VILNIUS UNIVERSITY

Jolanta
LATAKIENĖ

Feasibility of applying Attempted Suicide Short Intervention Program (ASSIP) in Lithuania: Patients' perspective

SUMMARY OF DOCTORAL DISSERTATION

Social sciences,
Psychology (S 006)

VILNIUS 2020

This dissertation was written between 2015 and 2019 at Vilnius University. The research was supported by the Research Council of Lithuania.

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This doctoral dissertation will be defended in a public/closed meeting of the Dissertation Defence Panel:
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The dissertation shall be defended at a public meeting of the Dissertation Defence Panel at 12PM on 18th September 2020 in meeting room 201 of the Faculty of Philosophy, Vilnius University. Address: Universiteto str. 9/1, LT-01513, Room No. 201, Vilnius, Lithuania

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VILNIAUS UNIVERSITETAS

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LATAKIENĖ

Trumpalaikės bandymo nusižudyti intervencijos programos (ASSIP) tinkamumas taikyti Lietuvoje: pacientų perspektyva

DAKTARO DISERTACIJOS SANTRAUKA

Socialiniai mokslai,
Psichologija (S 006)

VILNIUS 2020

Disertacija rengta 2015 – 2019 metais Vilniaus universitete.
Mokslinius tyrimus rėmė Lietuvos mokslo taryba.

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Disertacija ginama viešame Gynimo tarybos posėdyje 2020 m. rugsėjo mėn. 20 d. 12 val. Vilniaus universiteto Filosofijos fakulteto 201 auditorijoje. Adresas: Universiteto g. 9/1, Vilnius, Lietuva).

Disertaciją galima peržiūrėti Vilniaus universisteo ibliotekoje ir VU interneto svetainėje adresu: *https://www.vu.lt/naujienos/ivykiu-kalendorius*

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1. REVIEW OF THE LITERATURE

1.1. Theoretical concept and definition of suicide attempt

Suicide still remains a great problem in Lithuania: although suicide rates have been declining slightly in recent years, i. e. 28.7 suicides per 100 thousand inhabitants in 2016, 26.4 in 2017, 24.4 in 2018 (Institute of Hygiene, Health Information Center, 2018-2019), Lithuania remains among the five countries in the world with the highest suicide rates (2016 data, WHO, 2019) and leads in Europe according to this rate (2015 data, Eurostat, 2019).

In addition, many more people attempt suicide or engage in self-harm. Although the exact extent of such behavior is difficult to estimate due to the many challenges with registration, various authors estimate that one suicide accounts for approximately 20-30 suicide attempts (Goldsmith, Pellmar, Kleinman, & Bunney, 2002; Zalsman et al., 2016). The suffering of these people is not reflected in the suicide statistics, but is nonetheless real. In this context, it is particularly important that many scholars researching suicide have found that a previous suicide attempt predicts further suicidal behavior (Beghi, Rosenbaum, Cerri, & Cornaggia, 2013; Rogers, 2001). By researching those who have attempted suicide, we can both better understand the triggers for further attempts and look for effective interventions.

Van Heeringen, Hawton, and Williams (2000) once argued that suicide is a complex phenomenon arising from the interplay of social, psychological, and biological factors, so it is important to strive for an integrated model of suicidal behavior. However, not everything is as simple as one would like – Knizek and Hjelmeland (2007) recall that suicidology, from the perspective of science theory, is a particularly problematic field that does not have the usual feature of other disciplines – a comprehensive and unifying paradigm. As a result, the

authors propose to consider suicidology not as an independent branch of science but as an interdisciplinary field in which theories and models inevitably have to originate from different sciences and to deal with the related problems of terminological diversity (Knizek & Hjelmeland, 2007).

Suicidologists are still intensely debating whether suicide and suicide attempt are identical phenomena or whether there are significant differences (Silverman, Berman, Sanddal, O'Carroll & Joiner, 2007; Van Orden, Merrill & Joiner, 2005). There is currently no general agreement among suicidologists on what is meant by „suicide" or „suicide attempt", so many different terms are used, which leads to miscommunication and misunderstandings (Silverman et al., 2007a). Although there are discussions in suicidology about different conceptual interpretations of various forms of suicidal behavior – suicidal thoughts, suicide attempts and suicides – a review of theoretical models of suicidal behavior suggests that psychologists tend to exaggerate this distinctions. Joiner (2005) and O'Connor & Kirtley (2018), while arguing that there are fundamental differences between these different forms of suicidal behavior, only elaborate on the difference between suicidal thoughts and actions, saying that the presence of psychological pain or the desire to die are not by themselves sufficient to enact lethal self-injury, but that moderating factors such as acquired capability to commit suicide and others are also needed. Thus, the research data and the authors' views are still ambiguous.

There have been a number of attempts to classify various forms of suicidal behavior, one of the most widely recognized was made in 1996 by O'Carroll et al. They published a nomenclature which categorized suicidal behaviors according to three criteria: intent to die, signs and consequences of self-harm (no-injury, injury, death) (Silverman et al., 2007a). However, the main disadvantage of all similar classifications is that they have not become generally accepted, so Silverman et al. (2007a) attempted to develop a new, simpler nomenclature that would not be related to the concepts used in one

theory or another. **Intent** has become an integral, essential element of this new nomenclature, and it refers to the goal of behavior (Silverman et al., 2007a). According to the authors, intent should be understood as a conscious wish or desire to leave or escape from life, although this does not necessarily mean that a person has analyzed the actual lethality of chosen means. Silverman et al. (2007a) argue that while it is often not easy to measure and determine intent to die, without such a knowledge it is fundamentally impossible to distinguish between different forms of suicidal or other self-harming behavior. The authors suggest distinguishing self-harm, which aims to change one's environment or one's state, from suicide attempt, which is intended to remove oneself from the environment (Silverman et al., 2007a).

Summing up, in the nomenclature developed by Silverman et al. (2007b) all instances of suicidal behavior are divided according to two criteria – intent to die (none, undetermined, some) and outcomes (no injuries, non-fatal injuries, death). These authors define a ***suicide attempt*** as a „self-inflicted, potentially injurious behavior with a nonfatal outcome for which there is evidence (either explicit or implicit) of intent to die" (Silverman et al., 2007b, p. 273). This study also adopts this definition of suicide attempt, whereas the wide range of phenomena including suicidal ideation, self-harm, suicide attempt and suicide, is covered by the umbrella term *suicidal behavior*.

1.2. Problems in providing suicide attempt healthcare

One of the important links in suicide prevention is providing care to the highest risk groups. Several previous studies have revealed that providing appropriate specialized healthcare after a suicide attempt can reduce the likelihood of a repeated suicide attempt (Brown et al., 2005; Fleischmann et al., 2008; Gysin-Maillart, Schwab, Soravia, Megert, & Michel, 2016; Rudd et al., 2015). However, further scientific investigation is still required to determine how these interventions work and what factors make them effective (Rudd et al., 2015; Jobes, 2012; Calati & Courtet, 2016; Brown & Green, 2014). In

addition, the practical application of research results may not be as simple as it seems – e. g., a study conducted in Lithuania on the reasons for refusing care after a suicide attempt (Dadašev, Skruibis, Gailienė, Latakienė and Grižas, 2016) raises the question of how to help people who rely only on themselves, do not trust others and feel stigmatized. Therefore, only a good understanding of the problems in healthcare and barriers to help-seeking that arise from a variety of sources – cultural contexts, patient characteristics and attitudes – as well as consistent research methodologies enable good choices in effective healthcare methods or systems.

1.2.1. Effectiveness of brief suicide attempt interventions

People who have attempted suicide face a higher risk of subsequent suicidal behavior (Hawton, Zall & Weatherall, 2003; Sobolewski, Richey, Kowatch, & Grupp-Phelan, 2013) and death by suicide (Crandall, Fullerton-Gleason, Aguero, & LaValley, 2006; Karasouli, Owens, Latchford, & Kelley, 2015), especially in the first months after the first suicide attempt (Cedereke & Öjehagen, 2004). Findings from the UK suggest that these patients are more likely to die from other causes as well, especially if they are treated in a psychiatric hospital (Kapur et al., 2015). It is important to note that psychiatric care for certain groups of patients (i. e. men, patients of 65 years and older, and people who have previously self-harmed) has been beneficial and has reduced the risk of death (Kapur et al., 2015). However, the experiences of those discharged from a psychiatric hospital suggest that in order to reduce the risk of subsequent self-harm and suicide, it is essential to work collaboratively with the patient while deciding on their discharge and to provide adequate assistance in dealing with difficulties they faced both before they were admitted to the hospital and the ones arising post-discharge (Owen-Smith et al., 2014).

Based on these results, researchers are encouraging emergency hospitals to conduct a thorough assessment of the history of suicidal behavior and to provide special emergency interventions to such

patients. However, it seems that there is a lack of consensus on what kind of healthcare is the most effective.

