



# Surviving moment to moment: The experience of living in a state of ambivalence for those with recurrent suicide attempts

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**Objective.** This qualitative study aimed to capture the experience of living in the ambivalent space between life and death for adults with recurrent suicide attempts (RSA). It sought to expand upon an earlier study that explored the processes involved in transitioning away from RSA among adults, which revealed that occupying this ambivalent space is a crucial part of this process.

**Design.** Interpretive phenomenological analysis (IPA) was used. This methodology was designed to explore the lived experiences and meaning making and enabled interpretation of the multidimensional subjective experiences of RSA participants.

**Methods.** In-depth semi-structured interviews were conducted with eight adult women with a history of RSA who had participated in a therapeutic intervention at the research site (Skills for Safer Living: A Psychosocial/Psychoeducational Intervention for People with Recurrent Suicide Attempts [SfSL/PISA]). The six stages of IPA were followed to analyse the interview data.

**Results.** Analysis revealed the superordinate theme, 'surviving moment to moment', which refers to a precarious state of making decisions about one's life and destiny on a moment-to-moment basis without clear commitment to either life or death. Two subordinate themes were identified: 'deciding not to die in the moment' when the participants were more invested in dying than living and 'deciding to live in the moment' when they were more invested in living than dying.

**Conclusion.** The study illuminated the complex process of making decisions about ones' destiny on a moment-to-moment basis. It revealed the torment experienced when occupying this state, while paradoxically, also revealing how indecision about life and death provided a lifeline opportunity for those with RSA. Clinicians who recognize the subtle distinctions associated with this in-between state can tailor their interventions accordingly.

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## Practitioner points

- Surviving moment to moment is characterized by a state of emotional flux and uncertainty about one's destiny, where the person has not fully committed to either life or death.
- Within this state, there are two interlinked subprocesses, whereby the person is leaning more towards death or life.
- A critical feature in working with this client group is to recognize their ambiguity and the fragility and temporality of their decisions about their destiny.
- The practitioner has an opportunity to be a catalyst in the momentum towards life by demonstrating understanding of this survival struggle and tailoring intervention to fit with the nuanced processes within this state.

Among the group of people who attempt suicide, there is a subset of individuals who engage in recurrent suicide attempts (RSA). This subset is considered by some to be a 'unique population' (Da Cruz *et al.*, 2011; Monnin *et al.*, 2012), when compared to those with a single suicide attempt or no previous suicide attempt (Gibb, Andover, & Miller, 2009; Jakobsen, Christiansen, Larsen, & Waaktaar, 2011). They are reported to exhibit more severe psychological and social challenges that include struggling with future-oriented thinking (McLeod *et al.*, 1998); emotional dysregulation (Linehan, 1993); decreased levels of emotional awareness (Levine, Marziali, & Hood, 1997); difficulties in problem-solving (Hawton & Kirk, 1998); and challenges in interpersonal relationships (Kern, Kuehnel, Teuber, & Hayden, 1997). Such distinctions have been associated with higher complexity and comorbidities of severe psychiatric disorders (Da Cruz *et al.*, 2011; Monnin *et al.*, 2012); interactions between neurobiological factors and stress (Mann, 1998); and/or psychological and social risk factors including histories of trauma (Links, Kolla, Guimond, & McMain, 2013; Yip *et al.*, 2011), living in poverty (da Silva Cais *et al.*, 2009; Sinclair, Hawton, & Gray, 2010), and being female (Brådvik & Berglund, 2011; Scoliers, Portzky, van Heeringen, & Audenaert, 2009). However, it is unclear how these risk factors interact and they are inadequate predictors of suicide on an individual basis.

Treatment interventions for suicidality vary in targeted outcomes, and the central aim is to reduce symptoms, risk factors, and/or suicidal behaviours (Cuijpers *et al.*, 2013; Sledge *et al.*, 2014; Ward-Ciesielski & Linehan, 2014). Some interventions focus on addressing the needs of those with a specific diagnosis such as borderline personality disorder, including dialectical behaviour therapy (Linehan, 1993; McMain, Guimond, Streiner, Cardish, & Links, 2012) or good psychiatric management, an integrated psychotherapy incorporating behavioural and psychoanalytic theory (Links, Ross, & Gunderson, 2015; Sledge *et al.*, 2014). Others target a particular deficit such as problem-solving (Hawton & Kirk, 1998), errors in cognitive thinking modified through cognitive behaviour therapy (Tarrier, Taylor, & Gooding, 2008), or focus on fostering competencies and strengths such as solution focused brief therapy (Fiske, 2008). Despite multiple modalities and foci, systematic reviews of RCT's examining interventions for suicidality have identified multiple issues which challenge the proven efficacy of single modalities (Hawton *et al.*, 2016; Soomro & Kakhi, 2014;) when approached from a quantitative lens.

There is a dearth of research focusing specifically on the RSA group. It has been noted that people considered a suicide risk are viewed as vulnerable and are excluded from research studies (Lakeman, 2010). Research that has been completed often subsumes this group within samples of those with suicidal ideation, those who have made a single suicide attempt, or those who have died by suicide. This has resulted in a poor knowledge base to guide clinicians and contributes little to influence attitudes towards a group who

are stigmatized by the general population and health care professionals alike (Jo *et al.*, 2011; Miret *et al.*, 2010; Spence *et al.*, 2008) and who are at high risk of dying by suicide (Ruengorn *et al.*, 2011; Wong *et al.*, 2007).

This interpretative phenomenological analysis (IPA) study set out to address some of these issues by exploring the experience of living in the space between life and death with adults with RSA. The study participants were recruited from a single research site, which provides an intervention developed for people with RSA, Skills for Safer Living: A Psychosocial/Psychoeducational Intervention for People with Recurrent Suicide Attempts (SfSL/PISA) (Bergmans, Koorn, Eynan, & Pacey, 2014; Bergmans & Links, 2009), thus providing easy access to the RSA population.

