Original Article

Suicide Prevention: The Experiences of Recurrent Suicide Attempters (A phenomenological study)

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(Received: 3 July 2009; Accepted: 1 February 2010)

Objective: Presently, the issue of attempted suicide now poses one of the major challenges facing the health-care providers in Iran and other countries. Although in previous years, the number of people entering to hospital emergency departments after deliberately taking overdoses or injuring themselves has been steadily increased in Iran, however, there is less attention to the issue of suicide prevention. The main aim of this study is to understand the experiences of those who re-attempted suicide, along with regarding suicide prevention.

Methods: A qualitative phenomenological approach was applied. Purposeful samples of 12 patients who had a history of attempted suicide and were able to attend and respond to questions were recruited. Data was gathered by means of an in-depth semi-structured interview with each subject separately. The analysis of the data was conducted using the phenomenological analytic method defined by Colaizzi.

Results: Over all, 667 descriptive codes were extracted, which were later reduced to 36 interpretative codes and then to 8 explanatory codes. Finally, four fundamental constructs of structural factors, personal factors, caring institutions and social networks were identified.

Conclusion: The experiences of the participants showed that although individual factors are important and could influence suicide prevention, the structural and socio-cultural contexts which are out of individuals control are significant as well.

Declaration of interest: None.

Iranian Journal of Psychiatry and Behavioral Sciences (IJPBS), Volume 4, Number 1, Spring and Summer 2010: 4-12.

Keywords: Recurrence • Suicide Attempt •Suicide Prevention

Introduction

Suicide is a prevailing problem across the world and is one of the first 10 causes of death (1). According to estimations from World Health Organization (WHO), approximately one million died in year 2000 across the world, due to suicide (1). It has significant consequences for individuals including severe mental and physical disorders, long-term disabilities, and eventually, death (2), as well as negative effects on society at large, and environment, family, and the health care system. Suicide ideation is a complicated behaviour, beginning from thoughts of suicide to suicidal behaviour, followed by suicide attempt, in which, in some cases, leads to death (3). To reduce suicide rates, various strategies are applicable in terms of suicide-prevention strategies. These strategies should be designed in such a way that they include not only psychological factors, but contextual, social, and national variables as well (4).

Recently, the rates of suicide have been increasing in Iran and, at the same time, the age in which people committing suicide has been on a decline trend (5). It is also more widespread among Iranian women than men (6,7). The prevalence of suicide was calculated to be 9.4 in 100,000 in this country (8). In spite of these statistics, it appears it is still not viewed as a social and threatening problem. Few studies have been conducted regarding suicide prevention in Iran to propose practical strategies based on Iranian culture. Study and research in the developing countries, however, suggest that for a comprehensive understanding of suicide

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and suicide prevention, it is beneficial to apply qualitative approaches (9), emphasising the subjective and interpretative understanding of suicide (10). Qualitative approaches were developed as a response and critique to Durkheim's theory of suicide (11) to specifically address issues such as suicide definition, culture of suicide (10), suicide meaning (12) and actor intention (13).

This paper seeks to explore experiences of recurrent suicide attempters regarding suicide prevention. The qualitative methodology is applied to obtain a comprehensive understanding of the actual experiences of suicide attempters.

Materials and Methods

This research applied a qualitative method within the phenomenological approach. A purposeful sample was recruited. Sampling continued until data saturation, namely, that no new conceptual patterns were emerging (14). Semi-structured, in-depth interviews were conducted with twelve individuals who have attempted suicide previously and were admitted to Nour Hospital in Isfahan (Iran), during the year of 2007. Cases were available by two ways. First, individuals who had a history of suicide attempt in their medical records at the poison ward or psychiatric ward. They comprised of eight individuals who were invited for the interviews. Meanwhile, the research team identified and invited four other individuals whom recently attempted suicide and were institutionalized in a psychiatric ward. Those volunteers that were selected, who had attempted committed suicide at least two times, and who declared themselves willing and who were capable of talking about their experiences. The participants' medical reports were checked to ensure they are not suffering from acute psychosis, intense depression or bipolar disorder. Patients who had anti-social behaviour and those who were not able to complete the interview process were excluded.

