Illness, Crisis & Loss
2021, Vol. 30(1) 19–35

DOI: 10.1177/1054137319854656
journals.sagepub.com/home/icl
SAGE

"I Didn't Feel Treated as Mental Weirdo": Primary Findings on Helpful Relationship Characteristics in Suicide Attempt Health Care in Lithuania

Jolanta Latakienė[1], Greta Mastauskaitė[1], Odeta Geležėlytė[1], Eglė Mažulytė-Rašytinė[1], Jurgita Rimkevičienė[1], Paulius Skruibis[1], Konrad Michel[2], and Anja Gysin-Maillart[2]

Abstract

This article aims to investigate helpful relationship characteristics in suicide attempt health care. Semistructured interviews with seven participants (five women and two men; $mean_{age} = 26$) were conducted after a suicide attempt. All participants took part in the Attempted Suicide Short Intervention Program (ASSIP). Findings revealed the necessity of an egalitarian, attentive, benevolent, and competent relationship with health-care specialists. Coercive clinical management was considered disrespectful, while the needs for physical safety and freedom were expressed. A suicide-specific treatment program in addition to standard care was considered helpful, in particular the development of warning signs and safety strategies.

[1]Suicide Research Centre, Vilnius University, Vilnius, Lithuania
[2]University Hospital of Psychiatry, University of Bern, Bern, Switzerland

Corresponding Author:
Jolanta Latakiene, Vilnius University, Universiteto str. 9, Vilnius 01513, Lithuania.
Email: jolanta.latakiene@fsf.vu.lt

Keywords
ASSIP, suicide attempt, suicide prevention, helpful relationship characteristics

Introduction

Suicide attempters' increased risk of death by suicide has been well established in suicide research (Hawton, Zall, & Weatherall, 2003), especially in the first months after an attempt (Cedereke & Ojehagen, 2005). Thus, effective health care shortly after a suicide attempt is an important element of suicide prevention. Various interventions have been evaluated, for example, long-term psychological methods such as Mentalization-Based Therapy (MBT), Dialectical Behavior Therapy (DBT), brief interventions such as Collaborative Assessment and Management of Suicidality (CAMS) or Attempted Suicide Short Intervention Program (ASSIP), and Brief Cognitive Behavioral Therapy (CBT). However, what makes these interventions effective remains to be further investigated (Brown & Green, 2014; Calati & Courtet, 2016; Jobes, 2012). (Rudd et al., 2015) A limited number of studies have shown that suicidal behavior following attempted suicide can be reduced over time (Brown et al., 2005; Fleischmann et al., 2008; Gysin-Maillart, Schwab, Soravia, Megert, & Michel, 2016). These studies generally showed that the applied intervention had an influence on suicidal behavior but not on suicidal thoughts.

It is well established both theoretically and empirically that the therapeutic alliance is one of the most important factors in determining the effectiveness of psychotherapy (Fluckiger, Del Re, Wampold, Symons, & Horvath, 2011). Therefore, it is important to maintain a collaborative approach when providing services in order not to perceive a patient as incapable. In such a relationship, a person who attempted suicide becomes the expert of their own experience. Rogers and Soyka (2004) in their existential-constructivist perspective on suicides also indicate that health-care specialists should focus their attention on listening to what a patient has to say rather than stating their assumptions or evaluations. Being involved in a collaborative effort can empower a person to change their life, achieve a deeper understanding of oneself, and find alternative problem solutions in the event of a crisis. In addition, a positive health-care experience after a suicide attempt might even encourage further help-seeking (McKay & Shand, 2018).

Trust, respect, and empathy in a relationship with a health-care professional after a suicide attempt proved to be of importance in various studies (Hagen, Knizek, & Hjelmeland, 2018b; Kirkpatrick, Brasch, Chan, & Kang, 2017; McKay & Shand, 2018; Montross Thomas et al., 2014). The patients' views on the characteristics in the relationship with a health-care provider are relevant for the quality of the therapeutic process. When a patient feels the lack of

human relationships, empathic closeness, or emotional understanding, health-care professionals may contribute to their loneliness, frustration, and stigmatization (Ghio, Zanelli, Gotelli, Rossi, Natta, & Gabrielli, 2011). Patients might also feel that the health-care professional is preoccupied with evaluating the lethality of the attempt or the current suicide risk, which is usually the clinician's priority. Such an approach very often is a barrier for patients to open up about their pain and desperation (Gysin-Maillart et al., 2016; Rogers & Soyka, 2004). Therefore, patients' recommendations for future treatment often involve improving health-care specialists' understanding and listening skills (Montross Thomas et al., 2014). However, it is not clear whether empathy and respect are enough for health care to be effective in preventing future suicide attempts, or whether additional relationship qualities should be demonstrated.