One of the reasons why such a consistent view of aid for suicide attempts is still not achieved may be the problems of intervention research. Three groups of problems might be distinguished (a more detailed review is presented elsewhere: Latakienė, 2017):

1) **methodological problems** – research strategies are extremely heterogeneous, which raises issues of validity. Methods and objectives of interventions include maintaining communication, suicide risk assessment, motivation to continue treatment, psychoeducation, psychological counseling, or psychotherapy. Respondent samples also vary: people after a suicide attempt, psychiatric hospital patients, or general population with higher suicidality and depression. The duration of interventions ranges from 4 weeks to 24 months after a suicide attempt. In addition, it is extremely rare to gather participants' feedback on their satisfaction with the care received or its benefits, while most studies only consider the numbers of subsequent suicides or suicide attempts;
2) **not the most suitable populations are studied** – the research is mainly conducted in countries with low suicide rates and well-developed healthcare systems (Lopez-Castroman, Blasco-Fontecilla, Courtet, Baca-Garcia & Oquendo 2015), such as the USA, Canada, the United Kingdom, Sweden, Norway and the Netherlands. Most studies have been performed in countries where follow-up care after a suicide attempt (e.g. psychiatrist, psychologist, or referral to a GP) is routine in the healthcare system (Cedereke, Monti, & Öjehagen, 2002; Vaiva et al., 2006; Cebria et al., 2013; Bennewith et al., 2014 et al.). Only one study conducted in resource-constrained countries was found – Fleischmann et al. (2008) research included China, India, Iran, Brazil, and Sri Lanka. However, it was carried out as a part of the WHO research SUPRE-MISS. It therefore remains unclear to what extent these interventions were only part of the study and if they subsequently continued to be integrated into the routine healthcare practices;

3) **extremely contradictory results** – interventions applied under similar conditions and methods turn out to be sufficiently effective in some of the research, while elsewhere it is deemed ineffective. Researchers point to different reasons for such results, which often remain unclear. Research reviews suggest that supportive letters, a card with emergency contacts, or case management of a suicide intervention in long-term care helps to reduce the number of subsequent suicides (Mann et al., 2005). Less effective interventions include telephone conversations, intensive psychosocial support, and a combination of psychoeducation with family therapy (Mann et al., 2005). However, the later study by Vaiva et al. (2006) revealed a positive effect of a telephone conversation 1 month after a suicide attempt, and Fleischmann et al. (2008) study found that the combination of an information session and telephone contacts also reduces the likelihood of subsequent suicide. However, similar interventions in Taiwan have not helped to reduce subsequent suicide attempts and suicides (Wang, Wu, & Chen, 2015). Also, letters of support for patients discharged from a psychiatric hospital may be helpful if they are admitted to the hospital for the first time or receive little follow-up care after discharge (Bennewith et al., 2014). Indirect patient feedback on care received is also highly controversial, with some preferring to receive postcards less frequently as they received sufficient support after the discharge from a psychiatric hospital (Bennewith et al., 2014), while others were very happy not to be forgotten (Motto & Bostrom, 2001), yet others enjoyed short-term psychotherapy (Guthrie et al., 2001).

In summary, there does not yet appear to be sufficient empirical data to provide an unambiguous answer as to which psychological interventions are most effective after a suicide attempt (O'Neil et al., 2012; Mann et al., 2005). While some studies on short-term psychological interventions after a suicide attempt are successful, their results deserve careful interpretation due to the methodological difficulties of these studies (Brown & Green, 2014; O'Neil et al.,

2012). It is important to strengthen the methodological aspects of research, starting with the use of valid and reliable assessment methods, developing new methods to more accurately assess suicidal behavior over time, controlling investigator bias, and finally finding ways to retain participants and monitor long-term effects and outcomes (Brown & Green, 2014). Brown and Green (2014) also identify the examination of new, cost-effective methods in various populations and situations as the most important directions of further research. Finally, research on interventions in countries with high suicide rates and limited healthcare system resources could also help to achieve more consistent research results.

1.2.2. Benefits of short-term psychotherapy

Before discussing specific options for psychotherapy in detail, it is important to consider one of the biggest challenges in providing effective care: non-compliance with the treatment plan. Studies show that adolescents often have difficulty adhering to a treatment plan after a suicide attempt (Sobolewski et al., 2013; Renaud et al., 2009), and adults who refuse further treatment after an ER are more likely to die by suicide within a year (Pavarin et al., 2014). Thus, measures to increase motivation for continued treatment or being proactive in offering healthcare become particularly significant in order to reduce the number of repeated suicide attempts or suicides. Gysin-Maillart et al. (2016) emphasize that one of the reasons for the low level of collaboration may be that suicidal patients feel misunderstood by healthcare professionals who perceive suicide as a mental disorder according to the biomedical model. Patients themselves consider their personal experience of pain, suffering, despair, loss of self-esteem to be the most important element in a suicidal crisis – so it is important not to forget a person's ability to create a narrative, explain their experiences related to self-harm (Gysin-Maillart et al., 2016). Relatively simple organizational means, such as a phone call 4 and 8 months after the suicide attempt to encourage the patient to continue

or start treatment (Cedereke et al., 2002), agreeing on a specific appointment date instead of giving some general contacts, ensuring continuity of care by visiting the same doctor who admitted them to the ER department (Möller, 1989) might be beneficial in increasing motivation for treatment continuity. To sum up, it is sometimes concluded that there is no significant difference in the way to offer care or support to a person after a suicide attempt, the most important thing is to do so proactively (Vaiva et al., 2011).

Further two options for short-term standardized psychotherapy after a suicide attempt are ASSIP (Attempted Suicide Short Intervention Program) and specialized cognitive behavioral therapy (CBT).

ASSIP (Attempted Suicide Short Intervention Program) is a short-term, three to four session psychotherapeutic approach for suicide attempts that focuses on building an early therapeutic alliance combined with psychoeducation, cognitive case conceptualization, safety planning, and ongoing outreach (Gysin-Maillart et al., 2016). This intervention is a complementary method to the usual suicide attempt healthcare. Empirical studies support the efficacy of this method: patients in the ASSIP group had an 18.4% lower probability of at least one suicide attempt in 24 months than the control group, and a survival analysis showed an 83% lower risk of further suicide attempts (Gysin-Maillart et al., 2016). Important to note, this method is not intended to reduce the frequency or intensity of suicidal ideation – the authors emphasize that the purpose of the method is to help people understand what drives their suicidal thoughts and actions and to initiate safety strategies in advance. During the sessions ASSIP therapists mention that suicidal crises are likely to recur in the future, they can be triggered by life events at any time (Gysin-Maillart et al., 2016). The researchers believe that it is this narrowing down and concretization of the therapeutic goal that is one of the important factors in ASSIP's effectiveness along with patient-oriented, collaborative approach. Ongoing contact by letters can maintain a sense of connection with the therapist and serve as a reminder to the

patient that their suicidality has not gone away, therefore security strategy, observing stressful events is an important part of their life (Gysin-Maillart et al., 2016).

Application of cognitive behavioral therapy (CBT) to reduce suicide also has an empirical basis. A study by Brown et al. (2005) found that participants who attended at least 10 cognitive therapy (CT) sessions with an emphasis on security planning for future suicidal crises had a 50% lower risk of subsequent suicide attempt and a lower number of repeated suicide attempts than control group in 18 months after the first suicide attempt. Importantly, in this study psychotherapy was combined with case management: patients who did not attend counseling were contacted and efforts were made to ensure adherence to their treatment plan (Brown et al., 2005). Similar results were obtained by offering short-term, 12 to 16-session CBT to soldiers with suicidal ideation or after suicide attempts – a 60% lower risk of suicide attempt at 24 months compared with controls was reported (Rudd et al., 2015).

In summary, specialized short-term psychotherapy options such as ASSIP or CBT emphasizing safety planning appear to be useful and effective in helping people after a suicide attempt. Importantly, both of the psychotherapeutic methods discussed proactively seek to maintain collaborative contact with the patient in order to reduce the likelihood of their withdrawal from treatment. Both in short-term psychotherapy and in more general brief psychological interventions, the provider's active attempt to establish and maintain contact with the person who attempted suicide is likely to be one of the most important factors in helping that person return to a normal life.

1.2.3. Importance of qualitative research and a collaborative approach

Quantitative studies that have prevailed in suicidology for a long time are not suitable for understanding the experiences of a particular person attempting suicide, and may sometimes not be relevant at all

(e.g., Crocker, Clare, & Evans, 2006). Some researchers (Rogers, 2001; Aldrich & Cerel, 2009) take a categorical position stating that we have a good understanding of the diversity of risk factors of suicidal behavior, but do not know how these factors interact and do not have a scientific basis for proper communication with people in suicidal states. Moreover, the attempt *to explain* suicidal behavior as combination of measurable factors, which is common in the quantitative approach, has led suicidology as a field of science to a place where the same studies are often repeated, but the field itself has almost stopped moving forward altogether (Hjelmeland & Knizek, 2010). It is important to seek *to understand* suicidal behavior through more qualitative research, to see the different contexts of such behavior, to develop complex models, rather than to look for linear causality that is not inherent in human behavior.

It is important to note that this situation has started to change recently, and the publication of several studies based on a qualitative research strategy provides valuable insights into how strict gender norms can contribute to increased male suicide (Andoh-Arthur, Knizek, Osafo, & Hjelmeland, 2018; Knizek & Hjelmeland, 2018), the importance of the spiritual / religious dimension in the experiences of the Ghanaian suicide attempt (Akotia, Knizek, Kinyada & Hjelmeland, 2014), the peculiarities of the recovery process after a suicide attempt (Chan, Kirkpatrick, & Brasch, 2017) and how over-compliance with formal requirements and the lack of direct contact with patients may pose challenges for therapists in establishing alliance with a suicidal patient (Hagen, Hjelmeland, & Knizek, 2018).

Thus, qualitative research provides an opportunity to better understand the experience of patients receiving healthcare. It is well known both theoretically and empirically that the therapeutic alliance is one of the most important determinants of the effectiveness of psychotherapy (Fluckiger, Del Re, Wampold, Symons & Horvath, 2011). The importance of trust, respect, and empathy in a relationship with a health professional after a suicide attempt is also based on the results of various studies (Kirkpatrick, Brasch, Chan & Kang, 2017;

McKay & Shand, 2018; Montross Thomas, Palinkas, Meier, Iglewicz, Kirkland & Zisook, 2014; Hagen, Knizek & Hjelmeland, 2018). When a patient feels a lack of human connection, empathic closeness, or understanding of their emotional experiences, the health professional can be perceived as contributing to loneliness, frustration, and stigmatization experiences (Ghio, Zanelli, Gotelli, Rossi, Natta & Gabrielli, 2010). Patients may also feel that health professionals are more concerned about the assessment of the lethality of suicide attempt or the current risk of suicide, which is usually a clinician's priority. Such an attitude often becomes an obstacle for the patient to open up about their pain and despair (Rogers & Soyka, 2004; Gysin-Maillart et al., 2016). It is therefore important to maintain a collaborative approach in providing healthcare so that we do not consider the patient as powerless. In such a relationship, the person who attempted suicide becomes an expert of their own experience. Rogers and Soyka (2004) in their existential-constructivist approach to suicide also point out that health professionals should first focus on listening to what the patient wants to say, rather than making their own assumptions or assessments. Recommendations for treatment improvement as listed by patients themselves also often include improving the listening and understanding skills of health professionals (Montross Thomas et al., 2014). Engaging in collaborative efforts can enable the patient to begin to change their lives and gain a deeper understanding of themselves, and thus seek alternative solutions to problems during a crisis. In addition, a positive experience of receiving care in the healthcare system after a suicide attempt may even lead to a subsequent help-seeking (McKay & Shand, 2018). However, it is not clear whether empathy and respect are sufficient for the help received to be effective at preventing subsequent suicide attempts (both as perceived by the patients themselves and as indicated by research), or whether the relationship with the specialist should also reflect different, complementary characteristics.