The study expands upon a previous Grounded Theory study that explored the process of transitioning away from RSA among adults. That study revealed that this transition is characterized by three interlinked phases wherein the person shifts from a strong desire to die to a desire to live (Bergmans, Langley, Links, & Lavery, 2009). One of these phases is a state of extreme ambivalence, which this study explored in more depth.

The aims of the current study were to: gain an in-depth insight into living with ambivalence about life and death for RSA adults; capture the complexities of this experience; illuminate the meanings that people bring to this experience; and inform clinical intervention with this client group.

## Methods

Interpretive phenomenological analysis was chosen given its congruency with the exploratory aims of this study and for offering an approach that prioritizes depth of analysis over breadth when the concern is complex (Smith & Osborn, 2003, 2008). With its theoretical roots in phenomenology (lived experience), hermeneutics (interpretation), and ideography (the particular) (Pietkiewicz & Smith, 2012), the primary aim of IPA is to explicate the meaning individuals' make of their subjective experience, which the researcher then tries to make sense of. This process is known as the 'double hermeneutic' (Smith & Osborn, 2003, p. 53), whereby a meaningful narrative is co-constructed between the participant's phenomenological account and the researcher's interpretations of that account.

In IPA, the central purpose of the analysis is to discern meaning through a close and interpretative relationship with the data. Six stages of analysis are used, including initial reading of the text, identification of emergent themes, clustering of themes, production of a summary table, continuing analysis with other cases, and integration (Smith & Osborn, 2008). Thus, in IPA each transcript is analysed separately before completing analysis across data sets (Smith & Osborn, 2003). The application of each of these stages is described below.

Given the small sample sizes in IPA studies, their contextual nature and the philosophical assumptions underlying IPA, no attempt is made to generalize the findings to wider populations. However, some theoretical generalizations can be made.

## Participants

Inclusion criteria were adults – over 18 years of age; a history of self-reported RSA (two or more suicide attempts), which was established as they had all completed a therapeutic

group intervention for those with RSA at the research site (SfSL/PISA); able to give informed consent to participate; and English speaking. A purposive, convenient, and homogenous sample of eight women participants was recruited.

Demographic information is outlined in Table 1.

**Table 1.** Participant sociodemographic profile

Gender	8 women
Age	Mean: 43 years; Range: 30–60 years
Sexual orientation	Lesbian: 2; Bisexual: 1; Heterosexual: 4
Relationship status	Married: 1; Engaged: 1; Single: 1; Separated: 1; Divorced: 3; Common Law: 1
Age of first suicide attempt	Mean: 29 years; range: 12–45 years
Age of initial suicidal thinking	Mean: 18 years; range: 6–45 years
Number of suicide attempts	Mean: 6.75; range: 2–21 attempts

### **Data gathering**

Semi-structured one-to-one interviews were used for data collection, allowing for in-depth personal accounts to be generated (Smith & Osborn, 2003). Interviews lasted 45–90 min and were conducted by the lead author. An interview guide was followed, which gave sufficient flexibility to allow participants to share their experiences in their own way while ensuring that a basic line of inquiry consistent with the study aims was followed. The interviews began with open exploratory questions, such as, ‘What was it like for you living with the uncertainty about whether to live or die?’ ‘Looking back how do you understand this dilemma?’ This was followed by questions regarding their experiences of personal support and professional help, for example, ‘What did you find most and least helpful in your contact with clinicians?’ Probing questions were used to help participants elaborate and clarify their story, such as, ‘What was that like for you?’ or ‘What did that mean to you at that time, and now?’ Interviews were audio-recorded, transcribed verbatim, and verified to ensure accuracy of transcription. All potentially identifying information was removed, and the transcribed text was assigned an identification number.

### **Data analysis**

To enhance researcher reflexivity, journaling and discussions among the author analysts were used to expose preconceptions that might unduly influence the analysis. Each step of the analytic process was initially completed by the lead author and then reviewed by the co-authors prior to moving to the next stage.

#### *Step 1: Reading the text*

To commence the interpretation process, the transcript was read numerous times by the researcher to fully immerse herself in the text. Initial notes captured central issues within the participant’s narrative and reflected the analysts’ observations and reactions to the data.

*Step 2: Identifying emergent themes*

Labels were generated to capture the essence of the experiences described within the data. These were subsequently clustered into themes, paying particular attention to issues significant to the participants' experience of living between life and death.

*Step 3: Clustering themes*

The themes were then collated and categorized into groups of connected themes, generating a list of superordinate (higher level), subordinate (lower level), and minor themes.

*Step 4: Producing a summary table*

The clusters and associated themes were formulated into a table, which connected them to relevant participant quotes. This process involved carefully identifying higher order themes and eliminating non-relevant or subthemes not found prevalent throughout the text or lacking significant insight in the phenomenon of living between life and death.

*Step 5: Analysing other cases*

The foregoing stages were then repeated for each remaining transcript, discerning repeating patterns, and acknowledging convergences and divergences in the data.

*Step 6: Integration*

The agreed upon themes from each transcript were collated and reduced to a final table of one superordinate and two subordinate themes, each with a number of minor themes (Table 2), based on their ability to describe the richness of participants' experiences within and across the data.

**Table 2.** Superordinate, subordinate, and minor themes

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Surviving Moment to Moment (A precarious state of making decisions about one's life and destiny on a moment to moment basis without clear commitment to either life or death)	
Deciding not to die in the moment	Deciding to live in the moment
Enduring life	Gaining control
Seeing doom	Accepting help
Turning the corner	Making connections

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***Ethical considerations***

The study was approved by the Research Ethics Board at St. Michael's Hospital in Toronto, Canada. Recruitment and obtaining consent to participate in the study was assigned to a Research Co-ordinator. This was done to guard against participant confusion regarding the distinction between clinical intervention and research, as the interviewer was known to all participants in a clinical capacity.