Furthermore, studies in suicide research are typically quantitative (Hjelmeland & Knizek, 2010); therefore, they provide fewer opportunities to understand how health care is experienced by the recipients. Evidently, we need more qualitative research in suicide research if we are to move further instead of repeating the same studies on risk factors which have brought the field almost to a dead end (Hjelmeland & Knizek, 2010). Lately, some qualitative research has been published and provided valuable insights into how strict cultural gender norms might contribute to heightened men suicidality (Andoh-Arthur, Knizek, Osafo, & Hjelmeland, 2018; Knizek & Hjelmeland, 2018), the importance of spiritual/religious dimension in suicide attempt experience in Ghana (Akotia, Knizek, Kinyada, & Hjelmeland, 2014), the process of recovery after a suicide attempt (Chan, Kirkpatrick, & Brasch, 2017), and how formal requirements and lack of direct contact might challenge therapists connection with suicidal patients (Hagen, Hjelmeland, & Knizek, 2018a). Hagen et al.'s (2018b) study revealed that for suicidal patients in psychiatric wards in Norway experiencing a sense of companionship with professionals and receiving individualized care was important. Trusting relationships with staff who treated them with respect made them feel valued and their suffering and needs being understood. Authors in that study noted an increased focus on suicidality in providing care, although some mental health providers still lacked competence in providing individualized care for suicidal patients.

It is important to note that suicide rates in Norway (12 per 100,000 inhabitants) is similar to the rest of Europe, North America, and Australia (Norwegian Institute of Public Health, 2018) which is more than two to three times lower than in countries with high suicide rates, such as Lithuania. This is in addition to that Norway's National Plan for Suicide Prevention dates back to 1994 (Soras, 2000). In the light of this, the question remains whether research findings in countries with lower suicide rates and relatively well-developed health-care systems could be applicable to those countries with much higher suicide rates and less developed health-care systems (Lopez-Castroman, Blasco-Fontecilla, Courtet, Baca-Garcia, & Oquendo, 2015).

Lithuania made several attempts to develop a National Suicide Prevention Plan, but they never were funded and implemented. Vilnius, the capital of Lithuania, has developed a local suicide prevention plan in 2016, which is under implementation for the fourth year at the moment of writing this publication. Therefore, we see the need to understand how a different approach to suicidality—a straightforward and collaborative one (which is the basis of ASSIP)—is experienced by the patients in the context of a country with the high suicide rates, comprehensive suicide prevention only starting to take off, most of national mental health care being excessively medicalized and suicide stigma very much prevalent (Pūras et al., 2013; Skruibis, Geležėlytė, & Dadašev, 2015).

This article is part of a larger unpublished study on the difference between suicide attempt health-care experience by patients in treatment as usual (TAU) group and the ones in TAU plus ASSIP group. In this larger project, we imply mixed methods by using both quantitative instruments and qualitative semi-structured interviews. Here, we aim to reveal primary findings from interviews on helpful relationship characteristics in suicide attempt health care.

Method

Procedure

All participants were asked by their ASSIP therapist to take part in the study during their stay at the psychiatric ward after their most recent suicide attempt. After a written informed consent was obtained, a set of questionnaire on demographic and clinical variables was given to the patients, which was completed before the first ASSIP session. After this first measurement, participants received three to four ASSIP sessions in addition to TAU (see Participants and ASSIP treatment structure for details later). Participants were contacted within 4 weeks after their hospital admission for a research interview. Research interviews, which lasted 44 minutes on average, were conducted 78 days on average after a suicide attempt, recorded with an audio device, and then transcribed.

Interviews focused on participants' satisfaction with the help received from the health-care provider and its quality. Furthermore, areas that needed care as well as effective elements of the care provided were investigated. A semistructured interview designed by the researchers of this study was used for this purpose (see Table 1). The draft of the interview questions was tested in one pilot interview. Afterwards, asking to rate from 1 to 10 was included (Additional questions No. 1) for clarity; no major changes in the interview structure were done.

Study procedures were approved by Vilnius University's Psychological Research Ethics Committee (Permission No. 12, 2017-05-17). Participants received no payments.

Table 1. Structure of Interview Questions.

Interview questions
Opening question:
During this conversation, we are going to get a broader perspective on the health care you received after your last suicide attempt and its effectiveness. First of all, we are going to mark on this paper the sequence of services provided to you from your last suicide attempt up until now, and afterwards I will ask you more detailed questions about each element of help. What health-care service did you receive after a suicide attempt?
Additional questions:
1. On every kind of health care received:
○ How much did this service help you (from 1 to 10)? What was helpful and unhelpful? What behavior of the specialist makes this service helpful?
○ How much did you like this service (from 1 to 10)? What did you like and dislike about this service?
○ How competent was the specialist (from 1 to 10)? How would you describe your relationship with this specialist?
2. Which component of health care was the most helpful and why?
○ Please rank from most helpful to least helpful.
○ [About the most and least helpful] In what way does it stand out from the rest of the help you received?
○ What needs to be changed so that health care would be more effective? What you would like specialists to do differently?
3. Evaluation of health care:
○ In what way is this type of care similar to the one you have received previously?
○ In what way does this type of care differ from the one you have received previously?
○ How do you generally evaluate the health care you received after your last suicide attempt?
4. Health-care needs: What kind of help do you feel you require now? What kind of help is unavailable?
5. Importance of health care:
○ What is changing in your life while receiving this health care?
○ What would be different if you did not receive this help?
Closing question:
We want to get a comprehensive understanding about health care after a suicide attempt in this study. Is there anything else we should know that has not been covered?