1.3. Research problem, aim and objectives

Given the higher risk of subsequent deaths by suicide after suicide attempts (Cedereke & Öjehagen, 2004; Crandall et al., 2006; Karasouli et al., 2015; Sobolewski et al., 2013), various healthcare approaches after suicide attempt are implemented. However, there is still a lack of reliable empirical data on the effectiveness of suicide attempt interventions (Brown & Green, 2014; Mann et al., 2005; O'Neil et al., 2012), the research already conducted contains methodological problems and the results are often contradictory for reasons that are not entirely clear (e.g., Mann et al., 2005). At the same time, only a small number of studies asked for feedback or evaluation of patients' own satisfaction with the healthcare received. Since the prevailing research strategy is quantitative, only the numbers of subsequent deaths by suicide or suicide attempts are measured, which limits the possibility of delving into the experience of healthcare and understanding its processes and obstacles. In order to reveal these aspects in detail, qualitative research becomes useful.

The context of intervention research poses particular challenges too: research is conducted mainly in countries with low suicide rates and well-developed healthcare systems (Lopez-Castroman et al., 2015; Cedereke et al., 2002; Vaiva et al., 2006; Cebria et al., 2013; Bennewith et al., 2014, etc.). Moreover, it is unclear to what extent the interventions are being continued after the study and whether their results are put into practice. In this study, based on the directions for suicide attempt intervention research proposed by Brown and Green (2014), we chose to investigate the experience of ASSIP program for several reasons: 1) cost-effective – only 3-4 sessions, continuing contact maintained by e-mails; 2) applied in practice since 2016 in Vilnius, Lithuania; 3) effective – the study of the intervention authors revealed a 80% lower risk of a subsequent suicide attempt in 2 years compared to patients who did not participate in the intervention (Gysin-Maillart et al., 2016). Still, both the intervention itself and the study of its effectiveness were conducted in Switzerland, where 10.7

suicides occur per 100,000 inhabitants (data of 2015), so we assume that the application of this intervention, and possibly also the peculiarities of its operation in Lithuania, may have different nuances. Thus, it is worth exploring whether these interventions are appropriate as well as positively evaluated by patients in countries other than those in which they were developed – with high suicide rates, less developed and highly medicalized healthcare systems (Pūras et al., 2013), and with the cultural situation less favorable to talking openly about suicides, as in Lithuania (Skruibis, Geležėlytė, & Dadašev, 2015). We believe that a mixed methods research strategy is particularly useful for revealing these features due to the wider opportunities for new insights and results to emerge.

Based on these scientific and practical arguments and challenges, we chose to conduct an **ASSIP feasibility study**. According to Bowen et al. (2009), feasibility studies help to understand whether a particular intervention is appropriate for further research and application, and to refine whether and in what ways it should be modified to be relevant and sustainable. Obviously, the suitability of a particular psychological intervention can be assessed from a wide range of scientific and practical perspectives – e. g., healthcare system resources, specific institutional structure and resource adequacy, cost-effectiveness, financial, staff and administrative competencies, patients' perspectives. In order to focus this study, we chose to explore the patients' perspective. Based on Bowen et al. (2009), we selected the following criteria for assessing the feasibility of the ASSIP program in Lithuania:

- **Acceptability** – how do program participants react to it? To what extent is it considered suitable for them, satisfying their needs and liked by them? Hereinafter, the terms "satisfaction with the healthcare / care received" and "evaluation of the healthcare / care" are used as synonyms for this criterion.
- **Limited-efficacy** – does the program achieve the desired results in the intended population, i. e. to reduce suicidality in a sample of those who attempted suicide? In feasibility studies limited-efficacy

is understood in a much more moderate way than usual in intervention efficacy or effectiveness studies – it may be a convenient sampling, assessment of interventions based on intermediate results instead of final results with a limited statistical power. Hereinafter, terms "efficacy" and "effectiveness" are used in the context of the ASSIP program and treatment as usual (TAU) as synonyms for the concept of limited-efficacy as described here.

The **aim of the study** was to evaluate the feasibility of applying Attempted Suicide Short Intervention Program (ASSIP) in Lithuania from the perspective of patients.

Research **objectives**:

1. To compare changes in suicidality and psychological state (psychological well-being, depression) of those who received TAU and TAU together with the ASSIP program.
2. To reveal the similarities and differences of the evaluation of healthcare received between the two research groups.

2. METHODS

2.1. Procedures

1. Study procedures were approved by Vilnius University's Psychological Research Ethics Committee (Permission No. 12, 2017-05-17). Participants received no payments. Permits from the authors of quantitative instruments to use Lithuanian versions in this study were obtained.
2. Hospitals and mental health centers were contacted ragarding the study. The hospital management's permission to conduct the study was obtained.
3. Selection of potential research participants was performed. The exclusion criteria consisted of self-harm with no intent to die, serious cognitive impairment, current psychotic state, and difficulties with the Lithuanian language.

4. Potential study participants were invited to take part in the study and their written consents to participate in the research were obtained.
5. Research data was collected during two measurements:
    1) the **first measurement** took place while the research participant was still in the hospital – they were given research questionnaires (including a demographic questionnaire) and information on treatment and clinical characteristics was collected. Some treatment information (exact diagnosis, medication prescribed, number of days from suicide attempt to hospitalization) was also clarified with the psychiatrist in charge of their case. The study participant was given a unique identification code in order to link the participant's data between two measurements;
    2) four weeks after the study participant's admission to the hospital, the research team member contacted the participant by phone (which they left in the informed consent form) and agrees upon a **second measurement** time during which the study questionnaire was completed for a second time and a semi-structured interview was conducted. All meetings and interviews took place in a confidential environment – usually in a private or hospital psychologist's office, in Vilnius University's interview facilities, several interviews were held at the research participant's home due to participant's limited mobility. All interviews are audio recorded and later transcribed. The duration of the interviews ranged from 25 to 76 minutes, with a mean of 45 minutes, and was conducted from 30 to 110 days after the suicide attempt (64 days on average; see Table 1).

2.2. Participants and healthcare received

A total of 19 participants (12 women and 7 men; ages 20 to 67, M = 29.8 years, std = 10.9) participated in this study, who were admitted

to a psychiatric hospital after a suicide attempt. More characteristics of the participants and their suicide attempts are presented in Table 1. All characteristics were reported during the first measurement, except for the number of days from the suicide attempt to the interview and the healthcare received, which was collected during the second measurement. The sample consisted of two study groups:

- ***Treatment as usual and ASSIP intervention group*** (N = 11; 6 women and 5 men; age 22 to 45 years, M = 28.5 years, std = 6.3; hereinafter referred to as TAU+ASSIP group) – receiving treatment after a recent suicide attempt in one of the Vilnius (capital of Lithuania) psychiatric hospitals. They received the treatment as usual prescribed by a psychiatrist and participated in a specialized Attempted Suicide Short Intervention Program (ASSIP);
- ***Treatment as usual group*** (N = 8; 6 women and 2 men; age from 20 to 67 years, M = 31.6 years, std = 14.9; hereinafter referred to as TAU group) – receiving treatment after a recent suicide attempt in one of three psychiatric hospitals in two major Lithuanian cities, receiving the treatment as usual prescribed by a psychiatrist.

Treatment as usual consisted of:

- TAU+ASSIP group: 1) medication and consultations with a psychiatrist; 2) group psychotherapy (existential or psychodynamic); 3) individual psychological counseling; 4) all patients were offered activities of their choice: relaxation, art therapy, dance / movement therapy, physical exercises, pottery, knitting, crocheting, and woodwork classes.
- TAU group: 1) medication and consultations with a psychiatrist; 2) psychological assessment; 3) consultation with a psychologist or psychotherapist if prescribed by a psychiatrist; 4) additional services of the patient's choice: physiotherapy, music therapy, art therapy classes.