Considering the personal nature of the interview, it was possible that this could be experienced as distressing for participants. Thus, several steps were taken to minimize this risk, including: meeting with the Research Co-ordinator prior to the interview to discuss expectations and clarify limitations of the interview; providing the opportunity to take breaks or to terminate the interview at any time as necessary; giving the option to decline discussing a particular line of inquiry; and having a post-interview meeting with the Research Co-ordinator to ensure participant emotional and physical safety. If distress occurred, arrangements were in place for a post-interview in-depth risk assessment by an on-site clinician. Participants were also offered the opportunity to call the Research Co-ordinator if discomfort arose when they returned home. None of the participants reported elevated distress.

## Results

This IPA study explored living with ambivalence between life and death for those with RSA and revealed the superordinate theme 'surviving moment to moment'. This refers to a precarious state of making decisions about one's life and destiny on a moment to moment basis without clear commitment to either life or death.

Two interlinked subordinate themes, each with a number of minor themes, were identified within this state, 'deciding not to die in the moment' when participants were more invested in dying than living and 'deciding to live in the moment' when they were more invested in living than dying. Participants moved between these two decision-making processes depending on their life circumstances and subjective well-being. While not a staged process *per se*, successful navigation through the emotionally driven decision not to die created a foundational scaffold towards the more active decision to live.

but I found a lot of the time I was kind of in a 'should I, shouldn't I?' You know like I need a reason why I shouldn't kill myself today, and you know it's really looking like a good idea right now, but I really need to know why I shouldn't do this right now. So I had a lot of internal discussion with myself. . . (Madge)

It was physically and attitudinally demanding to hold the tension between the desire to end life while not convinced that this was the right choice, yet not believing in the possibility of a different and more fulfilling future. Participants desperately wanted to rid themselves of living in and with this tension, sometimes viewing death as the only option for relief.

I wanted all the noise in my head and the crying and the inability to function, to get out of bed, I wanted that to end. I wanted to be happy and active and the way I used to be but I didn't know how to get back to that so I had given up on that. I'd think 'oh I'm never going to be happy again. I'm going to live like this forever. Ah I don't want to live like this for the next 50 years of my life', and it was just such a horrendous thought um that you know, it seemed like a reasonable thing to do at the time. (Madge)

While participants experienced this state of ambivalence about both life and death as torturous, it provided a potential lifeline for them as they could decide not end their lives, while not committing to living in an equally uncertain world. Hence, suicide remained an option albeit in the background rather than the foreground of their minds as they became more able to choose to live in the moment.

Well clearly whatever methods I've used weren't successful. . .so if that's my way of leaving the scene because things become too difficult . . .[it] doesn't even work. So um it kind of traps you in life (laughs), and then you have a choice, which I guess I always had of making life worth living or finding another way [to end life]. (Vera)

### ***Deciding not to die in the moment***

'Deciding not to die in the moment' describes a state of extreme ambiguity that is characterized by uncertainty and fear of life, death, and the future. Participants experienced it as a highly tentative, fragile, and precarious state of existence wherein their emotional states were in flux and were overwhelming. Thus, their decision-making was driven primarily by intense and often uncomfortable emotions.

### *Enduring life*

Life was experienced as void of fulfilment or satisfaction. Participants felt out of control, extremely de-stabilized and unsafe.

I was useless. I was hopeless. I was lower than a snake's butt in a wagon rut. I wasn't feeling safe in my neighbourhood. I wasn't feeling safe with the people that I thought I could trust. I wasn't feeling safe in my own body. I wasn't feeling safe in mind. (Adrianna)

Their emotional states were erratic and they struggled to understand, name and articulate their emotions to themselves and others.

I couldn't express any of that, like not being able to get any of that out, so again, being a very action person, that's all that I could see, that I have to stop this feeling which I wasn't able to articulate. (Keesha)

### *Seeing doom*

Past experiences taught participants that life is unpredictable and often painful. Feeling misunderstood and judged; losing things and people of value such as relationships, employment, housing and finance; having negative interactions with others; and doubting their own competencies perpetuated negative thinking. Their internal dialogue concerned negative self-judgements, such as, being a bad person, parent or friend, being mentally ill or abnormal, being someone who would never meet familial or social expectations, and being bereft and alone. This self-perpetuating inner talk was taken as evidence that they were helpless in terms of influencing their future, leaving them with a strong sense of doom.

. . . I'm alone, I can't do this. No one really knows what I'm going through. I can't bear this burden any longer. (Penelope)

Their negative self-perceptions were sometimes perpetuated by unhelpful interactions with clinical staff or unsatisfactory responses from service providers, which further trapped them in a cycle of negativity.

... I felt like this is urgent and the attitude was that it wasn't so urgent. They said well you know we can send you to our crisis team. This was on a Friday or a Saturday, 'but they won't be in 'til Monday so you'll have to wait 'til then'. And I'm like 'what the fuck, I want to kill myself now and you're telling me wait 'til Monday to talk to someone about it'... (Madge)

Furthermore, shame and stigma negatively impacted their sense of self, interfered with their ability to understand and communicate thoughts of suicide, and thwarted their ability to reach out for help.

... I wasn't able to talk about any of those things nor was anyone I knew in my immediate universe able to talk about those things. ... I think the biggest thing I still struggle with 100% is shame and stigma, like it's still a big problem for me... (Keesha)

### *Turning the corner*

Despite having had some dissatisfactory experiences with services, participants also had positive interactions with clinicians, which influenced their decision not to die in the moment, for example, having the opportunity to explore and reflect on themselves and the meaning of their suicidality.

They spoke to me and you know they tried to get to the bottom of the situation as to why I did it instead of just giving me more pills or you know just pushing me to the side. It wasn't like that there [hospital]. (Susan)

### **Deciding to live in the moment**

'Deciding to live in the moment' describes how participants increasingly found themselves actively deciding to give life a chance. They had a growing awareness of options from which they could choose, thus decision-making was made at a cognitive level rather than relying on reactionary responses based on raw emotions.

### *Gaining control*

Deciding to live was perceived as a temporary decision with recognition that the situation might change and that the person might revert back to deciding not to die, however, awareness of choice was growing.

I might recognise earlier on when I make the choice to do things differently. But I wouldn't necessarily say I'm not going to play Russian roulette again. It's, it's a loaded gun. (Aria)

Participants tried to change old patterns of thinking and behaviour while being aware of the struggle that this involved. Although change was moving in a positive direction, their sense of instability sometimes piqued as they remained uncertain about what life might mean for them and were aware that they could not rid themselves of the option of death.