Enough time was allocated for establishing an appropriate relationship between participants and researchers. The interviews were conducted at the Nour Hospital, in a calm and suitable environment. Consent was taken prior to taking before commencing interviews. An interview check list was used to guide the interview process. The interview time ranged from 30 to 70 minutes each. They were recorded and transcribed verbatim. Conversations were recorded to ensure that emotionally-charged words and sentences could be distinguished and set apart by highlighting them in the text. To make ensure of the authenticity of the data and the validity of the results, data was presented to the participants and necessary corrections were made. Research team participated in all activities to enhance reliability. The data was analyzed according to Coaizzi's seven-stage method (15), a method especially suitable for phenomenological studies. First, the texts were carefully read to obtain a complete and comprehensive understanding of the ideas, experiences, and opinions of the participants. Then, words and sentences relevant to suicide prevention were noted. In the third stage, the researchers spelled out the meanings of each significant sentence by categorizing them into groups. The following narrative provides an example of how a code called "disability in doing daily routines" is extracted from an interview:

When I realized I can't read like before, I was disappointed. I couldn't do anything, even things like speaking. I couldn't talk like before. I was a talkative person - you know-, but not now. I could be very successful in sports…. I was a member of…. (Interview No. 1).

In the next stage, after combining repetitive codes and developing new categories, 667 codes were extracted in terms of clusters of topics. These clusters are referred to as descriptive codes (sub-concepts of the third level) or codes close to the actual terms used by the participants. Descriptive codes provided a detailed and exhaustive description of the phenomenon in the four categories around which the research revolves. From these codes, a new set of codes were generated; referred to as interpretive codes (or sub-concepts of the second level) which include the meaning and interpretation of previous codes. Overall, descriptive codes were reduced to 36 interpretative codes (12 codes attentive to attempted suicide and 24 codes attentive to

suicide prevention). Finally, and for explanatory purposes, interpretative codes were reduced into 8 explanatory codes (or sub-concepts of the first level) to summarize and explain the coding process. The resulting structure is constituted of two categories: (1) contexts of attempted suicide and (2) context of suicide prevention. By combining all codes, four fundamental constructs were generated. A final evaluation and validation was achieved by returning to participants and asking about the findings.

Results

The youngest and the oldest were 16 and 50 years of age, respectively. Four participants were women, while eight were men. Educational levels ranged from associate degree, to below high-school diploma. Five participants were married, six were single and one was divorced. The majority of the participants were unemployed. The least suicide attempts were two and the most were four. The majority of the participants were not drug abusers. The common methods used to commit suicide included drug overdose, hanging, gas poisoning, cutting vein and jumping. Participants who took an overdose were provided by buying their drugs personally from drug stores. A few of the participants decided on their suicide method by watching movies and gleaning information provided by media or books. One of the participants, for example, decided on his suicide method as follows:

…. I read this book about the story of that important guy whose wrist vein was cut in the bathroom… I learned from that…. (Interview No.12)

Figure 1 shows conceptual levels (interpretative and explanatory codes) of contexts of suicide attempts. Most of the participants committed their suicide within the family contexts, and personal and socio-economic contexts. The main interpretative codes were constituted by family problems.

Figure 2 shows contexts of suicide prevention. Contexts of suicide prevention are categorized in five explanatory codes including 'self-caring', 'medical care', 'psychological care and consulting', 'social interactions affected to suicide prevention' and 'socio-economic contexts'. Each explanatory code is derivative from different interpretative codes.

Figure 3 shows the inter-relationship between contexts of suicide attempts and contexts of suicide prevention. It should be noted that the experience comes from the combination of explanatory codes attentive to suicide attempt and suicide prevention, constituting four fundamental constructs of structural, personal, and caring factors as well as social networks.