Table 1. *Demographic and clinical characteristics of participants*

Characteristic	Participants' group		
	TAU + ASSIP (*n* = 11)	TAU (*n* = 8)	All (*n* = 19)
Education:			
Primary	-	1 (12.5%)	1 (5.3%)
Secondary	4 (36.4%)	3 (37.5%)	7 (36.8%)
Vocational	1 (9.1%)	1 (12.5%)	2 (10.5%)
Higher (non-university)	2 (18.2%)	2 (25%)	4 (20.1%)
University degree	4 (36.4%)	1 (12.5%)	5 (26.3%)
Marital status:			
Married	-	1 (12.5%)	1 (5.3%)
Single	8 (72.7%)	5 (62.5%)	13 (68.4%)
Divorced	3 (27.3%)	1 (12.5%)	4 (20.1%)
Residence area:			
Town	-	1 (12.5%)	1 (5.3%)
City	2 (18.2%)	3 (37.5%)	5 (26.3%)
Metropolitan	9 (81.8%)	3 (37.5%)	12 (63.2%)
Days: suicide attempt to interview			
Min	38	30	30
Max	110	74	110
M (Sd)	74.5 (20.6)	49.8 (12.7)	64.1 (21.5)
No. suicide attempts (life-time):			
One	2 (18.2%)	2 (25%)	4 (20.1%)
Two	3 (27.3%)	3 (37.5%)	6 (31.6%)
Three	2 (18.2%)	3 (37.5%)	5 (26.3%)
Four or more	4 (36.4%)	-	4 (20.1%)
In the last 6 months.:			
One	7 (63.6%)	6 (75%)	13 (68.4%)
Two	2 (18.2%)	2 (25%)	4 (20.1%)
Three	2 (18.2%)	-	2 (10.5%)
Method of last suicide attempt:			
Overdose	4 (36.4%)	4 (50%)	8 (42.1%)
Cutting	2 (18.2%)	-	2 (10.5%)
Hanging	-	2 (25%)	2 (10.5%)
Other methods	2 (18.2%)	-	2 (10.5%)
Combination of methods:	3 (27.3%)	2 (25%)	5 (26.3%)
Medication prescribed [a]*:*			
Antidepressants	10 (90.9%)	5 (62.5%)	15 (78.9%)
Antipsychotics	8 (72.7%)	4 (50%)	12 (63.2%)
Benzodiazepines	4 (36.4%)	4 (50%)	8 (42.1%)
Other	2 (18.2%)	-	2 (10.5%)
Unknown	-	1 (12.5%)	1 (5.3%)

Table 1. *(continued)*

Characteristic	Participants' group		
	TAU + ASSIP (n = 11)	TAU (n = 8)	All (n = 19)
Diagnosis (ICD-10)[b]*:*			
F32-33	8 (72.7%)	4 (50%)	12 (63.2%)
F60-61	3 (27.3%)	1 (12.5%)	4 (20.1%)
F10-19	2 (18.2%)	1 (12.5%)	3 (15.8%)
F21. F25	1 (9.1%)	2 (25%)	3 (15.8%)
F43	2 (18.2%)	-	2 (10.5%)
Unknown	-	2 (25%)	2 (10.5%)
Healthcare services received:			
Somatic hospital:			
ICU	6 (54.5%)	3 (37.5%)	9 (47.4%)
Psychosomatic ward	2 (18.2%)	-	2 (10.5%)
Psychiatric inpatient:			
Psychiatrist. medication	10 (90.9%) [c]	8 (100%)	18 (94.7%)
Psychological counseling	8 (72.7%)	5 (62.5%)	13 (68.4%)
Psychological assesment	1 (9.1%)	5 (62.5%)	6 (31.6%)
Group psychotherapy	5 (45.5%)	4 (50%)	9 (47.4%)
ASSIP program	11 (100%)	-	11 (57.9%)
Other services [d]	5 (45.5%)	4 (50%)	9 (47.4%)
After inpatient treatment:			
Psychosocial rehabilitation or daycare ward	4 (36.4%)	2 (25%)	6 (31.6%)
Psychological counseling / psychotherapy (outpatient)	4 (36.4%)	3 (37.5%)	7 (36.8%)

[a] Most study participants were prescribed multiple medications simultaneosly

[b] International Classification of Diseases (ICD-10) codes: F32-33 – major depressive disorder, single episode / recurrent; F60-61 – disorders of adult personality and behavior; F10-19 – mental and behavioral disorders due to psychoactive substance use; F21, F25 – schizotypal, schizoaffective disorders; F43 - reactions to severe stress, and adjustment disorders; Unknown - The diagnosis is unknown or participants reported being in a hospital "due to a suicide attempt".

[c] One participant in the TAU+ASSIP group received healthcare on the outpatient basis, medication was continued as previously prescribed.

[d] Physiotherapy, ocupational therapy, acitivities, relaxation, etc.

The TAU received by the study participants may have differed between groups for several reasons: 1) this healthcare was received in three different Lithuanian psychiatric hospitals, 2) the researchers did not have any influence on the treatment process and thus could not ensure uniformity of services provided. More specific differences are detailed and their possible impact on the results are taken into consideration in the Discussion.

ASSIP is a 3 to 4 sessions (60-90 min. length each, once a week) intervention followed by a subsequent regular contact by letters from the ASSIP therapist for 24 months. ASSIP is an add-on intervention to TAU, structured as follows:

- **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.

- **Semi-standardized 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). In this study the ASSIP therapists were three clinical psychologists; two of them 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.

2.3. Data collection and instruments

In this study, mixed methods were used: we combined qualitative and quantitative research data collection strategies.

The following questionnaires, which were completed during both measurements, were used to collect quantitative data on the psychological state of the participants:

- **WHO-5 Well-Being Index** (WHO, 1998) is a widely used questionnaire that measures various aspects of subjective psychological well-being over the past two weeks. The questionnaire consists of 5 statements that need to be rated on a scale from 0 (never) to 5 (all the time). The overall score may range from 0 to 25, but it is suggested to multiply the score by 4 to reflect the resulting well-being scores as a percentage ranging from 0 to 100 (Topp, Ostergaard, Sondergaard, & Bech, 2015).
- **Beck Depression Inventory-II, BDI-II** (Beck, Steer, & Brown, 1996). Designed to assess the severity of depressive symptoms in adults and adolescents over the past week, the questionnaire consists of 21 statements, which the participant is asked to evaluate on a four-point scale (from 0 to 3, where 0 means that there is no symptom, 3 – that the symptom is experienced strongly). Estimates

of all statements are added to evaluate the results obtained. The overall scale score ranges from 0 to 63 (the higher the number, the greater the tendency to depression).

- **Beck Scale for Suicidal Ideation, BSSI** (Beck & Steer, 1991). This is a questionnaire designed to assess the presence and intensity of suicidal thoughts over the past week. It consists of 21 statements that are requested to be rated on a three-point scale from 0 to 2. The overall score ranges from 0 to 42. If the first five statements are scored 0 by the participant, no further statements are requested to be rated (except for statements No. 20 and 21).
- **Suicide status form, SSF-IV** (Jobes, 2016). This form is designed to assess various elements of suicidality and is used to assess the change in these aspects while using the CAMS (Collaborative Assessment and Management of Suicidality) approach. Three of the five questions that make up Part A of the SSF Form "Key Assessment" are used in this study. The participant is asked to rate on a 5-point scale (where 1 – not experienced at all, 5 – very intense) currently experienced: psychological pain, hopelessness and general risk of suicide. We chose to use these items in particular in this study for two reasons: 1) these aspects of suicidality were not included in the other questionnaires used; 2) we assume that these elements of the suicidal state may change in a significant way within a short period of receiving healthcare.

Qualitative data was obtained during the interviews, which focused on participants' satisfaction with the care received from the healthcare provider and its quality. Furthermore, areas that needed care, as well as effective elements of the care provided were investigated. A semi-structured interview designed by the researchers of this study was used for this purpose (see Table 2).

Table 2. *The Structure of Interview Questions*

Interview questions
Opening question: During this conversation we are going to get a broader perspective on the healthcare 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 care. What healthcare service did you receive after a suicide attempt? Additional questions: 1. On every kind of healthcare received: o 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? o How much did you like this service (from 1 to 10)? What did you like and dislike about this service? o How competent was the specialist (from 1 to 10)? How would you describe your relationship with this specialist? 2. Which component of healthcare was the most helpful and why? o Please rank from most helpful to least helpful. o [About the most and least helpful] In what way does it stand out from the rest of the healthcare you received? o What needs to be changed so that healthcare would be more effective? What you would like specialists to do differently? 3. Evaluation of healthcare: o In what way is this type of mental healthcare similar to the one you have received previously? (if applicable) o In what way does this type of mental healthcare differ from the one you have received previously? ? (if applicable) o How do you generally evaluate the healthcare you received after your last suicide attempt? 4. Healthcare needs: What kind of care do you feel you require now? What kind of help is unavailable? 5. Importance of healthcare: o What is changing in your life while receiving this healthcare? o What would be different if you did not receive this healthcare? *Closing question:* We want to get a comprehensive understanding about healthcare after a suicide attempt in this study. Is there anything else we should know that has not been covered?

2.4. Data analysis

The statistical analysis program IBM SPSS Statistics 23.0 was used to process and analyze quantitative data. Data was analyzed using descriptive statistics. The analysis of questionnaire and scale scores was based on non-parametric statistical analysis criteria – comparisons between groups were performed using the Mann-Whitney U test, and the difference in estimates between the two measurements of the study was assessed by Wilcoxon test. The level of statistical significance $p < 0.05$ was chosen for the 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 re-read several times, and parts of the audio recordings were listened to once more when needed;
2) *condensing of raw information:* pieces of data that seemed relevant were paraphrased or summarized – thus creating semantic units. This way an outline of the interview was created for a more effortless further analysis;
3) *identifying preliminary themes:* in each interview, the singular semantic units are reviewed and similarities or recurring moments are sought, i. e. recurring themes are singled out. At this stage, less attention is paid to a detailed, accurate description of the theme, and more is sought to capture the diversity of recurring themes in the cases under consideration. One semantic unit can be assigned to several topics;
4) *creating a set of themes:* preliminary themes of the 5 most comprehensive interviews in both groups were joined and given concise, clear names that reflected their essence without digressing from the original data. At this stage, the smaller units of analysis that make up and describe the themes become sub-themes;

5) *applying a set of themes to the rest of the interviews*: the list of main themes created is applied to the rest of the sample, i. e. with each interview, the semantic units separated by data processing steps 1 and 2 are assigned to the appropriate main theme and / or a sub-theme. If an existing aspect of a main theme and / or sub-theme is not detected, the list of themes is updated;
6) The final result of interview data analysis is a comprehensive, clear list of main themes and sub-themes and a quantitative breakdown of the recurrence of themes in different interviews.

It is important to emphasize that this analysis of interview data is not a linear process. Steps of thematic analysis are separated out conditionally in order to define the actions taken, but the whole process is constantly reverted to previous stages, i.e. to the transcription of the interviews, highlighted semantic units or preliminary themes, thus clarifying and refining the final list of main themes and sub-themes.

The study was based on a semantic approach to the identification and interpretation of themes. Unlike the latent method of data analysis, semantic analysis formulates themes that describe rather than interpret data – the researcher does not try to see or see what lies *behind* what the participant is saying (Braun and Clarke, 2006). This study, based on the guidelines of semantic analysis, moves from data description (organizing emerging themes and repetitions in semantic content), to summarizing and interpretation, where an attempt is made to theoretically interpret the meaning of emerging themes in relation to the previous research.