Participants

In the present study, seven participants after a recent suicide attempt were examined, of which five were women ($\text{mean}_{\text{age}} = 27.4$ years, $SD_{\text{age}} = 4.7$) and two were men (mean_{age}=24.5 years, SD_{age}=0.7). In the last six months from the baseline measurement, two participants attempted suicide 3 times, the other five attempted suicide once. Further information on demographic and clinical variables is provided in Table 2.

Table 2. Baseline Demographic and Clinical Characteristics of the Participants.

Characteristic	Number of cases ($N = 7$)
Number of lifetime suicide attempts:	
First attempt	1
Second attempt	2
Third attempt	2
Fourth or further attempt	2
Method of last suicide attempt:	
Overdose	1
Cutting	2
Jumping from heights	1
Multiple methods:	3:
a) overdose and hanging	a) 1
b) overdose, alcohol, and drowning	b) 1
c) overdose, cutting, and hanging	c) 1
Diagnosis (ICD-10):[a]	
F10.1	1
F25.1	1
F32.2	2
F33.2	4
F61	2
Psychotropic drugs prescribed:	
Antidepressants	7
Antipsychotics	5
Tranquilizers	3
Others	1

[a]International Classification of Diseases (ICD-10) codes: F10.1, alcohol abuse disorder; F25.1, schizoaffective disorder, depressive type; F32.2, major depressive disorder, single episode, severe without psychotic features; F33.2, major depressive disorder, recurrent, severe without psychotic features; F61, mixed and other personality disorders.

According to Silverman, Berman, Sanddal, O'Carroll, and Joiner (2007), a *suicide attempt* is a self-inflicted, potentially injurious behavior with a nonfatal outcome for which there is evidence (either explicit or implicit) of intent to die. Therefore, the exclusion criteria consisted of self-harm with no intent to die, serious cognitive impairment, current psychotic state, and difficulties with the Lithuanian language.

All participants except for one were admitted into a general hospital in Vilnius (Lithuania) and afterwards into a psychiatric hospital after their suicide attempt. TAU, which was prescribed by a psychiatrist, consisted of different variations of the following elements: (a) psychopharmacological treatment and consultations with a psychiatrist, (b) group psychotherapy (existential or

psychodynamic approach), (c) individual psychological counseling, and (d) all patients were offered activities of their choice: relaxation, art therapy, dance/movement therapy, physical exercises, pottery, knitting, crocheting, and woodwork classes. Furthermore, all patients participated in the ASSIP (Gysin-Maillart et al., 2016; Michel & Gysin-Maillart, 2015) alongside their TAU. Three participants started ASSIP while being in inpatient ward, two while visiting hospital's day care center, and two as outpatient clients. All participants except for one received individual psychological counseling from a different psychologist than their ASSIP therapists, two of them also participated in group therapy. At the moment of interview, two participants were visiting hospital's daycare center or psychosocial rehabilitation center, three continued to receive outpatient psychological counseling (two of them from the same psychologist who was their ASSIP therapist, one from a different psychologist), and two were not receiving further mental health care.

Researchers and Therapists

Interviews were conducted by two researchers: a doctoral student and a post-graduate student of the department of Clinical Psychology at Vilnius University. The ASSIP therapists were three clinical psychologists; of them, two received their PhD in the field of suicidology. All ASSIP therapists have undergone training on the application of ASSIP while being supervised by experienced ASSIP trainers. The researchers and ASSIP therapists were not the same people. Study researchers did not have any influence on TAU or ASSIP treatment.

ASSIP Treatment Structure

ASSIP is a three- to four-session (60–90 minutes length each, once a week) intervention followed by a subsequent regular contact by letters from the ASSIP therapist during 24 months. ASSIP is an add-on intervention to TAU.

First session: A narrative interview is conducted in which patients are asked to tell their personal stories on how they had reached the point of attempting suicide. All interviews are video-recorded, with the patients' consent.

Second session: Patient and therapist, seated side-by-side, watch sequences of the first session, interrupting when necessary to seek or add additional information. The goal of this session is to reflect on the suicidal process and to identify important life issues relevant to the suicidal crisis. Patients receive a psychoeducative handout to read and write comments on before the next session is due. After the session, the therapist prepares a draft of the case conceptualization.