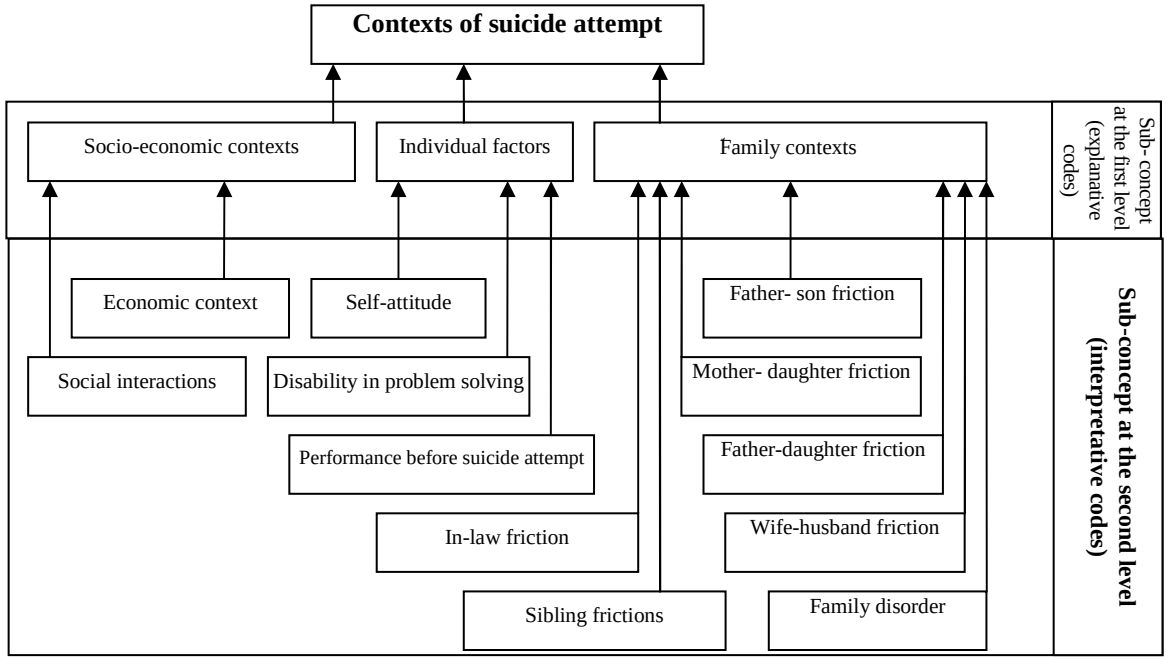

Figure 1. Conceptual levels (interpretative and explanative codes) of contexts of suicide attempt