3. MAIN RESULTS

3.1. Evaluation of psychological state and suicidality

To achieve the study objectives, participants in both study groups completed the questionnaire sets twice: first measurement was taken during their hospital stay and second measurement occurred after their

participation in the interview. The results of these questionnaires are summarized in Table 3.

Table 3. *Comparison of psychological state between first and second measurement and between groups*

Characteristic	Participants' group			Intergroup differences *Z; p*
	All (*n* = 19)	TAU + ASSIP (*n* = 11)	TAU (*n* = 8)	
	M (SD)			
Psychological well-being (PSO-5)				
1 measurement	30.1 (21.18)	32.73 (20.46)	26.5 (23.02)	-0.46; 0.65
2 measurement	43.58 (19.18)	44.36 (21.50)	42.5 (16.83)	
Difference *Z; p*	-3.35; **0.001**	-2.20; **0.03**	-2.53; **0.01**	
Depressiveness (BDI)				
1 measurement	29.11 (14.99)	30.55 (17.33)	27.13 (11.86)	-0.21; 0.84
2 measurement	22.42 (16.08)	21.36 (17.06)	23.88 (15.64)	
Difference *Z; p*	-2.40; **0.02**	-2.31; **0.02**	-0.93; 0.35	
Suicidal ideation (BSSI)				
1 measurement	17.79 (11.36)	20.55 (12.82)	14 (8.28)	-1.32; 0.19
2 measurement	14.21 (9.80)	13.81 (10.57)	14.63 (9.35)	
Difference *Z; p*	-1.74; 0.08	-2.14; **0.03**	-0.63; 0.53	
Suicidality (SSF)				
1 measurement	7.58 (3.58)	8.27 (3.80)	6.63 (3.25)	-0.80; 0.43
2 measurement	6.68 (3.73)	6.73 (3.50)	6.63 (4.27)	
Difference *Z; p*	-1.73; 0.08	-2.15; **0.03**	-0.11; 0.92	

Notes: *n* – number of study participants; *M* – average; *SD* – standard deviation; Intergroup differences – Mann-Whitney U test results in comparing averages between TAU+ASSIP and TAU group; Difference – Wilcoxon test results in comparing averages between 1st and 2nd measurement in both groups separately and in the whole sample. Statistically significant differences are presented in bold.

These results reveal that the differences between the groups were not statistically significant at the time of the first measurement.

Comparing the results between the two measurements, i. e. change in well-being while receiving healthcare, study participants rated their psychological well-being with statistically significantly higher scores and felt less depressed. Estimates of suicidal ideation intensity and overall suicidality decreased, but these differences were not statistically significant. However, it is important to note that in the TAU+ASSIP group, the differences between the two measurements were statistically significant in all questionnaires: an increase in psychological well-being, a decrease in depression, less frequent suicidal thoughts, and a decrease in overall suicidality. In the TAU group, only the assessment of psychological well-being between the two measurements increased statistically significantly. While the depression scores decreased, the difference was not statistically significant. Of particular note, TAU group reported more frequent suicidal ideation during the second measurement and overall suicidality did not decrease between measurements. Although these differences are not statistically significant, they reveal that without suicide-specific treatment, these participants did not experience positive effects on their suicidality that brought them to a psychiatric hospital in the first place.

3.2. Evaluation of the quality of healthcare received

In addition to the exploratory questions during the interviews, participants were also asked to give an oral score from 1 to 10 (1 is the worst rating and 10 is the best) how much each type of care received: 1) helped them; 2) was liked by them; 3) the specialist was competent. The results are summarized in Table 4.

It is important to note that the processing of these results revealed uneven detail in the responses, i. e. not all the research participants answered all three questions about each type of healthcare. Also, not all participants received the same health-care services, which is why the total number of people who evaluated the service varies between different services. Therefore, for those types of care where the number

of respondents was the lowest (All care in general, Somatic hospital, Medication, Other specialists and Staying in hospital / environment in general), the answers of one participant to all three questions were averaged to obtain one overall score and thus reflect assessments of the major part of study participants.

Table 4. *Evaluation of the quality of healthcare received*

Kind of healthcare evaluated		Participants' group					
		All (n = 19)		TAU+ASSIP (n = 11)		TAU (n = 8)	
		M	*n*	*M*	*n*	*M*	*n*
All care in general		7.38	8	7.25	4	7.5	4
In somatic hospital[a]		7.83	10	6.9	7	10	3
In psychiatric ward:							
Psychologist	Helped	7.89	14	7.79	7	8	7
	Liked	9.18	11	9.07	7	9.38	4
	Competent	9.3	10	9	5	9.6	5
Psychiatrist	Helped	8.73	13	8.57	7	8.92	6
	Liked	8.45	11	7.67	6	9.4	5
	Competent	8.71	17	8.67	9	8.75	8
Medication	Liked	7.17	9	5.7	5	9	4
Other specialists [b]		6.6	11	5.63	5	7.41	6
ASSIP program	Helped	-	-	8.6	10	-	-
	Liked	-	-	8.78	9	-	-
	Competent	-	-	9.73	11	-	-
Staying in hospital / environment in general		6.15	8	4.65	5	8.64	3

[a] Including ambulance and ER

[b] Social workers, physiotherapists, occupational therapy, nurses, relaxation

The analysis of the results revealed that the participants of the TAU+ASSIP group rated all types of received healthcare with lower scores than the participants of the TAU group. The largest differences were observed in the overall assessment of hospital stay and its environment (mean score 4.65 in the TAU+ASSIP group and 8.64 in the TAU group), in evaluating medication (mean 5.7 in the TAU+ASSIP group and 9.0 in the TAU group) and in the assessment of somatic hospital care (mean score 6.9 in the TAU+ASSIP group and 10 in the TAU group). It is also important to note that in both groups the ratings of psychiatric hospital psychologists and psychiatrists are very similar and quite high (ranging from 7.67 psychiatrists' care in the TAU+ASSIP group to 9.6 psychologists' professionalism in the TAU group).

ASSIP program evaluations are quite high – compared to other psychological care both in general and in TAU+ASSIP group, ASSIP program helpfulness and professionalism of specialists were evaluated with higher scores (helpfulness: ASSIP 8.6 points, other psychologists 7.89 overall and 7.79 in TAU+ASSIP group; professionalism: ASSIP 9.73 points, other psychologists 9.3 in total and 9.0 in TAU+ASSIP group). Important to note, that the likeability of the ASSIP program was rated lower than other psychological care – 8.78, compared to 9.18 for other psychologists in general and 9.07 in the TAU+ASSIP group. This difference could be explained by the participants' feedback that the peculiarities of the ASSIP program‘s format posed particular challenges – some participants felt tense about filming during the first session and felt uncomfortable watching this video during a later session.

In the overall sample, the worst assessment was for staying in the psychiatric hospital and its environment – 6.15 points, the best for the professionalism of the psychologists in the psychiatric hospital – 9.3 points. Trends in evaluations in two groups are slightly different: in the TAU+ASSIP group, the worst overall evaluation was for staying in the psychiatric hospital and its environment – 4.65 points, highest – professionalism of ASSIP therapists (9.73 points). In the TAU group

the lowest scores were for other specialist's – 7.41 points, highest – helpfulness of the somatic hospital (10 points). Thus, due to the different number of participants, the aggregated data seems to be reflecting the evaluations of the healthcare received by the TAU+ASSIP group to a greater extent than the TAU group.

3.3. Interview results

Interview thematic analysis resulted in 9 main themes emerging, with 27 sub-themes. Table 5 summarizes the distribution of main themes and sub-themes in our sample.

Table 5. *Main themes and sub-themes emerging from interview analysis*

Main themes and sub-themes	Participants' group		
	TAU +ASSIP (n = 11)	TAU (n = 8)	All (n = 19)
1. POSITIVE IMPACT OF HEALTHCARE:			
Care received saved a life, protected from another suicide attempt, was sufficient	10	7	17
Changed outlook, better understanding of one's difficulties and ways to help oneself	9	7	16
2. HELP-SEEKING AND DIFFICULTIES ACCEPTING CARE:			
Difficulties accepting care: hopelessness, loneliness, unwillingness to talk about problems, excessive self-reliance	8	5	13
Help-seeking, involvement and self-support	9	1	10
Influence of personal qualities and feelings on the care received	8	0	8
Feelings or behaviors related to suicide attempt	6	0	6
Self-treatment	0	3	3

Table 5. *(continued)*

Main themes and sub-themes	Participants' group		
	TAU +ASSIP (n = 11)	TAU (n = 8)	All (n = 19)
3. IMPORTANCE OF A PROFESSIONAL, EGALITARIAN RELATIONSHIP WITH SPECIALISTS:			
Specialists' competency, benevolence and attentiveness	11	8	19
Relationship based on mutual trust and collaboration	10	7	17
Specialists' professional attitude and competence	10	6	16
4. IMPORTANCE OF HOSPITAL'S PHYSICAL CONDITIONS AND ENVIRONMENT:			
Importance of hospital's safe, calm, orderly environment and rules	3	8	11
Importance of community with other patients	2	7	9
5. ADVERSE CONSEQUENCES OF A DISRESPECTFUL RELATIONSHIP AND TOO STRICT TREATMENT METHODS:			
Strict, inattentive, insensitive relationship is unhelpful	9	5	14
Staff's incompetence, unprofessional behavior	7	4	11
Coercive, inadequate treatment methods and rules are unhelpful	6	2	8
Lack of psychological help, insufficient care	0	8	8
Staying in psychiatric ward and its environment was unhelpful	6	0	6