Third session: The patients' comments on the handout are discussed. The case conceptualization is revised collaboratively, revealing individual needs, vulnerabilities, and typical triggering events that precede a suicidal crisis. Long-term

goals, warning signs, and safety strategies are copied to a credit-card size folded leaflet (a memo-card, called *hope leporello*) and given to the patient.

Fourth session (optional): In a *mini exposure*, safety strategies are practiced using the video recording from the first session. In present study cases, this fourth session was not applied.

Semistandardized letters: Participants were sent letters over a period of 24 months, every 3 months in the first year and every 6 months in the second year. In present study, the effect of these letters is not explored due to short research follow-up period.

For further details, see the ASSIP manual (Michel & Gysin-Maillart, 2015).

Data Analysis

Hybrid thematic analysis by Boyatzis (1998) was used for interview data analysis. Thematic analysis aims to develop coding schemes or themes, which are used for further data analysis. Analysis was conducted in several steps:

1. *data familiarization:* interview transcriptions were reread several times, and parts of the audio recordings were listened to once more when needed;
2. *condensing of raw information:* only pieces of data that seemed relevant were paraphrased or summarized, this way an outline of the interview was created for a more effortless further analysis;
3. *identifying preliminary themes:* summarized pieces of transcription of the five most comprehensive interviews were reviewed;
4. *creating a set of themes:* preliminary themes were then joined and given concise, clear names that reflected their essence without digressing from the original data. Two researchers then reviewed all themes to make sure that there were no overlaps and compiled a list of major themes.

Results

Three major themes concerning the relationship with various health-care specialists after a suicide attempt emerged from the first three interview question groups (see Table 1) analysis: (a) the importance of a professional, egalitarian relationship with specialists; (b) adverse consequences of a disrespectful attitude from a caregiver, as well as overly strict treatment methods; and (c) effective elements of suicide-specific psychological care. Some excerpts from interviews will be presented to illustrate the results in more detail, with the names of participants changed in order to preserve confidentiality.

Importance of a Professional, Egalitarian Relationship With Specialists

Participants stressed the benefits of a health-care specialist's competency, benevolence and attentiveness, and also the importance of hospital's physical

conditions. All the participants mentioned they valued their ASSIP therapist's professionalism, goodwill, and collaboration:

> . . . And the psychologist I worked with is really, really professional. Well, when she is talking to me, she shows it, I can truly feel it, I mean, that it is sincere, natural, how can I say it. Yes, it was very important to me. (Eglė, 143)

A friendly and helpful relationship with the psychiatrist was also an important aspect of the perceived effectiveness of health care:

> She chose a treatment, made some good adjustments for me as I felt that I was lacking energy and asked to change something. And she agreed to do so. I felt that she understands me, it was easy to talk to her. (Goda, 147–149)

> Well she knows how to notice [things], how to be compassionate, (3s), how to help well professionally, when a person knows what she is talking about, well in general, and it helps. (Darius, 248)

Participants also mentioned that the listening, understanding, sincerity, and attentiveness of other specialists and staff were helpful.

> One nurse listened to me quite well, she asked what happened, and why? Well she listened to what the reason was. One of the nurses was very kind. (Ilona, 103)

> [With physiotherapist] Communication was free, I was not, I did not feel as if I was from somewhere else or mentally ill, and as if she was talking to me in a strange way, honestly. Everything was [done] in a genuine, normal way. Professionally, I would say. Communication was professional and kind. Knowing that I was so sensitive, it [suicide attempt] is a sensitive matter to me. (Eglė, 131)

Another important element named was the hospital's physical conditions, which is a reflection of the quality of care patients received: the more physical safety, freedom, opportunities to talk with other patients participants experienced, the more satisfied with care they felt.

> Well of course the environment was safe in hospital. It would not be this safe at home. (Goda, 333)

> Maybe it would be a good way to help, to keep people who attempted suicide with those alike, who face similar problems. Well it might be depression, or I don't know, hysterias, or something like that, surely the reasons are different, but that commonality is helpful. (Darius, 437)

Adverse Consequences of a Disrespectful Relationship and Overstrict Treatment Methods

The participants revealed that the hospitalization was not helpful if the therapeutic relationship was disrespectful or they felt the treatment methods were too strict. Moreover, inattentiveness when dispensing medicines, being only concerned about formalities (e.g., discussing sick leave issues without showing any signs of empathy), breach of confidentiality, or asking patients to lie were the factors that ruin the relationship according to participants.

> I told them that I do not want to stay here, so they said to me: 'we are admitting you against your will.' I came to the hospital and they are telling me to sign here, confirm that, or express my will to be here, 'otherwise we can easily go to the court and hospitalize you by force.' I signed that I was there by my will and they kept me even a bit longer than a month. (Darius, 166)

Patients being bedbound and isolated, while caregivers were occupied with physical reactions and were insensitive to emotions of the patients admitted into their emergency care facility, were considered as overstrict treatment methods.