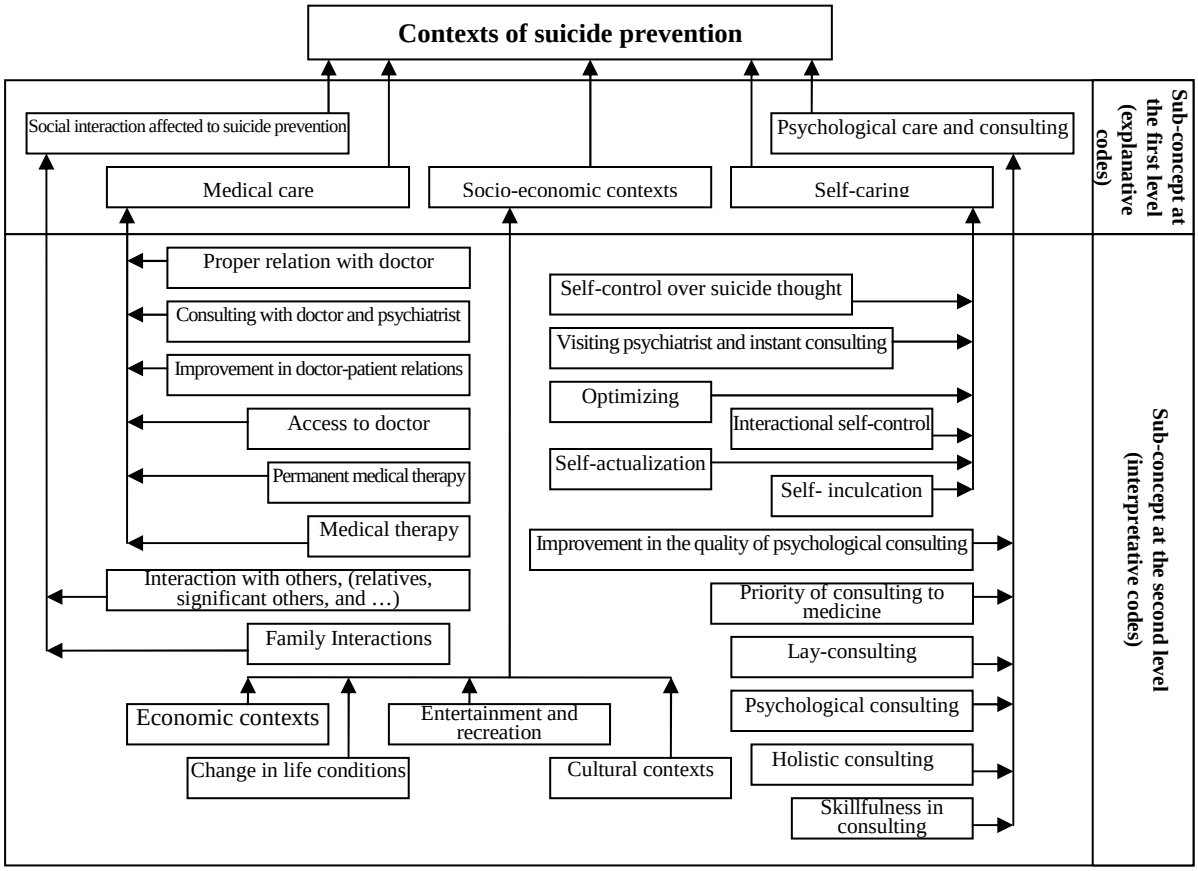

Figure 2. Conceptual levels (interpretative and explanatory codes) of context of suicide prevention

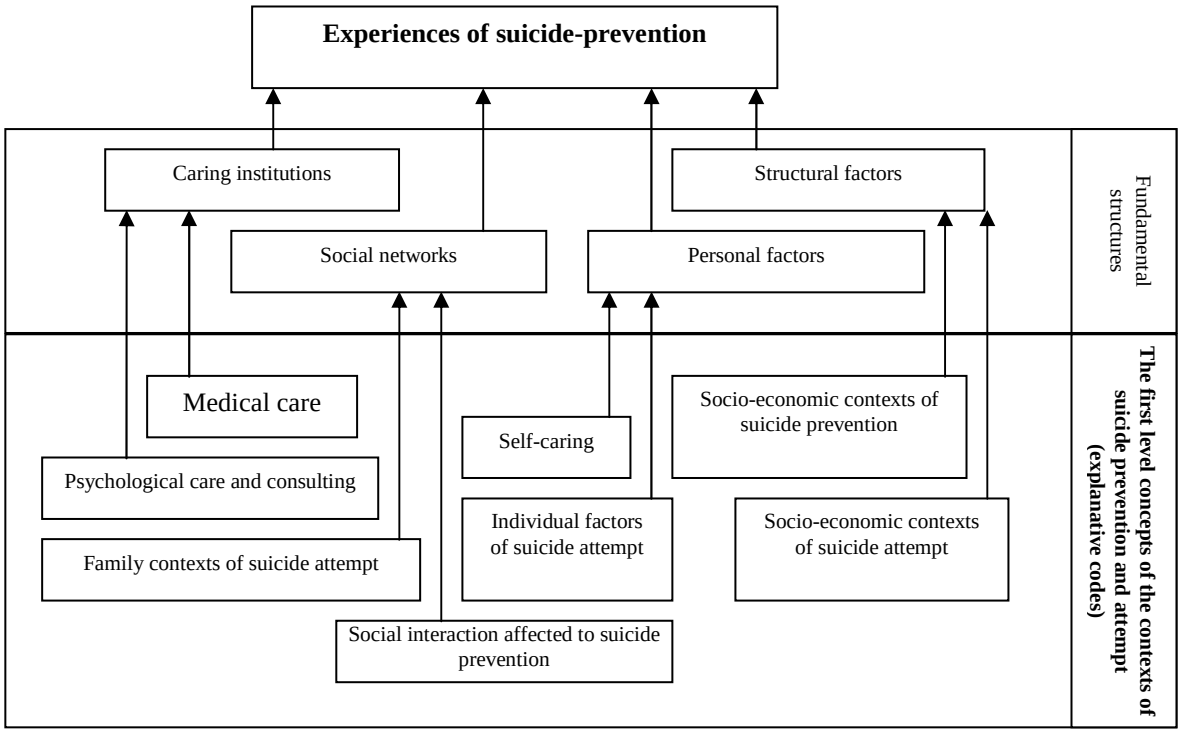

Figure 3. Interrelationship between suicide attempts and suicide prevention

Structural factors

Abstract concepts in the context of suicide attempt that are generated from themes in the interviews include low economic situation and societal anomies. The internal interplay of these two factors is of curial importance. Inadequate economic situation stems from unemployment, financial problems and lack of proper housing situation. One of the participants explains:

I am jobless now. I worked in the city council for one year. I had a job there. I went to free market; one day you could get the job, one day you couldn't. Then I went. … They said bring a recommendation letter. When I brought one, I was told the job was given to someone else… (Interview No. 8).

Participants also complained about lack of welfare, entertainment and happiness in the society and considered these elements as contributing to suicidal thoughts prevention. One of the participants says in this regard:

If you are happy you don't want to do this (suicide attempt). I feel OK only when I am happy (Interview No.2)

Participants also think religious practices, faith and beliefs are decisive in suicide prevention. One participant observed:

I feel relieved when I pray (Interview No.11).