I mean behaviour you can change, not always the thought processes is what I'm finding. Um and the sort of sense of it's a big struggle and, I'm almost getting the sense that it becomes a

bigger struggle after you have more insight. It's sort of this ongoing, and it's a script that's hard to delete. I mean you know all the therapy and all the groups can help you press the delete button perhaps a little more often, but it's still there. (Vera)

In moving away from a strong death focus towards the possibility of a different and more rewarding life participants came to recognize alternative ways of seeing and understanding their world. This process gradually gave them a sense of being more in control of themselves and their lives.

... Just seeing things through someone else's eyes changed how I could see it through my own eyes and that you know then sooner or later it empowers you to say well 'Wait a minute, why am I doing this to myself?' (Madge)

### *Accepting help*

Participants came to see that professional help was necessary to promote and integrate their new learning about their needs and their suicidality. Clinicians who demonstrated compassion and understanding provided opportunities for reflection, which gradually reshaped their view of themselves and their lives and reinforced their sense of stability.

He brought it home and he also said that he thought that that the reason for a lot of them [suicide attempts] was that I believed that I failed my brothers and my sister because of how their lives turned out. I said 'You know I'm scared if I failed them I might fail my own kids'. And he said 'You've got to stop blaming yourself for your brother and sister'. And nobody had ever said that before either. ... I've never thought of things like this before you know like wanting to secure my boys future. (Susan)

However, changing old patterns was a slow and ongoing process for participants that required reinforcement from others. This allowed them to hold hope and helped them to continue with their battle to remain life focused.

I think you need ongoing tune-ups or whatever. So I think that's critical because without that there is no hope. I mean then you're back where you were. I mean it's one thing to move forward and identify when you need the help. ...but you're not much further ahead if there's nothing to meet the need. ... (Vera)

As participants self-understanding increased and they learned new ways of seeing the world and managing their distress, they wanted to share this learning with those around them. This allowed their change process to be supported by those close to them as well as professionals, thereby building their support networks.

... Once I learned that. ... 'this too shall pass, ... a feeling is just a feeling' ... You say these things a hundred times over in your head and that's when you learn. ...and then you go talk to your friends, family, your partner or whoever and get them to help reiterate that stuff with you. ... (Keesha)

### *Making connections*

Through meeting, others who had experienced RSA participants came to realize that they were not alone in their in-between world. This challenged their view of

themselves as being different and allowed them to open up to others about their fears and anxieties.

...When I could understand that people struggle with suicidality, that it's not uncommon, that people struggle with depression, that people struggle with thoughts of harming themselves... it just wasn't me. Because for a long time I just thought it was me... Once I learned that there were folks walking with heavy boots all over the place then, I just felt like I could say to my friends, my parents, like ya know, 'I'm not a freak here.' (Keesha)

They found ways to communicate their distress to those who understood their struggle and were familiar with their newly acquired language. Thus, they became more discerning about who they approached for help.

Knowing that when I wasn't safe, being able to come in here [hospital] and say I wasn't safe. Having people listen to me when I said I wasn't safe and that was basically all I could say at that point... When I'm able to say quite simply to somebody that I know speaks the same language... I knew that he knew what I was saying. Whereas if I had gone anywhere else and said I'm not safe they might've just know turned around and said 'what the hell are you talking about?' and thrown me back out. (Adrianna)

Reaching out to others was new, and hence, it involved challenging old patterns of avoidance. Participants realized that, rather than improving their situation, this often increased their sense of shame and isolation. This in turn fuelled negative perceptions, such as not being deserving of help or that nothing would work for them. Thus, participants needed to push themselves and take courage to connect with others.

... I think it takes a lot of guts for a person to say 'I'm feeling very depressed or I'm isolating' or whatever, 'it would be really helpful if you did x, y, z', like that's a really hard conversation to have with people. (Keesha)

In summary, surviving moment to moment is experienced as an ambiguous state wherein participants vacillate between deciding not to die and deciding to live, with a gradual move towards more consistent decisions to live. This shift was facilitated by learning how to communicate their distress and gaining an increased sense of personal control and agency as they developed skills to keep themselves safe and a language to communicate their distress. It was enhanced by the understanding, support, and commitment of professionals who were experienced as 'Non-judgmental, compassionate', espoused values of 'Faith, hope, strength' and were able to 'stick it out' (Penelope).

## Discussion

There are a small number of qualitative studies investigating the trajectory towards and away from suicidality in addition to living with suicidality that resonate with key findings from this study. Such work identifies the themes of 'emotional pain' (Selby, Joiner, & Ribeiro, 2014) and 'suffering' (Lakeman & FitzGerald, 2008) when living with suicidality, and the importance of 'connection', 'coping', and 'turning points' when overcoming suicidality (Chung, Caine, Barron, & Badaracco, 2015; Gordon, Stevenson, & Cutcliffe, 2014; Han, Chou, Liu, Rong, & Shiau, 2014). Furthermore, many of these studies identified that clinicians' attitudes and behavioural responses impacted on the persons' ability to

seek, engage with, and benefit from professional help (Gordon *et al.*, 2014; Sun, Long, Tsao, & Huang, 2014).

In this study, the ‘emotional struggle’ is reflected in the tension and turmoil associated with making profound decisions about life and death, often driven by dysregulated emotion that defies understanding over an extended period. While being a torturous state of survival, it acts as a lifeline because one can decide to live while holding open the possibility of death, thus ambivalence keeps the person alive (Caruso, 2009), which may partially explain RSA, as the person remains uncertain about both life and death. ‘Suffering’ is evident as survival is characterized by fear, being trapped in truncated thinking (Williams, Crance, Barnhofer, & Duggan, 2005) with little sense of control, not knowing what options are available to survive challenging moments, or what the future might entail. The theme of ‘connection’ is also evident as participants identified that inability to trust others and/or fear of recrimination and negative responses prevented them from reaching out and seeking help, while reconnecting with themselves and others fostered support and a sense of belonging rather than difference (Gordon, 2016). Participants elucidated that the ability to identify or articulate their emotional distress in a way that can be understood by themselves and others is a core struggle, which reflects the high levels of alexithymia among the RSA group (Bergmans & Eynan, 2014).