> In intensive care there were also drugs, everywhere drugs, drugs, drugs, drugs. Isolation is what was the least helpful. Observed ward, and bestial behavior, that is what helped the least. <. . .> I am afraid . . . I was even, even lost for words due to that fright. The staff are horrible, they shout, oh oh oh oh (5s) I have a lesson now, I have to try all means to cling to life, just so as not to go back to that nightmare. (Ilona, 193; 91)

Furthermore, more than a half (four out of seven) of participants found that their stay in an inpatient psychiatric ward was not helpful at all. Some compared their stay to a nightmare and expressed anger that the psychiatric system is not changing, others stressed their fear to continue treatment and mentioned several cases when the hospital did not meet their needs for food, activities, and communication.

> Very bad conditions, I mean, even those kinds of people should not stay there. Well first of all, I am hyperbolizing a bit, but they are making you starve, they do not serve food at all, you need to ask visitors to bring food. Another thing, I mean, since most of patients are alcoholics, so there is no one to talk to, and I think such people need it after a suicide attempt, some sort of intimacy. (Darius, 140–142).

Important to note that ASSIP was never mentioned as a source of such disrespectful relationship or harmful treatment.

Effective Elements of Suicide-Specific Psychological Care

Five out of seven participants evaluated ASSIP as the most helpful part of all treatment they received. The variety of methods, specificity, developing a memo-card (*hope leporello*), and work on warning signs of future suicidal crisis were named as effective elements of suicide-specific psychological care. Participants stressed the importance of ASSIP therapists' sincere wish to help and collaborate with patients. Empathy and understanding were equally as important as feeling a sense of direction, experiencing insights, and stating goals and tasks.

Conversations, planning short-term goals, creating realistic plans, wondering what will be in one or two years, since I am afraid I might not reach that year or two, so simply just wondering what I am going to do next week, and the week after. (Žemyna, 82)

Because I have a starting point from which it might begin and how to notice it. For now, fortunately, I did not have a chance to try it out much, but I am certain that it helped and that now I have something more concrete to stand up on when a crisis will emerge once again. (Tomas, 149)

In comparison to previously received in-patient or out-patient mental health care, the specificity and intensity of the care was appreciated, as for example, one participant who had attended group therapy previously said:

> It [previous help] was focused on more general experiences, provided support, strengthened the ways we react to our surroundings, developed emotional intelligence in general, we worked on these things more then. But it was not a matter of death or life then. While now, in particular, everything was based on the fact, I mean, that it is either death or life. (Eglė, 299)

Another participant, who attempted suicide a few times in the last 6 months also reported that the main difference in his health care received after previous and the most current suicide attempt was taking part in ASSIP intervention this time.

Discussion

Participants of this research study from Vilnius (Lithuania) stressed that the presence of professionalism, egalitarian attitude, and respect was crucial for forming a beneficial therapeutic relationship after a suicide attempt. However, not in all cases are patients fortunate enough to experience acceptance and respect from hospital staff. As our participants revealed, isolation and being in a ward on observation may be perceived as disrespectful. Based on participants' reports, the collaborative therapy ASSIP, combining different psychological care methods, like developing clear and realistic therapy plans, and

a memo-card (*hope leporello*), as well as the work on warning signs for future suicidal crises is considered as being effective.

Our results are in agreement with other research regarding empathy and respect as necessary qualities for a relationship with a person after a suicide attempt (Hagen et al., 2018b; Kirkpatrick et al., 2017; McKay & Shand, 2018; Montross Thomas et al., 2014). However, participants of this study also stressed that the suicide-specific treatment ASSIP in five cases out of seven was the most helpful part of their treatment, especially working on short-term and long-term goals and developing suicide crisis management strategies collaboratively. These findings are in agreement with other research, which shows that safety planning, using alternative problem-solving options, creating future-oriented plans, and get involved in activities serve as protective factors after a suicide attempt (Chan et al., 2017). We can conclude that health care, and in particular psychological services, should be more specialized when dealing with a patient after a suicide attempt than other mental health disorders in a psychiatric ward. Providing that our participants made a critical evaluation of TAU and only gave a positive feedback about ASSIP, we believe ASSIP to be an important add-on treatment that adequately meets patients' need for collaborative, empathic, and suicide-specific care.

Furthermore, participants' evaluation with regard to the fact that staying in a psychiatric ward was not helpful might be related to unfavorable relationships with health-care specialists involved. Disregarding the patient as a person after a suicide attempt might result in internalized stigma, what may lead to further feelings of loneliness and therefore become a barrier for sharing their pain, which is consistent with previous research (Ghio et al., 2011; Rogers & Soyka, 2004). Distrust in others and overreliance on oneself have already been revealed as important barriers for seeking help while in suicidal crises in Lithuanian sample (Dadašev, Skruibis, Gailienė, Latakienė, & Grižas, 2016). Negative experiences during hospitalization may also affect trust in the health-care system, which might reduce the chance of a person approaching a health-care specialist in a future suicidal crisis.