Social Network

One of the most important factors causing suicide attempt in this study lies within the family context. Family problems are mainly crystallized in the conflicts and frictions among family members (father-son frictions, daughter-mother frictions, and husband-wife frictions). Disorder in family is also visible in some of these cases. This concept is derivative from sub-concepts of low family low literacy level, disturbed family, aggressive family behaviour and family pressures on individual.

According to the participants, emotional and instrumental family support, attention to family interaction, intimate friends, social contacts, friends support and encouragement, and fulfilment of individual expectations are all effective factors in suicide prevention. One of the participants stated:

I only expect my family to be a little more appreciative of its children; not only me, but my other sisters as well (Interview No. 9).

Some of the participants also stressed on their harmful social relations within family, mentioning divorce as an escaping window from suicide attempt. One participant believes:

I think if troubled couples get divorced early in their marriage… this (i.e. suicide attempt) wouldn't happen (Interview No. 11).

Caring institutions

As it is clear in figure 2, caring institutions are composed of two interpretative codes: medical care and counselling and psychological care. Participants mention improvement in the quality of psychological consulting and doctor-patient relationship, and access to their doctor as can be decisive in suicide prevention. One of the participants says:

If one finds a good doctor with whom he can talk friendly, it is much better than talking with an inflexible and cold person (Interview No. 9).

According to the participants, follow- up with suicide prevention therapy is important. Some of them believe follow- up therapy is not exclusively related to caring institutions, but rather, families should also be educated to functions of caring institutions, including permanent therapy via medicine, and methods of adjustment with acute conditions and crisis. One of the participants reported:

I have been visiting a doctor for three years…. His time is very short but he always says nice things to me which make me relaxed (Interview No. 1).

Participants also emphasize 'holistic counselling' which includes focusing on a complex set of factors, and not just specific problems affecting suicide attempt. One of the participants observes:

Counselling was very good. I was hopeful that my husband also joins me; so that his behaviour would change a little. But unfortunately he didn't (Interview No. 6).

Some of the participants mentioned lay consulting, (e.g. consulting with close friends, family members or authoritative persons) is useful in suicide prevention.

Personal factors

Participants mentioned various experiences regarding personal resistance against suicide.

For example, throw away suicidal thoughts by throwing away negative thinking, delay in the moment of decision, and focus on alternative ways. Interaction with others is crucially significant; as participants believe self-control in the moment of suicide attempt can be achieved by asking for other's reaching out for help, contacting others and telling them about the situation. Likewise, inattention to stressful environmental conditions is another practical strategy in suicide prevention. One of the participants explains:

My experience!? If the relation with your family is good, if you could talk with them and release yourself of the negative thoughts, or ask for their help, then you don't get to this point (Interview No. 12).

Finally, some of the participants mentioned strategies to cope with the ever-increasing disability and weakness, distrust and isolation. These include trusting their learning abilities, and learning positive daily life skills such as how to work, study, or exercise. Participants believe self-inculcation and positive ideas about life (e.g. life is valuable, beautiful, full of love, relaxation and hope) can improve suicide-prevention strategies.

Discussion

The purpose of this study was to investigate the experiences of suicide prevention based on recurrent suicide attempters. Furthermore, this study was designed to explore the factors contributing to suicide attempt and strategies relevant to suicide prevention.

The data suggests four fundamental construct composed of a combination of experiences regarding suicide attempt and suicide prevention. The constructs are structural factors, personal factors, social networks, and caring institutions.

1. Structural factors are related to social institutions. The individuals faced with these institutions are either passive or have little power to make an influence. These factors stem from society's socio-economic and cultural conditions. Based on the findings, the following can be suggested as decisive in suicide prevention:

- Improvement and change in society's socio-economic well-being,
- Improvement in economic system and employment, regarding income of high-risk individuals,
- Attention to cultural spheres (e.g. religion and beliefs, especially how values could be beneficial to cope with precarious conditions),
- Provisions for entertainment and recreational environments,
- Attention to public education and cultural norms (e.g. abstaining from blaming individuals for their faults and mistakes),
- Using proper strategies for drug-control,
- Controlling media and educational materials and avoid teaching people about suicide methods.