This study supports prior research that suggests that the essence of intervention goes beyond attenuating risk factors, pharmacotherapy and instrumental care to include collaboration, respect, individualized approaches, and an inherent belief in the value of the suicidal person (Cutcliffe, Stevenson, Jackson, & Smith, 2006) where the pain has been acknowledged and validated (Gordon *et al.*, 2014; Sun *et al.*, 2014). Participants also identified the critical role of compassionate, non-judgemental, respectful, and available support persons who understood their unique struggle with life and death. Thus, the findings provide further evidence that the kind of responses that clinicians make to those who are experiencing suicidal struggles can influence their momentum towards life.

This study provides a more nuanced understanding of the state of suicidal ambivalence, surviving moment to moment. This consists of two interrelated yet distinct dimensions of ambivalence. Each dimension is steered by competing desires, one characterized by the primacy of emotion over cognition (deciding not to die in the moment), while the other is characterized by the primacy of cognition over emotion (deciding to live in the moment). In the first, where the orientation is inward, the sense of agency in decision-making is significantly limited and compromised. Whereas in the second, where the orientation is more outward and there is more awareness and insight and less intense emotion, there is more opportunity for conscious decisions based on a sense of personal agency. These distinctions carry important clinical implications.

### ***Implications for clinical practice***

Clinicians working with RSA clients who are in this survival state can tailor their responses depending on whether the person is leaning more towards living or dying. They have an opportunity to intervene in ways that facilitate movement towards deciding not to die when in an emotionally charged crisis state, or deciding to live when the person is less distressed and more stable. As noted in previous works, skill development and enhanced self-understanding are associated with healing from suicidality (Gordon *et al.*, 2014; Han *et al.*, 2014; Leitner, Barr, & Hobby, 2008). However, the emphasis placed on each of these key areas needs to fit with the unique survival position that the client is occupying.

Deciding not to die in the moment is a place that is fraught with fear, vulnerability, and fragility. Thus, intervention at this point can centre on early-stage treatment strategies including safety planning, de-escalation of the intensity of the crisis situation through the use of crisis management strategies (Granello, 2010), and development of a therapeutic alliance to enhance emotional containment and stabilization (Livesley & Clarkin, 2016; Najavits, 2015). Alexithymia is evident among this group (Bergmans & Eynan, 2014); therefore, helping them to learn a vocabulary to identify and express emotions can help to create a 'story' that enhances their understanding of their intense emotional turmoil. This is important given that 'undifferentiated states of high emotional arousal – *unstoried emotions* – are almost always experienced as disorganizing, distressing, and frightening by participants' (Angus & Greenberg, 2007, p. 21).

The clinician can help to contextualize and enhance the clients' understanding of their subjective sense of victimhood when they believe that they have little or no sense of agency (Pascual-Leone & Greenberg, 2007). Explicitly acknowledging the client's decision not to die in the moment can also enhance this. However, gaining a sense of agency and control over suicidality is an evolving process that requires time and it is worth bearing in mind that becoming suicide attempt free could take up to a median 7.18 years (Perry *et al.*, 2009), thus clinician patience is necessary so that he/she can move at the clients pace.

When the client is in a place of deciding to live, intervention is a fluid combination of raising awareness about the function of suicide and one's unique vulnerabilities, expanding awareness and regulation of emotions, identifying emerging needs, and consolidating de-escalation and problem-solving skills in the event of a future crisis. It is worth noting that with greater awareness often comes further de-stabilization until the client accepts their own agency and recognizes their ability to take moments of control and to make active decisions.

The capacity to challenge and change entrenched thinking patterns is difficult; thus, only when 'the iron is cold' (Pine, 1986) and the client is less distressed and more oriented towards living, can interpretations or observations that are 'useable' (Pine, 1986) be introduced. Participants elucidated that when in this place exploration into the meaning of their suicidality is more possible and tolerable. This can be fostered by examining the possible functions of RSA, for example, a communication about their internal experience or a quest for help (Latakienė *et al.*, 2015; Zayas & Gulbas, 2012); a coping strategy to distract from negatively attributed emotional states (Linehan, 1993; Selby *et al.*, 2014); an effort to eradicate perceptions of imperfection when believing that the expectations of others or self can never be met (Flett, Hewitt, & Heisel, 2014); or a perception of oneself as a burden (Joiner, 2005).

Participants also benefited from being able to meet others who lived with RSA, with whom they could speak openly about their deep-seated fear and shame. Hence, the group factor of 'universality' (Yalom & Leszcz, 2005) allowed them to be heard and understood by those who shared the same suicidal struggle, aiding to diminish their perception of this being unique to them and their feeling of being alone.

Finally, some participants experienced negative attitudes and responses by clinicians which they found unhelpful and at times destructive. These responses can serve to diminish the extremely fragile state of the client, resulting in them perceiving themselves as inherently flawed and not deserving of help (Bergmans, Spence, *et al.*, 2009). Therefore, clinicians need to reflect upon, and if necessary challenge, their own assumptions about this client group.

## Conclusions

This study provides a unique insight into suicidal ambivalence and identifies the state of survival on a moment to moment basis for those with RSA. It sheds light on the complex and painful process of decision-making about one's destiny as participants grappled with the angel of death while also grappling with the demons in their lives. It identifies two interrelated subprocesses that can be occupied when in this position, one that reflects being primarily invested in dying where decisions are emotionally driven and one that reflects being more invested in life where decisions are more cognitively driven. Movement between these two states is somewhat precarious for a time and depends on both the person's life circumstances and their subjective sense of well-being, which can change at any time.