The relation between the first two themes (*Importance of a professional, egalitarian relationship with specialists* and *Adverse consequences of a disrespectful relationship and over-strict treatment methods*) needs to be discussed as they may seem to contradict each other. It looks that patients experienced quite an ambivalent combination of relationships toward them from different health-care specialists at the same time. This also raises a question for further research on how do patients after a suicide attempt make sense of such a wide array of quality of relationships and how does this affect their own coming to terms with staying alive after they just expected to be dead? We also need to keep in mind the huge variety of health-care specialists' qualifications, attitude, and skills in suicide prevention in general psychiatric hospital. Providing that participants expressed satisfaction with suicide-specific intervention ASSIP, we can conclude that

suicide attempt health care could be more consistent and beneficial for the patients if provided in a specialized department or facility instead of general psychiatric wards. Probably, the current situation in Lithuania reflects the certain stance in a debate whether suicidality should be considered only as one symptom of broader underlying psychopathology or a separate issue best dealt with in a suicide-specific, patient-centered, collaborative manner (Jobes, 2012).

Certain limitations need to be considered regarding the results of this research. First, it should be mentioned that at the time of this study, ASSIP therapists had not yet completed their training, which could have had an impact on the results. Second, we did not explore the experience of receiving follow-up letters from ASSIP therapist, since present study interviews took place earlier than participants received their first letter. Two participants did not have pure ASSIP therapists as add-on resource in suicidal crises since they continued psychological counseling with them after ASSIP sessions were finished. Also, most of the participants were women (five out of seven); therefore, the specific experiences of men with health care after a suicide attempt might be insufficiently reflected in our findings and need further scientific investigation. Finally, transferability of results, in forms of theoretical and analytical generalization (Hjelmeland & Knizek, 2010), from this study will be largely determined by the practical utility of our insights for a particular readers' situation, practice, or research.

Conclusions

To our knowledge, this was the first study in Lithuania and broader post-Soviet region reporting on the patients' experience of a combination of TAU and suicide-specific, collaboratively focused intervention after a suicide attempt. An empathic, respectful relationship with health-care specialists is crucial in receiving beneficial care after a suicide attempt. However, some people still experience disregard, disrespect, or experience an excessively strict treatment management; therefore, in this study, the patients were rather critical toward standard treatment. A collaborative, patient-oriented therapeutic approach, focusing on a joint understanding of the suicidal crisis, developing personal warning signs, and safety strategies for future suicidal crises are important elements of ASSIP so that a person feels that help is effective and therefore might prevent a further suicide attempt. The add-on treatment ASSIP was perceived positively by patients who had attempted suicide; therefore, this brief therapy seems to fulfill the needs which may supplement TAU.

Declaration of Conflicting Interests

The authors declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The authors disclosed receipt of the following financial support for the research, authorship, and/or publication of this article: This research was supported by the Research Council of Lithuania under Grant No. S-MIP-17-113.

ORCID iD

Jolanta Latakienė http://orcid.org/0000-0002-7983-9866

References

Akotia, S., Knizek, B., Kinyanda, E., & Hjelmeland, H. (2014). "I have sinned": Understanding the role of religion in the experiences of suicide attempters in Ghana. *Mental Health, Religion & Culture*, *17*(5), 437–448. doi:10.1080/13674676.2013.829426

Andoh-Arthur, J., Knizek, B., Osafo, J., & Hjelmeland, H. (2018). Suicide among men in Ghana: The burden of masculinity. *Death Studies*, *42*(10), 658–666. doi:10.1080/07481187.2018.1426655

Boyatzis, R. E. (1998). *Transforming qualitative information: Thematic analysis and code development*. London, England: SAGE.

Brown, G.K., Ten Have, T., Henriques, G.R., Xie, S.X., Hollander, J.E., & Beck, A.T. (2005). Cognitive Therapy for the Prevention of Suicide Attempts: A Randomized Controlled Trial. *JAMA*, 294, 563–570. doi:10.1001/jama.294.5.563.

Brown, G. K., & Green, K. L. (2014). A review of evidence-based follow-up care for suicide prevention—Where do we go from here? *American Journal of Preventive Medicine*, *47*(3S2), S209–S215. doi:10.1016/j.amepre.2014.06.006

Calati, R., & Courtet, P. (2016). Is psychotherapy effective for reducing suicide attempt and non-suicidal self-injury rates? Meta-analysis and meta-regression of literature data. *Journal of Psychiatric Research*, *79*, 8–20. doi:10.1016/j.jpsychires.2016.04.003

Cedereke, M., & Ojehagen, A. (2005). Prediction of repeated parasuicide after 1-12 months. *European Psychiatry*, *20*, 101–109. doi:10.1016/j.eurpsy.2004.09.008