2. Social networks, according to definition are the web of social relationships surrounding an individual (16) including close relationships with family members, relatives, neighbours, friends and community. The data shows that social interactions can be both facilitator and preventative, depending on the situation. The following can be suggested to affect suicide prevention:

- Stay in contact with high-risk individual, by friends, relatives and those who individual cares for them,
- Attention to high-risk individual's expectations and demands,
- Attention to mental and physical needs of the high-risk individual,
- Emotional and instrumental support by parents,
- Emotional and instrumental support by partners at crucial moments,
- Positive and constructive interactions within family network,
- Control and eliminate harmful relationships within family and with relatives,
- Emotional dependence to family members (Children-parents) is especially important in suicide prevention,
- Insistence to continue marriage in some disordered families increases the possibility of suicide attempt. Therefore, if the relationship cannot be repaired, divorce can modify the situation.

3. Caring institutions, formally and informally, should take care of the high-risk individuals.

With respect to these findings, which emphasize the medical as well as consulting and psychological caring methods, the following can be suggested to prevent from suicidal thoughts:

- Access to physician, psychiatrist and other care-related specialists at crucial moments,
- Improvement in the quality of the relationship between high-risk individuals and their physician,
- Using and insisting in drug therapy,
- Attention to utilizing psychological consultants on a continuing basis,
- Sometimes priority should be given to psychological consultation over drug therapy,
- Improvement in the quality of the psychological consultation,
- Holiness attitude and skilfulness in psychological consultation,
- Using lay consultants.

4. Personal factors are psychological characteristics attentive to both suicide attempt and suicide prevention. Following, can be suggested as decisive methods, in personal dimension:

- Self-control over suicide thoughts,
- Refer to physician and instant consultation,
- Interactional self-control,
- Self-inculcation,
- Self-entertainment,
- Self-actualization,
- Optimizing.

Findings at the structural level, including socio-economic and cultural factors, are consistent with other studies (16-19). Also, findings related to strategies controlling suicide methods are congruent with the studies in industrialized societies (20). Findings related to social networks are indicative of the fact that the most important factor in suicide attempt is harmful family relationships - a fact also confirmed by the previous studies in Iran (20-23). Findings on suicide-prevention strategies (e.g. establishing contact with others and attention to high-risk individuals' expectations and demands) are to some extend congruent with strategies offered by other researches for other societies (24). Findings with respect to the fact that marriage, having children and good relations with relatives could to some extend be supportive of suicide prevention, is compatible with other studies (25). However, divorce as a suicide-prevention strategy is not mentioned in previous studies.

Findings also indicate that caring institutions could prevent from suicide attempts by providing emergency admission to high-risk individuals. This confirms other studies and strategies suggested by other societies (24-26). In this respect, data related to follow -up experience is compatible with the literature on suicide- prevention strategies. Data emphasizes the improvement in the quality of the specialized consultation. The importance of a qualified counsellor in suicide prevention has been emphasized by other studies (20). Lay counselling, as well, has been suggested as a preventative strategy (24).

With respect to individual factors, findings are compatible with other studies which examined how to repel suicidal thoughts (24), how to be interactionally self-controlled, how to be self-actualizer (27), how to be optimized, how to evolve inculcation, empowerment, self-trust and even controlling of daily routines to reduce suicidal feelings (28).

In sum, it should be apparent that findings of this study have similarities with those of other studies, but there are also some differences. This is a qualitative study concentrated on the general situation. As such, it considers a complex mixture of personal, social and cultural factors differing from quantitative studies where concentration is mainly based on personal factors and caring methods. This study may indeed be similar to Coggon's study (9) based on focus groups, which introduced strategies for youth suicide prevention.

This study can function as an important tool for suicide-prevention strategies, taking into consideration the fact that in Iran, research on suicide prevention is not common yet (29). The findings, we hope, could provide a possibility of planning for suicide prevention and suicide control. Meanwhile, it should contribute to the enrichment of suicide literature in Iran and other countries.

Conclusion

The main aim of this research was to understand the experiences of suicide prevention based on recurrent attempters. Understanding suicide prevention requires a holistic approach. There is no doubt that improvement of individual health is a significant factor in suicide prevention. However, the main contexts of suicide attempts are familial, social, and economic contexts. It is suggested that suicide prevention needs to focus on the structural factors and planning to improve national and local factors.

Limitation of the study:

We would like to extend our gratitude to all the interviewees who kindly agreed to share their experiences, feelings, attitudes, and information with us. This project was founded by the Health Humanities Research Center (HHRC) and Behavioural Sciences Research Center (BSRC) affiliated to Isfahan University of Medical Sciences.

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