Table 5. *(continued)*

Main themes and sub-themes	Participants' group		
	TAU +ASSIP (n = 11)	TAU (n = 8)	All (n = 19)
6. EFFECTIVE ELEMENTS OF SUICIDE-SPECIFIC PSYCHOLOGICAL CARE:			
Combination of several different types of psychological assistance, specificity, security planning, noticing of signs of crisis and learning new self-help methods	11	N/A	
Psychological care was important	6	N/A	
Current healthcare is more specific, intensive	3	N/A	
7. UNEQUIVOCAL EVALUATION OF MEDICATION:			
Positive effects and evaluation of medication	8	6	14
Side-effects of medication and low effectiveness	7	3	10
8. VARYING NEEDS FOR CARE AFTER DISCHARGE:			
Help-seeking obstacles: poor well-being, financial and relationship difficulties	5	6	11
Need for further psychological care	3	5	8
Positive changes after hospital: self-reliance, relatives' and peers' support	4	1	5
9. POSSIBLE ASPECTS OF IMPROVING EFFECTIVENESS OF CARE:			
Continuous, intensive, specific psychological care	7	5	12
Complex healthcare, family inclusion	3	5	8

4. DISCUSSION

4.1. Evaluation of ASSIP program

The results of the psychological well-being and suicidality questionnaires revealed a significant difference in the suicide-related experiences of the study participants – in the TAU+ASSIP group, the scores of suicidal ideation and overall suicidality decreased between the first and second measurements, but remained largely unchanged in the TAU group. In addition, participants in the TAU+ASSIP study revealed several elements of the effectiveness of suicide-specific psychological care in response to their participation in the ASSIP program. All but one of the participants in this group shared that they were helped by a combination of several different ways of psychological care, specificity, building up a security plan, noticing signs of crisis and learning new ways of self-help. Five of the eleven study participants rated the importance of psychological care in the treatment process, and three of the eleven stressed that the ASSIP program was effective, focused, and structured. While comparing the healthcare received after recent suicide attempt with the health-care services received earlier, three out of eleven participants noted the specificity to suicide and intensity of current healthcare as helpful factors. Such supporting elements identified by the participants of this study can also be understood in the context of an integrated motivational-volitional model of suicidal behavior (O'Connor & Kirtley, 2018), since they respond to all three groups of moderators contributing to suicidal ideation and subsequent actions. For example, learning new ways of self-help can be understood as strengthening problem-solving skills (threat to self moderator), noticing signs of crisis – increased ability to recognize motivational moderators (eg, feeling a burden, negative attitudes or negative future thinking), and security planning − reduction of availability and suspension of suicide planning (volitional moderators). The importance of psychological care in general after a suicide attempt is also known from the results

of previous studies (Rancāns, Lapiņš, Renberg, & Jacobsson, 2003), and is particularly effective when structured, emphasizing specific behaviors and cognitive aspects, and includes safety planning and improving problem-solving skills (Simon et al., 2016; Chan et al., 2017). Thus, we conclude that conventional treatment of mental disorders or the usual helpful characteristics of relationships with professionals (such as collaboration, egalitarian approach, respect, empathy, etc.) are not sufficient for suicide attempt healthcare to be experienced as a means of reducing suicidality. It is necessary to focus on suicidality in particular and strengthen the patient's ability to cope with suicidal thoughts or impulses.

4.2. Importance of complex care

Significant differences between the groups became apparent in evaluating the complexity of the healthcare received – the balance between psychological and medical healthcare. The difference between the study groups was particularly pronounced in the numerical evaluations of medication received – the mean score in the TAU+ASSIP group was 5.7 and in the TAU group 9. Although a similar proportion of both study groups named a positive impact and evaluation of medication (eight out of eleven in the TAU+ASSIP group, six out of eight in the TAU group), twice as many in the TAU+ASSIP group (seven out of eleven) than in the TAU group (three out of eight) at the same time reported experiencing side effects and poor efficacy of medication. A particularly striking difference is that in the TAU group, all eight study participants experienced a lack of psychological support and insufficient care, while in the TAU+ASSIP group, this sub-theme was not revealed by any of the participants. Finally, when sharing ideas on how to increase the effectiveness of healthcare, more than twice as many participants in the TAU group (five out of eight) than in the TAU+ASSIP group (three out of eleven) mentioned the importance of complex healthcare and the involvement of relatives into the treatment process. These

results are consistent with other researchers' insights into the importance of psychological services which promote better understanding of one's condition and teach new coping strategies (Daigle, Pouliot, Chagnon, Greenfield, & Mishara, 2011), the benefits of appropriate medication after suicide attempt when a diagnosis of mental disorder is present (Wang, Lightsey, Tran, & Bonaparte, 2013) and the importance of loved ones' support for returning to daily life and continuing treatment after a suicide attempt (Chan et al., 2017; Hom, Stanley & Joiner, 2015; Hogan & Grumet, 2016; Wang et al., 2013).

We understand the differences between the study groups as a reflection of the fact that TAU+ASSIP group participants received a more complex healthcare (see Table 1 – in the TAU+ASSIP group two participants were in a psychosomatic ward and in the TAU group none; in the TAU+ASSIP group eight out of eleven received a psychologist's consultations in a psychiatric hospital, while only five out of eight in the TAU group; although a similar proportion in both groups participated in group psychotherapy, a higher proportion in the TAU group participated in psychological assessment – 5 out of 8 (in 2 cases only assessment was performed, no consultation) when only one in the TAU+ASSIP group), the importance of which is also acknowledged by the participants in the TAU group, who stated that the healthcare they received was too one-sided, based on a medicalized approach. We also consider that receiving more complex healthcare contributed to a more critical assessment of medications received by TAU+ASSIP participants than in the TAU group – by receiving a wider range of health care services, TAU+ASSIP participants were able to distinguish more nuanced aspects of different types of care, had a better chance to compare services. Finally, these results can also be understood in the light of the suicidologist Schneidman's idea that although the origins of suicidal behavior are multifaceted, it is essentially a mental process taking part in our consciousness whose main stimulus is an unbearable psychological pain due to unmet psychological needs (Schneidman, 2002). It is then

understandable that medication can be helpful only partially, since it can not provide changes, which are the most important for suicidal behavior – help in dealing with psychological pain or finding ways to meet one's psychological needs. This requires complex, psychological and often social and community-based care and services.

4.3. Significance of hospital conditions, environment and community

We observe differences between the groups in terms of the significance of the hospital environment and conditions in the treatment process. Numerical evaluations of the care received reveal this difference: the average score for the psychiatric hospital stay and it's environment is 4.65 in the TAU+ASSIP group and 8.64 in the TAU group. The importance of a safe, calm, orderly environment and hospital rules were mentioned by all eight TAU group participants and only by three TAU+ASSIP group participants during the interviews. The importance of communication and community in the treatment process was also emphasized by all but one of the participants in the TAU group and only by two in the TAU+ASSIP group. In addition, only in the TAU+ASSIP group, the stories of six of the eleven study participants presented evaluations that hospitalization in a psychiatric ward and its environment was not helpful at all. The importance of a sense of security converges with the results of other studies (Samuelsson et al., 2000; Berg, Rørtveit & Aase, 2017), as does the experience of community with other patients, which can help to restore hope and thus reduce the risk of repeated suicide attempt (Radcliffe & Smith, 2007; You, Van Orden & Conner, 2011; Berglund, Åström, & Lindgren, 2016). The impact of these aspects on the decreasing risk of suicide can also be explained theoretically – experiencing security, care, and community can alleviate a person's sense of thwarted belongingness (Joiner, 2005), and the emergence of hope can reduce hopelessness (Baumeister, 1990; Williams & Pollock, 2000).

We consider that the differences between study groups may reflect varying experiences of study participants regarding treatment in different wards. On the other hand, perhaps in the TAU+ASSIP group, study participants are more critical of the quality of services received. This is also reflected in the numerical evaluations of the care received during the interviews, where all types of services received were rated in lower scores by TAU+ASSIP group participants than by TAU group participants. Given that only TAU group revealed a sub-theme of lack of psychological support and insufficient care (all eight TAU group participants and none in the TAU+ASSIP group), we hypothesize that TAU+ASSIP group participants may have experienced a sense of security and community interacting with their psychologists, so they put less emphasis on the importance of hospital's conditions or communication with other patients.

4.4. Importance of relationship with healthcare specialists

All study participants stressed the importance of relationship with healthcare specialists after a suicide attempt. It is well known that healthcare specialists' behavior is an important aspect which might be helpful or become an obstacle in the treatment process (Crowe, Deane, Oades, Caputi & Morland, 2006). 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 (Gysin-Maillart, Soravia, Gemperli & Michel, 2017; Hagen et al., 2018a; Kirkpatrick et al., 2017; McKay & Shand, 2018; Montross Thomas et al., 2014; Shand, Vogl & Robinson, 2018). In addition, based on the interpersonal-psychological theory of suicidal behavior (Joiner, 2005), we can hypothesize that if a person feels accepted and valued by others after a suicide attempt, it may reduce their sense of thwarted belongingness and perceived burdensomeness. Also, social support can act as a protective factor against repeated suicide attempts, i.e. a pre-motivational phase element according to the IMV model of suicidal behavior (O'Connor & Kirtley, 2018).

On the other hand, almost all participants in this study also experienced various manifestations of disrespectful relationships and overly strict treatments or rules, which hindered their involvement in the healthcare process, which is in line with the findings of other researchers (Clarke, Usick, Sanderson, Giles-Smith, & Baker, 2014; Gysin-Maillart et al., 2017). Disregarding the patient as a person after a suicide attempt might result in internalized stigma, which 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., 2010; Rogers & Shand, 2004). It can even strengthen the sense of burdensomness (Joiner, 2005) and in that way encourage early self-discharge from hospital or repeated suicide attempts (Kan, Ho, Dong & Dunn, 2007; Samuelsson, Wiklander, Åsberg, & Saveman 2000). 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 healthcare system, which might reduce the chance of the person approaching a healthcare specialist during a future suicidal crisis.

The relation between the two main themes (*3. Importance of a professional, egalitarian relationship with specialists* and *5. Adverse consequences of a disrespectful relationship and too strict treatment methods*) needs to be discussed as they may seem to contradict each other. It seems that the patients experienced quite an ambivalent combination of relationships towards them from different healthcare specialists at the same time. This also raises a question for further research on how patients after a suicide attempt make sense of such a wide array of quality of relationships and how this affects 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 healthcare specialists' qualifications, attitudes and skills in suicide prevention in general psychiatric hospital.