Chan, K. J., Kirkpatrick, H., & Brasch, J. (2017). The reasons to go on living project: Stories of recovery after a suicide attempt. *Qualitative Research in Psychology*, *14*(3), 350–373. doi:10.1080/14780887.2017.1322649

Dadašev, S., Skruibis, P., Gailienė, D., Latakienė, J., & Grižas, A. (2016) Too strong? Barriers from getting support before a suicide attempt in Lithuania, *Death Studies*, *40*(8), 507–512. doi:10.1080/07481187.2016.1184725

Fleischmann, A., Bertolote, J. M., Wasserman, D., De Leo, D., Bolhari, J., Botega, N. J., ... Thanh, H. T. (2008). Effectiveness of Brief Intervention and Contact for Suicide Attempters: A Randomized Controlled Trial in Five Countries. *Bulletin of World Health Organization*, 86(9): 703–709. doi:10.2471/BLT.07.046995

Fluckiger, C., Del Re, A. C., Wampold, B. E., Symonds, D., & Horvath, A. O. (2011). How central is the alliance in psychotherapy? A multilevel longitudinal meta-analysis. *Journal of Counseling Psychology*, *59*(1), 10–17. doi:10.1037/a0025749

Ghio, L., Zanelli, E., Gotelli, S., Rossi, P., Natta, W., & Gabrielli F. (2011). Involving patients who attempt suicide in suicide prevention: A focus group study. *Journal of Psychiatric and Mental Health Nursing*, *18*, 510–518. doi:10.1111/j.1365–2850.2011.01697.x

Gysin-Maillart, A., Schwab, S., Soravia, L., Megert, M., & Michel, K. (2016). A novel brief therapy for patient who attempt suicide: A 24-months follow-up randomized controlled study of the attempted suicide short intervention program (ASSIP). *PLoS Medicine*, *13*(3), e1001968. doi:10.1371/journal.pmed.1001968

Hagen, J., Hjelmeland, H., & Knizek, B. (2018a). Connecting with suicidal patients in psychiatric wards: Therapist challenges. *Death Studies*, *41*(6), 360–367. doi:10.1080/07481187.2017.1284955

Hagen, J., Knizek, B., & Hjelmeland, H. (2018b). Former suicidal inpatients' experiences of treatment and care in psychiatric wards in Norway. *International Journal of Qualitative Studies on Health and Well-being*, *13*(1), 1461514. doi:10.1080/17482631.2018.1461514

Hawton, K., Zahl, D., & Weatherall, R. (2003). Suicide following deliberate self-harm: Long-term follow-up of patients who presented to a general hospital. *British Journal of Psychiatry*, *182*(6), 537–542. doi:10.1192/bjp.182.6.537

Hjelmeland, H., & Knizek, B. L. (2010). Why we need qualitative research in suicidology. *Suicide and Life-Threatening Behavior*, *40*(1), 74–80. doi:10.1521/suli.2010.40.1.74

Jobes, D. (2012). The collaborative assessment and management of suicidality (CAMS): An evolving evidence-based clinical approach to suicidal risk. *Suicide and Life Threatening Behavior*, *42*, 640–653. doi:10.1111/j.1943-278X.2012.00119.x

Kirkpatrick, H. B., Brasch, J., Chan, J., & Kang, S. S. (2017). A narrative web – based study of reasons to go on living after a suicide attempt: Positive impacts of the mental health system. *The Journal of Mental Health and Addiction Nursing*, *1*(1), 3–9. doi:10.22374/jmhan.v1i1.10

Knizek, B., & Hjelmeland, H. (2018). To die or not to die: A qualitative study of men's suicidality in Norway. *BMC Psychiatry*, *18*, 263. doi:10.1186/s12888-018-1843-3

Lopez-Castroman, J., Blasco-Fontecilla, H., Courtet, P., Baca-Garcia, E., & Oquendo, M. A. (2015). Are we studying the right populations to understand suicide? *World Psychiatry*, *14*(3), 368–369. doi:10.1002/wps.20261

McKay, K., & Shand, F. (2018). Advocacy and luck: Australian healthcare experiences following a suicide attempt. *Death Studies*, *42*(6), 392–399. doi:10.1080/07481187.2017.1359218

Michel, K., & Gysin-Maillart, A. (2015). *ASSIP—Attempted Suicide Short Intervention Program: A manual for clinicians*. Göttingen, Germany: Hogrefe Publishing.

