one awful experience. What can "seem" impulsive to an observer, however, is the decision to carry out the act of suicide at a particular moment in time. Why now, someone may ask of another, whose suicide appears like a rash act coming out of nowhere?

On the contrary, often the decision to die by suicide happens when a negative circumstance becomes the tipping point, the proverbial "camel straw". A precipitating factor, such as a marital breakup or a job loss, combines with other existing but perhaps not as apparent or obvious risk factors directing that person to suicidal action. This is a time where any one of us - those who do "get it" - can make a huge difference. Our humanity and empathy can go a long way to helping someone at risk. By providing a compassionate ear, a sounding board, or a simple, caring presence, we can help avert a death by suicide.

Suicidal Behaviours

Anyone can experience thoughts of suicide, in fact most people do though typically fleetingly. Also, the vast majority of people at risk of suicide are not experiencing a high acuity of a comorbid mental illness, outside of depression. 4% of the adult population in the United States will have thoughts of suicide in any given year. 1.1% will make plans to die by suicide, and 0.6% of those people will attempt suicide.

These numbers are so small because, though tragic, it is very difficult for a person to take their own life. In fact, it may be the most difficult thing that someone can ever undertake (Centers for Disease Control and Prevention, 2015). a habituation to the fear and pain of self-injury through repeated exposure, which enables them to overcome the powerful instinct for self-preservation. All three elements must be present for someone to die by suicide. As Joiner

As Joiner says, "Killing is hard to do", especially to kill oneself, as we are biologically hard-wired to live (Joiner, 2005).

Joiner's Interpersonal theory of suicidality posits that to attempt suicide a person must feel a strong sense of "(perceived) burdensomeness", that they are of no use to anybody and better off dead. They must also experience "thwarted belongingness", an extreme lack of connection to anyone or society in general. Last and most crucial, they must have "acquired capability", says, "Killing is hard to do", especially to kill oneself, as we are biologically hard-wired to live (Joiner, 2005).

Therefore, at the point of suicidal crisis, the individual has typically lost all hope and sees no other alternative than to end their life.

"The Caring Conversation"

So, how do we help someone who is in crisis? A person who appears suicidal? The answer may surprise you. It may be as fundamental as a thoughtful conversation.

You, as helper, can aid the person at risk to gain sufficient perspective and insight that they themselves can identify reasons for living. I know this may seem simplistic, but its effects are powerful.

Having a caring conversation with the person at-risk can provide basic, life-saving assistance in their moment of need. With the proper knowledge and training, the ability to actively listen, and - above all - the desire to really help someone, any one of us can bring someone back from the precipice of a final, fateful decision. Simple in concept, a caring conversation, for most of us, is difficult to achieve. We must be willing to enter and sit in the person's discomfort with them, and truly listen.

A seminal study by Seiden (1978) looked at suicide attempters at the Golden Gate bridge in San Francisco from its opening in 1938 up to 1971. He found that 90% of attempters who were thwarted in their intentions—either by passersby, bridge patrols, or police—to die by suicide did not go on to attempt again, either at the Golden Gate,

another bridge, or by some other means. The intervention of just one person was enough to snap them out of their constricted time and space mindset and out of their stasis of acute crisis. This caring intervention can refute deep-seated feelings of thwarted belongingness and can provide a lasting anchor for the person at risk in future: they are not alone and others do care if they live or die.

Another story involving a Golden Gate suicide was mentioned in a 2003 *New Yorker* article, *Jumpers: The fatal grandeur of the Golden Gate Bridge,* documenting suicides in the San Francisco Bay area (itself the inspiration for the documentary film, *The Bridge*).

> With the proper knowledge and training, the ability to actively listen, and - above all - the desire to really help someone, any one of us can bring someone back from the precipice of a final, fateful decision.

A San Francisco psychiatrist recounts a suicide note of a young male who died by jumping from the bridge. It stated, "If one person smiles at me, I will not jump" (Friend, 2003, p.6). Evidently, the man sought human connection so desperately. Unfortunately, no one acknowledged his presence on the bridge and no one smiled either. He jumped to his death.

A trial conducted by Motto and Bostrom looked at how "caring letters" sent to discharged psychiatric inpatients affects future suicide attempts. One group received a letter of encouragement once a month for 5 years, while a control group received none. The letters were concise but supportive. They found fewer suicide attempts for those receiving regular "caring texts" than those in the control group (Motto & Bostrom, 2001). The study has been replicated in Australia using postcards (with even fewer words of encouragement than the previous study) which saw similar positive outcomes. Currently, the U.S. military is sending these messages via electronic mail, and preliminary results also show a marked reduction in attempts among email recipients (Joiner, personal communication, May 3, 2018). These cases powerfully illustrate how even the smallest gestures to connect can generate profound therapeutic effects.

Active listening invites opportunity for a person at-risk to divulge how they are truly feeling within a safe setting of trust. Such conversation can allow a person to reflect on why they might want to die, but also to see their own strengths and why living would be the better alternative to dying. This encouragement of autonomy is often the next step towards recovery.