The study highlights how being in this ambiguous state can both torment the person and provide them with a lifeline opportunity potentially serving as a turning point on their suicide trajectory. It also illuminates how shifting towards an outward life focused orientation can be facilitated by clinicians who demonstrate understanding and compassion, acknowledge the struggle associated with this in-between state and intervene in a validating and authentic manner to meet the person where they are at any point in time. Thus, the clinician's role is to empathize with the fragility and uncertainty of the client and their struggle, acknowledge their courage, assist in expanding their understanding, insight and emotional literacy, and enhance skills to manage their lives. However, to do this requires that the clinician be aware of their own assumptions about RSA and critically examine their attitudes and behavioural responses towards this client group.

## References

- Angus, L. E., & Greenberg, L. S. (2007). *Working with narrative in emotion-focused therapy*. Washington, DC: American Psychological Association.
- Bergmans, Y., & Eynan, R. (2014). What changes? What does it mean? A clinical intervention for people with recurrent suicide attempts. In J. R. Cutcliffe, J. C. Santos, P. S. Links, J. Zaheer, H. G. Harder, F. Campbell, R. McCormick, K. Harder, Y. Bergmans & R. Eynan (Eds.), *Routledge international handbook of clinical suicide research* (pp. 237–248). Abingdon, Oxon, UK: Routledge International.
- Bergmans, Y., Koorn, K., Eynan, R., & Pacey, C. (2014). Creating an intervention for people with recurrent suicide attempts. In J. R. Cutcliffe, J. Santos, P. S. Links, J. Zaheer, H. Harder, F. Campbell, R. McCormick, K. Harder, Y. Bergmans, & R. Eynan (Eds.), *International handbook of clinical suicide research* (pp. 227–236). Abingdon, Oxon, UK: Routledge International.
- Bergmans, Y., Langley, J., Links, P. S., & Lavery, J. V. (2009). The perspectives of young adults on recovery from repeated suicide-related behavior. *Crisis, 30*(3), 120–127. <https://doi.org/10.1027/0227-5910.30.3.120>
- Bergmans, Y., & Links, P. S. (2009). Reducing risk factors through group intervention for suicide-related behavior. *Annals of Clinical Psychiatry, 21*(1), 11–19.
- Bergmans, Y., Spence, J. M., Strike, C., Links, P. S., Ball, J. S., Rufo, C., . . . Eynan, R. (2009). Repeat substance-using suicidal clients-how can we be helpful? *Social Work in Health Care, 48*, 420–431. <https://doi.org/10.1080/00981380802592013>
- Brådvik, L., & Berglund, M. (2011). Repetition of suicide attempts across episodes of severe depression. Behavioral sensitization found in suicide group but not in controls. *BMC Psychiatry, 11*, 1–7. <https://doi.org/10.1186/1471-244X-11-5>
- Caruso, K. (2009). Suicide and ambivalence [Online]. Retrieved from <http://www.suicide.org>
- Chung, I. W., Caine, E. D., Barron, C. T., & Badaracco, M. A. (2015). Clinical and Psychosocial Profiles of Asian Immigrants Who repeatedly attempt suicide: A mixed-method study of risk and protective factors. *Crisis, 36*, 353–362. <https://doi.org/10.1027/0227-5910/a000334>

- Cuijpers, P., de Beurs, D. P., van Spijker, B. A. J., Berking, M., Andersson, G., & Kerkhof, A. J. F. M. (2013). The effects of psychotherapy for adult depression on suicidality and hopelessness: A systematic review and meta-analysis. *Journal of Affective Disorders, 144*, 183–190. <https://doi.org/10.1016/j.jad.2012.06.025>
- Cutcliffe, J. R., Stevenson, C., Jackson, S., & Smith, P. (2006). A modified grounded theory study of how psychiatric nurses work with suicidal people. *International Journal of Nursing Studies, 43*, 791–802. <https://doi.org/10.1016/j.ijnurstu.2005.09.001>
- Da Cruz, D., Pearson, A., Saini, P., Miles, C., While, D., Swinson, N., . . . Kapur, N. (2011). Emergency department contact prior to suicide in mental health patients. *Emergency Medicine Journal, 28*, 467–471. <https://doi.org/10.1136/Emj.2009.081869>
- da Silva Cais, C. F., Stefanello, S., Fabrício Mauro, M. L., Scavacini, Vaz., de Freitas, G., & Botega, N. J. (2009). Factors associated with repeated suicide attempts: Preliminary results of the WHO Multisite Intervention Study on Suicidal Behavior (SUPRE-MISS) from Campinas, Brazil. *Crisis, 30*(2), 73–78. <https://doi.org/10.1027/0227-5910.30.2.73>
- Fiske, H. (2008). *Hope in action*. New York, NY: Taylor & Francis Group LLC.
- Flett, G. L., Hewitt, P. L., & Heisel, M. J. (2014). The destructiveness of perfectionism revisited: Implications for the assessment of suicide risk and the prevention of suicide. *Review Of General Psychology, 18*(3), 156–172. <https://doi.org/10.1037/gpr0000011>
- Gibb, B. E., Andover, M. S., & Miller, I. W. (2009). Depressive characteristics of adult psychiatric inpatients with a history of multiple versus one or no suicide attempts. *Depression and Anxiety, 26*, 58–574. <https://doi.org/10.1002/da.20412>
- Gordon, E. (2016). *Transcending suicidality: Re-vitalizing worthiness*. Saarbrücken, Germany: Lambert Academic Publishing.
- Gordon, E., Stevenson, C., & Cutcliffe, J. R. (2014). Transcending suicidality. In J. R. Cutcliffe, J. C. Santos, P. S. Links, J. Zaheer, H. G. Harder, F. Campbell & R. McCormick et al. (Eds.), *Routledge international handbook of clinical suicide research* (pp. 39–51). Abingdon, Oxon, UK: Routledge International.
- Granello, D. H. (2010). A suicide crisis intervention model with 25 practical strategies for implementation. *Journal of Mental Health Counseling, 32*, 218–235. <https://doi.org/10.17744/mehc.32.3.n6371355496t4704>
- Han, H.-p., Chou, C.-h., Liu, I.-C., Rong, J.-R., & Shiau, S. (2014). New Start: The life experiences of recovering suicidal adolescents. *European Scientific Journal, 10*, e-ISSN: 1857-7432. Retrieved from <http://eujournal.org/index.php/esj/article/viewFile/2741/2593>
- Hawton, K., & Kirk, J. (1998). Problem solving. In K. Hawton, P. M. Salkovskis, J. Kirk & D. M. Clark (Eds.), *Cognitive behavior therapy for psychiatric problems. A practical guide* (pp. 406–426). New York, NY: Oxford Medical Publications.
- Hawton, K., Witt, K. G., Taylor Salisbury, T. L., Arensman, E., Gunnell, D., Hazell, P., . . . van Heeringen, K. (2016). Psychosocial interventions for self-harm in adults. *Cochrane Database Systematic Review, 12*(5), CD012189. <https://doi.org/10.1002/14651858.CD012189>
- Jakobsen, I. S., Christiansen, E., Larsen, K. J., & Waaktaar, T. (2011). Differences between youth with a single suicide attempt and repeaters regarding their and their parents history of psychiatric illness. *Archives of Suicide Research, 15*, 265–276. <https://doi.org/10.1080/13811118.2011.589731>
- Jo, S. J., Lee, M. S., Yim, H. W., Kim, H. J., Lee, K., Chung, H. S., . . . Seo, Y. M. (2011). Factors associated with referral to mental health services among suicide attempters visiting emergency centers of general hospitals in Korea: Does history of suicide attempts predict referral. *General Hospital Psychiatry, 22*, 294–299. <https://doi.org/10.1016/j.genhosppsych.2011.01.008>
- Joiner, T. (2005). *Why people die by suicide*. Cambridge, MA: Harvard University Press.
- Kern, R. S., Kuehnel, T. G., Teuber, J., & Hayden, J. L. (1997). Multimodal cognitive-behavior therapy for borderline personality disorder with self-injurious behavior. *Psychiatric Services, 48*, 1131–1133.
- Lakeman, R. (2010). What can qualitative research tell us about helping a person who is suicidal? *Nursing Times, 106*(33), 23–26.