Montross Thomas, L. P., Palinkas, L. A., Meier, E. A., Iglewicz, A., Kirkland, T., & Zisook, S. (2014). Yearning to be heard: What veterans teach us about suicide risk and effective interventions. *Crisis: The Journal of Crisis Intervention and Suicide Prevention*, *35*, 161–167. doi:10.1027/0227-5910/a000247

Norwegian Institute of Public Health. (2018). *Suicide and suicide attempts in Norway*. Public Health Report. Retrieved from http://www.fhi.no/artikler/?id=110540

Pūras, D., Šumskienė, E., Veniūtė, M., Šumskas, G., Juodkaitė, D., Murauskienė, L., . . . Šliužaitė, D. (2013). *Iššūkiai įgyvendinant Lietuvos psichikos sveikatos politiką. Mokslo studija* [Challenges in implementing Lithuanian mental health policy. Science studio]. Retrieved from http://www.fsf.vu.lt/dokumentai/Naujienos_Mokslo_pasiekimai/MOKSLO_STUDIJA_issukiai_igyvendinant_Lietuvos_psichikos_sveikatos_politiką.pdf

Rogers, R. J., & Soyka, K. M. (2004). "One size fits all": An existential—constructivist perspective on the crisis intervention approach with suicidal individuals. *Journal of Contemporary Psychotherapy*, *34*(1), 7–22. doi:10.1023/B:JOCP.0000010910.74165.3a

Rudd, M.D., Bryan, C.J., Wertenberger, E.G., Peterson, A.L., Young-McCaughan, S., Mintz, J., ... Bruce, T. O. (2015). Brief Cognitive-Behavioral Therapy Effects on Post-Treatment Suicide Attempts in a Military Sample: Results of a Randomized Clinical Trial eith 2-Year Follow-Up. *American Journal of Psychiatry*, *172*, 441–449. doi: 10.1176/appi.ajp.2014.14070843

Silverman, M. M., Berman, A. L., Sanddal, N. D., O'Carroll, P. W., & Joiner, T. E., Jr. (2007). Rebuilding the tower of babel: A revised nomenclature for the study of suicide and suicidal behaviors Part 2: Suicide-related ideations, communication, and behaviors. *Suicide and Life-Threatening Behavior*, *37*, 264–277. doi:10.1521/suli.2007.37.3.264

Skruibis, P., Geležėlytė, O., & Dadašev, S. (2015). The stigma of suicidal behaviour. In D. Gailienė (Ed.), *Lithuanian faces after transition: Psychological consequences of cultural trauma*. Vilnius, Lithuania: Eugrimas.

Soras, I. (2000). *The Norwegian Plan for Suicide Prevention 1994-1999: Evaluation findings*. Retrieved from https://www.med.uio.no/klinmed/english/research/centres/nssf/articles/prevention/Soraas.pdf

Author Biographies

Jolanta Latakienė is a Clinical Psychologist in private practice, PhD student and researcher at the Suicide Research Centre at Vilnius University. Her research focuses on qualitative analysis of adolescent and adult suicide attempters' experience. She is also currently studying to become an existential therapist.

Greta Mastauskaitė has a master's degree (Vilnius University) in Clinical Psychology. Currently, she is a volunteer in the Crisis Intervention Center, an emotional youth support hotline and also provides consultations as a private practitioner. Her academic research focus is on psychological crises, especially suicidal crises, and grief after various loses.

Odeta Geležėlytė PhD, is a clinical psychologist and a researcher at the Suicide Research Centre, Vilnius University, Lithuania. Her research areas include suicide and bereavement.

Eglė Mažulytė-Rašytinė is an assistant professor in the Institute of Psychology and a Researcher in the Suicide Research Centre at Vilnius University. She earned her qualification as a Clinical Psychologist in 2013 and Ph.D. at Vilnius University in 2017. Her interests in both research and clinical practice lie in the area of suicidology and trauma psychology.

Jurgita Rimkevičienė is a Clinical Psychologist and a researcher at the Suicide Research Center at Vilnius University, Lithuania. She earned her PhD on impulsivity of suicide attempts at the Australian Institute for Suicide Research and Prevention, Griffith University, Australia. Her current research

interests focus on the effectiveness of the suicide prevention system, suicide risk assessment, and suicide stigma.

Paulius Skruibis is an associate professor at Vilnius university, where he is heading Suicide Research Centre. He's is also working as a Clinical Psychologist in private practice and delivering training in suicide prevention.

Konrad Michel is professor emeritus of psychiatry at the University Hospital of Psychiatry in Bern, Switzerland, is a clinical psychiatrist and psychotherapist with an active clinical private practice. A major focus of his work is on the various aspects of the therapeutic relationship with the suicidal patient. In cooperation with Anja Gysin-Maillart PhD, Dr. Michel developed a three-session intervention for suicide attempters, ASSIP (Attempted Suicide Short Intervention Program), which has been evaluated in a RCT with 24 months follow-up, showing a significant reduction of re-attempts.

Anja Gysin-Maillart PhD, is Psychoterapist, Senior Psychologist and Research Fellow at the University Hospital of Psychiatry in Bern, Switzerland. Her research interests focus on suicide prevention, ASSIP (Attempted Suicide Short Intervention Program), psychotherapy research, brief intervention, outreach elements and neuropsychology.