Attitudes Toward Suicide

So, what is holding us back? Why are we so often not able to intervene with people in suicidal crisis or even prevent people from going down that road?

A significant barrier to suicide prevention is perpetuated by us directly: stigma (International Association for Suicide Prevention & World Health Organization, 2013).

There are widespread beliefs that someone at risk and their desire to die cannot be stopped, that it is inevitable. Or some feel that they have no business interfering in the choices that people make, including the decision to die. Or, most disturbing of all, some may just not care whether someone chooses to die by their own hand. I think that these feelings and beliefs are more often than not the result of stigma.

Our attitudes toward suicide and our personal feelings toward it are influenced by stigma. It can prevent our being of any help to someone on the verge of killing themselves.

The casual conversation will not ever effectively help someone at risk if the helper does not truly believe that the person-at-risk can even be helped. Our attitudes toward suicide and our personal feelings toward it are influenced by stigma. It can prevent our being of any help to someone on the verge of killing themselves. How can someone effectively help someone else at risk for suicide, if they have an inherent bias which may impede a successful intervention?

We, as would-be helpers, must be cognizant of our possible (probable?) "unhelpful" attitudes and biases at the outset. We must address the issue of suicide stigma and how it affects us from the "get-go".

Exacerbating stigma is our societal value of independence; which stifles our help-seeking and our help-offering; we believe that personal matters should be self-managed. Interdependence, on the other hand, posits that we do not exist in isolation, relationships matter and it is together with other people that we grow, heal and strengthen.

Strengths Over Deficiencies

As mentioned above, most people who consider, attempt, or die by suicide do not actually want to die; they just want the pain of living to end. Given the option, they would choose life. However, when someone is considering suicide they no longer see any other option. Too often, these people suffer alone and die alone.

We must recognize that a suicidal person can be helped and can recover, even if their recovery is non-linear and fraught with setbacks and recurring attempts, as is frequently the case. We must make the effort to hear and help these individuals and try to work with them to emphasize the assets, not the deficits, in their lives.

To acknowledge that someone is not their disease or is not an individual reduced to the action of recurrent suicidality, is the aim.

An assets-based approach is designed to focus on the person's strengths. A therapist or a caring individual can work with the person at risk to incorporate them into

To acknowledge that someone is not their disease or is not an individual reduced to the action of recurrent suicidality, is the aim.

We must also, clinicians and laypeople alike, encourage an individual's self-empowerment in this process. They should be directly invested in their own recovery, thus giving them the opportunity to evolve from passive to active participants in their own recovery process (Amering & Schmolke, 2009).

a safety plan to offset adverse experiences and prevent outcomes like suicidal behaviour, while emphasizing their unique abilities during their recovery and healing processes (Xie, 2013). It promotes the protective factors in someone's life and champions resilience, strength, and hope.

Connections

Preventing suicide all comes down to working together. The person contemplating suicide and the person presenting a compassionate ear need to work together to avert a pointless death. The isolated suicidal individual needs to feel a strong connection to another human being. The rest of us must acknowledge our potential to help and reach out to them.

Once established, these connections have the potential to expand exponentially throughout society, in our physical lives, and in cyberspace. The conversation surrounding suicide proliferates, the fear and taboo associated with it dissipates, and the stigma slowly erodes.

We will come to realize, as individuals, as communities, as a society, that suicide is preventable and that we, each and every one of us, can make a difference.

References

Amering, M. & Schmolke, M. (2009). *Recovery in mental health: Reshaping scientific and clinical responsibilities*. Chicester, UK.: Wiley-Blackwell.

Centers for Disease Control and Prevention. (n.d.). *Suicide-Facts at a glance-2015*. Retrieved from https://www.cdc.gov/violenceprevention/pdf/suicide-datasheet-a.pdf

Friend, T. (2003). Jumpers: The fatal grandeur of the Golden Gate Bridge. *New Yorker*. Retrieved from https://www.newyorker.com/magazine/2003/10/13/jumpers

International Association for Suicide Prevention & World Health Organization. (2013). *Stigma: A major barrier to suicide prevention*. Retrieved from https://www.iasp.info/wspd/pdf/2013/2013_wspd_brochure.pdf

Joiner, T. (2005). *Why people die by suicide*. Cambridge, MA.: Harvard University Press.

Motto, J. & Bostrom, A. (2001). A randomized controlled trial of postcrisis suicide prevention. *Psychiatric Services, 52*(6), 828-833.

Seiden, R. (1978). Where are they now? A follow-up study of suicide attempters from the Golden Gate Bridge. *Suicide and Life-Threatening Behavior, 8*(4), 203-216.

Xie, H. (2013). Strengths-based approach for mental health recovery. *Iranian Journal of Psychiatry and Behavioral Science, 7*(2), 5-10.

Canadian Mental Health Association
Mental health for all

Centre for Suicide Prevention
T 403 245 3900
csp@suicideinfo.ca

suicideinfo.ca
@cspyyc