- Lakeman, R., & FitzGerald, M. (2008). How people live with or get over being suicidal: A review of qualitative studies. *Journal of Advanced Nursing*, *64*(2), 114–126. <https://doi.org/10.1111/j.1365-2648.2008.04773.x>
- Latakiénė, J., Skruibis, P., Dadašev, S., Grižas, A., Dapševičiūtė, I., & Gailienė, D. (2015). “They Don’t Take It Seriously”. Perceived reactions of surrounding people to suicide communication. *Illness, Crisis & Loss*, *24*(3), 126–136. <https://doi.org/10.1177/1054137315589691>
- Leitner, M., Barr, W., & Hobby, L. (2008) Effectiveness of interventions to prevent suicide and suicidal behaviour: a systematic review. Health & Community Care Research Unit, Liverpool University, InfoTech UK Research, Scottish Government Social Research. Retrieved from <http://www.scotland.gov.uk/Publications/2008/01/15102257/0>
- Levine, D., Marziali, E., & Hood, J. (1997). Emotion processing in borderline personality disorders. *The Journal of Nervous and Mental Disease*, *185*, 240–246.
- Linehan, M. M. (1993). *Cognitive behavioral treatment of borderline personality disorder*. New York, NY: The Guilford Press.
- Links, P. S., Kolla, N., Guimond, T., & McMain, S. (2013). Prospective risk factors for suicide attempts in a treated sample of patients with Borderline Personality Disorder. *Canadian Journal of Psychiatry*, *58*(2), 99–106. <https://doi.org/10.1177/070674371305800207>
- Links, P. S., Ross, J., & Gunderson, J. G. (2015). Promoting good psychiatric management with patients with borderline personality disorder. *Journal of Clinical Psychology*, *71*, 753–763. <https://doi.org/10.1002/jclp.22203>
- Livesley, W. J., & Clarkin, J. F. (2016). A general framework for integrated modular treatment. In J. W. Livesley, G. Dimaggio & J. F. Clarkin (Eds.), *Integrated treatment for personality disorder* (pp. 19–47). New York, NY: The Guilford Press.
- Mann, J. J. (1998). The neurobiology of suicide. *Nature Medicine*, *4*, 25–30.
- McLeod, A. K., Tata, P., Evans, K., Tyrer, P., Schmidt, U., Davidson, K., ... Catalan, J. (1998). Recovery of positive future thinking within a high-risk parasuicide group: results from a pilot randomized controlled trial. *British Journal of Clinical Psychology*, *37*, 371–379. <https://doi.org/10.1111/j.2044-8260.1998.tb01394.x>
- McMain, S. F., Guimond, T., Streiner, D. L., Cardish, R. J., & Links, P. S. (2012). A randomized controlled trial of dialectical behavior therapy versus general psychiatry management for borderline personality disorder: Clinical outcomes and functioning over a 2-year follow-up. *American Journal of Psychiatry*, *169*(6), 650–661. <https://doi.org/10.1176/appi.ajp.2012.11091416>
- Míret, M., Nuevo, R., Morant, C., Sainz-Cortón, E., Jiménez-Arriero, M. Á., López-Ibor, J. J., ... Ayuso-Mateos, J. L. (2010). Quality of the written information about suicide attempters. *Psychiatry and Mental Health*, *3*(1), 13–18. [https://doi.org/10.1016/s2173-5050\(10\)7003-0](https://doi.org/10.1016/s2173-5050(10)7003-0)
- Monnin, J., Thiemard, E., Vandel, P., Nicolier, M., Tio, G., Courtet, P., ... Haffen, E. (2012). Sociodemographic and psychopathological risk factors in repeated suicide attempts: Gender differences in a prospective study. *Journal of Affective Disorders*, *136*(1), 35–43. <https://doi.org/10.1016/j.jad.2011.09.001>
- Najavits, L. (2015). *Seeking safety [powerpoint presentation]*. Retrieved from <http://docslide.us/documents/lisa-najavits-seeking-safety-the-stages-of-change-prochaska-diclemente.html>
- Pascual-Leone, A., & Greenberg, L. S. (2007). Emotional processing in experiential therapy: Why “the Only Way Out Is Through”. *Journal of Consulting Clinical Psychology*, *75*, 875–887. <https://doi.org/10.1037/0022-006X.75.6.875>
- Perry, C. J., Fowler, J. C., Bailey, A., Clemence, A. J., Plakun, E. M., Zheutlin, B., & Speanburg, S. (2009). Improvement and recovery from suicidal and self-destructive phenomena in treatment-refractory disorders. *The Journal of Nervous and Mental Disease*, *197*(1), 28–34.
- Pietkiewicz, I., & Smith, J. A. (2012). A practical guide to using interpretive phenomenological analysis in qualitative research psychology. *Czasopismo Psychologiczne*, *18*, 361–369. English version retrieved from: 2014 Pietkiewicz & Smith – <https://www.researchgate.net/publication/263767248>. <https://doi.org/10.1469/cppj.20.1.7>