4.5. Obstacles to involvement into receiving healthcare

There were some differences between the involvement in healthcare process between TAU group and those involved in the ASSIP program in addition to TAU. We note that when it came to seeking help and difficulties in accepting healthcare, a smaller proportion of TAU group participants spoke of their efforts to seek help and get involved (one out of eight in the TAU group compared with nine out of eleven in the TAU+ASSIP group). Also, only in the TAU group, the experience of three participants revealed a sub-theme of self-medication – non-adherence to the treatment plan or changing doses without consulting a doctor. In addition, only in the TAU+ASSIP group did we observe sub-themes about the influence of personal qualities and feelings on the healthcare received (eight participants out of eleven) and about feelings and behaviors related to suicide attempt (six participants out of eleven). It is important to note that a similar proportion of study participants in both groups (eight out of eleven in the TAU+ASSIP group and five out of eight in the TAU group) revealed various difficulties in receiving care – hopelessness, loneliness, unwillingness to talk about problems and excessive self-reliance. The ambivalence of experiences is well known both from other studies on the attitude towards care after a suicide attempt (Dadašev, 2017; Grižas, 2014) and is theoretically characteristic of the suicidal crisis at its various stages (e.g., Schneidman, 2002). We consider that participation in ASSIP program may have contributed to a better self-reflection of participants in this study, both about their contribution to healthcare and about the suicide attempt itself, as they were able to tell their story on suicide attempt and review it with the help of a therapist during ASSIP sessions. TAU group participants did not have a chance to do so. At the same time, we hypothesize that these differences between groups may reflect a stronger avoidance behavior tendency (in talking about one's suicide attempt or help-seeking) in the TAU group. Such results are consistent with previous research, which reveals that excessive self-reliance and self-sufficiency are one of the most

significant barriers to help-seeking in a suicidal crisis (Dadašev et al., 2016), and are often hampered by shame experiences after attempting suicide (Grižas, 2014; Wiklander, Samuelsson, & Åsberg, 2003). Provided that only the TAU group revealed the sub-theme of lack of psychological support, we consider that participants in this group may not have received the necessary support and normalization of their experiences – without having the opportunity to share their suicide attempt story, they may feel that their experiences are not worthy of others' attention.

4.6. Overall evaluation of care and changes while receiving healthcare

The results of the study also showed that the general psychological state of all study participants improved – psychological well-being ratings became higher, and participants felt less depressed than before receiving care. These results are complemented by qualitative data. Almost all participants in this study shared that the healthcare they received had a positive impact on them – helped prevent another suicide attempt or introduced various perceived changes after the care received, such as a changed outlook or a better understanding of one's difficulties and ways to help oneself. As it is well known from other studies that the risk of subsequent death by suicide after a suicide attempt is higher, especially in the first few months after the attempt (Cedereke and Öjehagen, 2004; Crandall et al., 2006; Karasouli et al., 2015; Sobolewski et al., 2013), we believe that the results of this study also converge with the insights of other researchers that changing coping skills and emerging new goals encourage people to return to life and deal more effectively with suicidal crises (Chan et al., 2017). In addition, almost all participants in this study stated that in order to increase the effectiveness of healthcare, it is important to ensure its continuity after hospital discharge and to look for ways to diminish obstacles for further help-seeking. These post-hospital care needs echo the insights of other researchers that it is helpful to have a call or visit

with a psychiatrist or psychologist after a discharge (McKay & Shand, 2018) or that psychotherapy provided at a later time after a suicide attempt, on an outpatient basis, is sometimes more effective than counseling while still in an inpatient ward (Calati & Courtet, 2016). When interpreting these results, it is important to take into account the proportion of those who refused to participate or continue to participate in this study, which was quite substantial – only 19 out of 69 potential study participants took part in the interview (27.5%). We can guess that those who refused to participate in our study may be generally more negative about the care they received, and therefore refuse to engage in additional healthcare-related matters, such as participating in this study.

4.7. Summary of results and novelty of the study

Providing that participants of this study made a unequivocal evaluation of TAU and only gave a positive feedback about ASSIP and its impact on their suicidality, we believe ASSIP to be an important add-on treatment that adequately meets patients' need for collaborative, empathic and suicide-specific care. We believe that, being currently one of the shortest specific suicide attempt interventions (Gysin-Maillart et al., 2016), ASSIP can also adequately address the need for health care facilities to be cost-effective. Thus, the results of the research show that the ASSIP program can be applied in Lithuania, it can be integrated into the current mental health care system – for example, as an additional healthcare besides to the usual treatment in a psychiatric hospital.

Based on these results we also conclude that healthcare, 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. While developing treatment as usual after a suicide attempt, it is important to ensure its complexity and continuity after hospital discharge, the quality of psychological care and the inclusion of suicide-specific psychological services, which

would focus on recognizing signs of crisis, development of a security plan and strive to retain collaborative, empathetic and respectful relationship between healthcare specialists and patients during the whole care process.

To our knowledge this was the first study in Lithuania and the broader post-Soviet region reporting on the patients' experience of a combination of treatment as usual and suicide-specific, collaboratively focused intervention after a suicide attempt. Moreover, it is one of the few studies that reveals the patients' perspective in the evaluation of care, not only measures the effectiveness of the healthcare in terms of the number of subsequent suicides and suicide attempts. This study also relied on mixed methods of data collection and analysis, both quantitative and qualitative, which is still rare in this area of research. The integration of different approaches has provided an opportunity to gain a more detailed understanding of the ways in which care affects patients' condition and to raise assumptions about why interventions are effective. The results of this study revealed the importance of suicide-specific, psychological, and complex healthcare for all patients after a suicide attempt, based on a collaborative, egalitarian, and professional relationship with healthcare professionals. In reality, however, patients are also often faced with an overly medicalized approach, disrespect, and too strict treatment methods. 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).

What is new is that the differences between study groups in this research show that individuals who received only routine mainly medication-based treatment after a suicide attempt (TAU group) are more likely to avoid talking about their suicide attempt, engage in help-seeking, or continue treatment. In addition, it is more difficult for them to reflect on their contribution to the healthcare process and to evaluate the quality of the care received in a nuanced and critical way

compared to the recipients of a more complex healthcare (TAU+ASSIP group). We consider that avoidance may also be a reflection of the still strong stigma of talking about suicide openly in Lithuania (Skruibis et al., 2015), and the fact that suicide-specific psychological care is not offered to all people after suicide attempts reflects the extent of this stigma in the healthcare system. Significant and new findings from this study revealed that suicidal ideation and overall suicidality did not change for those who received only TAU, and that both of these evaluations of suicidality decreased in those who participated ASSIP program in addition to TAU, justifying the importance and benefits of suicide-specific support. Thus, the novelty of this study lies in the fact that it was possible to clarify the specificity of the impact of ASSIP.

We believe that these findings may be of importance both in the Lithuanian context and in other regions with high suicide rates. Due to the combination of peculiarities of suicidal state (i.e. ambivalence towards care, feelings of hopelessness and loneliness) and cultural suicide-related stigma, proactivity of health professionals in planning suicide attempt healthcare is crucial.

4.8. Limitations of the study and guidelines for further research

Certain limitations need to be considered regarding the results of this research. The first group of limitations has to deal with the methodological aspects of the study. In particular, it was a feasibility study of the ASSIP program. For ethical and organizational reasons, we rejected the idea of randomized controlled sampling strategy and chose to gather two groups of study participants separately according to the same selection criteria. This poses a challenge to unequivocally explain the differences between the changes in groups' psychological state and suicidality and the differences in evaluations of the care received – whether it is due to the impact of the ASSIP program, or different competencies and personal characteristics of professionals in different hospitals, or the state and personality qualities of study

participants. In order to manage the impact of this limitation when describing and analyzing the results of this study, we tried to maintain a descriptive style, avoiding the search for cause-effect relationships, and instead considering relationships between variables in question. In the future, it would be valuable to analyze the possibilities and limitations of the application of ASSIP in more detail and to evaluate the effectiveness of this program in Lithuania in larger and homogeneous samples, conducting a randomized controlled trial.

The second group of limitations includes the difficulties of organizing the study and the features of the study sample. In this study, we encountered a high drop-out rate – from 69 potential study participants, only 31 participated in the first phase of data collection, and only 19 of them participated in the second phase and gave an interview (27.5%). This difficulty arose due to the fact that researchers did not have any influence on the participants' healthcare, which created a number of intermediate links between the potential participant and the researchers. In the TAU+ASSIP group, participants were invited and the first measurement was performed by their ASSIP therapists. TAU group participants were referred to the researchers by the hospital administration, but when the researcher arrived at the hospital, the initial selection quite often revealed that the potential study participant had already been discharged from the hospital or did not actually meet all the selection criteria. In addition, although a number of patients agreed to participate in the first measurement, they may have changed their decision regarding participation in the study within a month of their admission (the majority, 10 of 13 who dropped out between the first and second measurements no longer wished to continue their participation or could no longer be contacted). Thus, we do not have the opportunity to know in more detail how the care received is evaluated by those who did not finish this research process. In future research, it is important to search for ways to reach these individuals. The experience of this study shows that if a healthcare specialist invites a patient to participate in the study, the majority of patients agree to

participate in the study and remain in it (11 of 26 potential study participants in the TAU+ASSIP group took part in the interview – 42%; while only 8 from 43 in the TAU group – 19%).

The sample size of the study (19 participants) also highlighted the limitations of statistical analysis of quantitative data. Due to the small number of participants (11 in the TAU+ASSIP group and 8 in the TAU group) we could not assume a normal distribution of the data, so we could not rely on the usual statistical criteria used to compare the two samples (e. g., t-test) and used non-parametric tests – Mann-Whitney U and Wilcoxon. Understandably, the statistical power of these criteria is more limited than that of the parametric criteria. On the other hand, according to Bowen et al. (2009), in feasibility studies, which is often the first step before conducting large-sample studies, it is a sufficient and adequate methodology for a limited-efficacy testing.

It is also important to consider the demographic disparities between the two study groups and their potential impact on the study results. We observe an unequal gender distribution among the study participants – in the TAU+ASSIP group there were five men out of eleven, and in the TAU group only two men out of eight participants. Therefore, we assume that the peculiarities of the evaluations of the healthcare received by men in the TAU group may not be sufficiently revealed and require further scientific investigation. Also in the TAU+ASSIP group, a higher proportion of study participants had higher or university degree education (6 out of 11; 54.5%) compared to the TAU group (3 out of 8; 37.5%) and a larger proportion live in a metropolitan area (9 participants, 81.8% TAU+ASSIP group and 3 participants, 37.5% in TAU group). Perhaps this may have contributed to the result that TAU+ASSIP group participants have better self-reflection skills, revealed through a more detailed description of their feelings and behaviors related to suicide attempt and involvement into care process, and are more critical of the TAU received. Still, these are only assumptions and hunches because we did not measure self-reflection or critical thinking skills in this study. In addition, it is important to note that TAU group participants were not invited to

participate in the ASSIP program, i. e. we do not know which of them would potentially have agreed to participate and which would have refused, and in the TAU+ASSIP group we do not have data on those individuals who have been offered to participate in the ASSIP program and have refused. In future surveys, it would be valuable to collect more data and to be able to compare the demographics of those who agree and refuse to take part in new interventions, as well as to control the impact of demographics on results in larger samples.

Third, it is important to name the limitations related to the initial stage of application of the ASSIP program in Lithuania. 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. Also, 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 out of eleven did not receive pure ASSIP therapy as an add-on resource in suicidal crises since they continued psychological counseling with the same therapists after ASSIP sessions were finished. Bearing in mind that all participants in the ASSIP program responded positively to it, we assume that without these limitations, the differences between the groups would have been even more pronounced. At the same time, we believe that in future research it would be valuable to look for organizational and methodological ways to evaluate the effectiveness of the new ASSIP program in Lithuania by using quantitative methods in a larger samples and in a longer follow-up research period.

Lastly, 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. We believe that this study and its results may be useful for researchers who work in suicide attempt research, as well as for practitioners working with suicidal patients and looking for ways to better understand their needs, and ultimately for authorities responsible for quality and development

of healthcare, trying to provide the best possible healthcare after a suicide attempt. We believe that these results can also be valuable for other countries, especially those with high suicide rates, that are introducing or intending to introduce the ASSIP program.

CONCLUSIONS

1. Patients' psychological state improved after treatment in a psychiatric hospital in both study groups – psychological well-being ratings became higher and depressiveness decreased. However, the intensity of suicidal ideation and overall suicidality decreased only in the group of those who participated in the ASSIP program. Various aspects of TAU have been assessed ambiguously or negatively, and feedback on the ASSIP program has been purely positive. Therefore we conclude that ASSIP is a feasible complementary intervention that appropriately responds to patients' needs for collaborative, empathic, suicide-specific support.
2. In revealing aspects of the effectiveness of suicide-specific psychological assistance, ASSIP participants emphasized the combination of several different types of psychological assistance, specificity, security planning, noticing of signs of crisis and learning new self-help methods. ASSIP program was evaluated as effective, focused, and structured.
3. ASSIP program participants have a stronger capacity for self-reflection, which was revealed through sharing ideas on the influence of personal qualities and feelings on the care received, as well as feelings or behaviors related to suicide attempt. Those who received only TAU had stronger avoidance tendencies – a smaller part of them shared their efforts to seek help and get involved in it, only in this group the sub-theme of self-treatment was revealed.

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LIST OF PUBLICATIONS / PUBLIKACIJŲ SĄRAŠAS

Scientific publications on dissertation topic / Mokslinės publikacijos disertacijos tema

- **Latakienė, J.,** Mastauskaitė, G., Geležėlytė, O., Mažulytė-Rašytinė, E., Rimkevičienė, J., Skruibis, P., Michel, K., Gysin-Maillart, A. (2019). „I Didn't Feel Treated as Mental Weirdo": Primary Findings on Helpful Relationship Characteristics in Suicide Attempt Health Care in Lithuania. *Illness, Crisis, & Loss*. Article first published online: June 7, 2019, 1-17. doi: 10.1177/1054137319854656
- **Latakienė, J.** (2017). Trumpalaikių psichologinių intervencijų po bandymo nusižudyti veiksmingumo tyrimų problemos. *Jaunųjų psichologų mokslininkų darbai,* 5, [8 p.]. Vilnius: Vilniaus universiteto leidykla. ISSN 2019-9958. eISSN 2351-4620. doi: 10.15388/JMPD.2016.5.4
- **Latakienė, J.,** Skruibis, P., Dadašev, S., Grižas, A., Dapševičiūtė, I., & Gailienė, D. (2016). "They Don't Take It Seriously": Perceived Reactions of Surrounding People to Suicide Communication. *Illness, Crisis & Loss, 24*(3), 123-136. doi: 10.1177/1054137315589691
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- **Latakienė, J.**, Geležėlytė, O., Mažulytė-Rašytinė, E., Rimkevičienė, J., Dadašev, S., Skruibis, P. *What do we add to suicide attempt treatment as usual by introducing ASSIP?* Oral presentation at *30th World Congress of the International Association for Suicide Prevention*, September 17-21, 2019, Derry-Londonderry, United Kingdom.
- **Latakienė, J.**, Mastauskaitė, G., Geležėlytė, O., Mažulytė-Rašytinė, E., Rimkevičienė, J., Skruibis, P., Michel, K., Gysin-Maillart, A. *Is empathy enough? Preliminary findings on helpful relationship characteristics in suicide attempt healthcare*. Oral presentation at *30th World Congress of the International Association for Suicide Prevention*, September 17-21, 2019, Derry-Londonderry, United Kingdom.
- **Latakienė, J.,** Skruibis, P., Dirmotaitė, E. *Healthcare system usage and diagnosed mental health disorders before suicide in Lithuania.* Oral presentation at *17th European Symposium on Suicide and Suicidal Behaviour*, September 5-8, 2010, Ghent, Belgium.
- **Latakienė, J.,** Mastauskaitė, G., Geležėlytė, O., Mažulytė-Rašytinė, E., Rimkevičienė, J., Skruibis, P. *Experience of an attempted suicide healthcare effectiveness: Preliminary findings.* Poster presentation at *17th European Symposium on Suicide and Suicidal Behaviour,* September 5-8, 2010, Ghent, Belgium.
- **Latakienė, J.**, Mastauskaitė, G., Geležėlytė O., Mažulytė-Rašytinė E., Rimkevičienė J., Skruibis, P. *Pagalbos po bandymo nusižudyti veiksmingumo patyrimas: pradinės įžvalgos.* Žodinis pranešimas *Lietuvos psichologų kongrese*. 2018 m. gegužės 15-17 d., Klaipėda, Lithuania.
- **Latakienė, J.,** Skruibis, P., Dirmotaitė, E. *Diagnosed mental health disorders and contacts with health professional prior to completed suicide in Lithuania.* Oral presentation at *5th European*

Congress of Psychology, July 11-14, 2017, Amsterdam, Netherlands.

- **Latakienė, J.,** Skruibis, P. *„Jie netiki, kad aš rimtai“: Suvoktos aplinkinių reakcijos į suicidinę komunikaciją“.* Žodinis pranešimas Lietuvos psichologų kongrese „Psichologija: mokslu grindžiama praktika žmogui ir visuomenei“. 2016 m. gegužės 6-7 d., Kaunas, Lithuania. (Kongreso pranešimų santraukų leidinys, ISBN 978-609-454-217-6)
- **Latakienė, J.** *„Trumpalaikių psichologinių intervencijų po bandymo nusižudyti tyrimų problemos“*. Žodinis pranešimas XIII-ojoje Jaunųjų mokslininkų psichologų konferencijoje „Mokslas, kuris įkvepia“. 2016 m. balandžio 22 d., Vilnius, Lithuania. (Pranešimų santraukų leidinys, ISBN 978-609-459-691-9)
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Jolanta Latakienė received a Bachelor's degree in Psychology in 2012 and a Master's degree in Clinical Psychology with distinction (Cum Laude) in 2014 at Vilnius University. During 2015-2020, she continued her doctoral studies in psychology at Vilnius University.

Jolanta Latakienė has been an active researcher in suicidology since 2010, currently at the Suicide Research Centre at Vilnius University. Together with her colleagues, she conducts research, presents findings in national, international conferences and for the general public as well as prepares journal articles. Jolanta Latakienė is a member of the Lithuanian Psychological Association and the Association of Suicide Prevention Lectors.

Jolanta Latakienė is also a practitioner working in private counseling practice since 2014 and giving lectures in suicide prevention. She is a certified safeTALK® trainer. She is currently training at the Institute of Humanistic and Existential Psychology (HEPI, Birštonas, Lithuania) to become an existential therapist.

Jolanta Latakienė 2012 m. baigė psichologijos bakalauro studijas ir 2014 m. įgijo klinikinės psichologijos magistro laipsnį su pagyrimu (Cum Laude) Vilniaus universitete. Tęsė doktorantūros studijas 2015-2020 metais Vilniaus universitete.

Jolanta Latakienė atlieka mokslinį darbą suicidologijos srityje nuo 2010 m., šiuo metu Suicidologijos tyrimų centre Vilniaus universitete. Kartu su kolegomis vykdo mokslinius tyrimus, rezultatus pristato nacionalinėse ir tarptautinėsė konferencijose, viešumoje, rengia mokslinius straipsnius. Jolanta Latakienė yra Lietuvos psichologų sąjungos bei Savižudybių prevencijos mokytojų asociacijos narė.

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9 Saulėtekio Ave., Building III, LT-10222 Vilnius
Email: info@leidykla.vu.lt, www.leidykla.vu.lt
Print run copies 35