- Pine, F. (1986). Supportive psychotherapy, a psychoanalytic perspective. *Psychiatric Annals*, *16*, 527–529.
- Ruengorn, C., Sanichwankul, K., Niwatananun, W., Mahatnirunkul, S., Pumpaisalchai, W., & Patumanond, J. (2011). Incidence and risk factors of suicide reattempts within 1 year after psychiatric hospital discharge in mood disorder patients. *Clinical Epidemiology*, *3*, 305–313. <https://doi.org/10.2147/CLEP.S25444>
- Scoliers, G., Portzky, G., van Heeringen, K., & Audenaert, K. (2009). Sociodemographic and psychopathological risk factors for repetition of attempted suicide: A 5-year follow-up study. *Archives of Suicide Research*, *13*, 201–213. <https://doi.org/10.1080/1381110902835130>
- Selby, E. A., Joiner, Jr, T. E., & Ribeiro, J. D. (2014). Comprehensive theories of suicide. In M. K. Nock (Ed.), *Oxford handbook of suicide and self-injury* (pp. 286–307). New York, NY: Oxford University Press.
- Sinclair, J. M. A., Hawton, K., & Gray, A. (2010). Six year follow-up of a clinical sample of self-harm patients. *Journal of Affective Disorders*, *121*, 247–252. <https://doi.org/10.1016/j.jad.2009.05.027>
- Sledge, W., Plakun, E. M., Bauer, S., Brodsky, B., Caligor, E., Clemens, N. A., . . . Myers, M. (2014). Psychotherapy for suicidal patients with Borderline Personality Disorder: An expert consensus review of common factors across five therapies. Borderline personality disorder and emotion dysregulation. *BioMed Central*, *1*, 16. Retrieved from <http://bpded.biomedcentral.com/article/s/10.1186/2051-6673-1-16> <https://doi.org/10.1186/2051-6673-1-16>
- Smith, J. A., & Osborn, M. (2003). Interpretative phenomenological analysis. In J. A. Smith (Ed.), *Qualitative psychology: A practical guide to research methods* (pp. 51–80). London, UK: Sage.
- Smith, J. A., & Osborn, M. (2008). Interpretative phenomenological analysis. In J. A. Smith (Ed.), *Qualitative psychology: A practical guide to research methods* (pp. 53–79). London, UK: Sage.
- Soomro, G. M., & Kakhi, S. (2014). Deliberate self-harm (and attempted suicide). Systematic review 1012. *BMJ Clinical Evidence*. Retrieved from <http://clinicalevidence.bmj.com/x/systematic-review/1012/overview.html>
- Spence, J. M., Bergmans, Y., Strike, C., Links, P. S., Rhodes, A. E., Watson, W. J., . . . Rufo, C. (2008). Experiences of substance using-suicidal males who present frequently to the ED. *Canadian Journal of Emergency Medicine*, *10*, 339–346. <https://doi.org/10.1017/S1481803500010344>
- Sun, F. K., Long, A., Tsao, L. I., & Huang, H. M. (2014). The healing process following a suicide attempt: Context and intervening conditions. *Archives of Psychiatric Nursing*, *28*(1), 55–61. <https://doi.org/10.1016/j.apnu.2013.10.004>
- Tarrier, N., Taylor, K., & Gooding, P. (2008). Cognitive-behavioral interventions to reduce suicide behavior: A systematic review and meta-analysis. *Behavior Modification*, *32*(1), 77–108. <https://doi.org/10.1177/0145445507304728>
- Ward-Ciesielski, E. F., & Linehan, M. M. (2014). Psychological treatment of suicidal behaviors. In M. K. Nock (Ed.), *Oxford handbook of suicide and self-injury* (pp. 367–384). New York, NY: Oxford University Press.
- Williams, M., Crance, C., Barnhofer, T., & Duggan, D. (2005). Psychology and suicidal behaviour: Elaborating the entrapment model. In K. Hawton (Ed.), *Prevention and treatment of suicidal behaviour: From science to practice* (pp. 71–90). Oxford, UK: Oxford University Press.
- Wong, J. P. S., Steward, S. M., Claassen, C., Lee, P. W. H., Rao, U., & Lam, T. H. (2007). Repeat suicide attempts in Hong Kong community adolescents. *Social Science & Medicine*, *66*, 232–241. <https://doi.org/10.1016/j.socscimed.2007.08.031>
- Yalom, I., & Leszcz, M. (2005). *The theory and practice of group psychotherapy*. New York, NY: Basic Books.
- Yip, P. S. F., Hawton, K., Liu, K., Liu, D., Ng, P. W. L., Kam, P. M., . . . Wong, T. W. (2011). A study of deliberate self-harm and its repetition among patients presenting to an emergency department. *Crisis*, *32*, 217–224. <https://doi.org/10.1027/0227-5910/a000069>
- Zayas, L. H., & Gulbas, L. (2012). Are suicide attempts by young Latinas a cultural idiom of distress? *Transcultural Psychiatry*, *49*, 718–734. <https://doi.org/10.1177/1363461512463262>