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Lifesaving turning points: First-person accounts of recovery after suicide attempt(s)

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ABSTRACT

This study explores the recovery processes of persons who had attempted suicide. Semi-structured interviews were conducted with eight persons who had attempted suicide and the data were analyzed by means of systematic text condensation. The participants described lifesaving turning points, which were connected to meaningful relationships, taking control over one's own life, and establishing a new everyday life. Suicide prevention efforts must be adapted to individual needs. First-person knowledge is important if we are to understand what is seen as helpful and should be emphasized when implementing suicide prevention work.

Suicidality, a process involving thoughts, feelings, and possible actions regarding taking one's own life (Hjelmeland, 2022) is an individual experience; therefore, first-person knowledge is crucial to prevent suicide (Fitzpatrick & River, 2018; Webb, 2010; White et al., 2016). Earlier studies where people with lived experiences of suicidality have been interviewed have shown that attachment to others, the perception of being understood and accepted by others, and therapeutic relationships are crucial to prevent suicide (Lakeman & FitzGerald, 2008). In a systematic review of qualitative studies, Berg et al. (2017) found that attachment to health personnel, protection from oneself and one's suicidal impulses, and having control over one's life were important if suicidal people were to feel safe during hospitalization. When these needs were not met, suicidality and the probability of suicide attempts increased. However, the biomedical approach in mental health care, often is inconsistent with the personal stories about what is helpful (Borg & Kristiansen, 2004; Fitzpatrick & River, 2018; Hagen et al., 2018; Webb, 2010). Fitzpatrick and River (2018) argue that we must "move away from paternalistic approaches and begin to work *with* persons who are, or have been, suicidal to acknowledge them as experts in the development of comprehensive, acceptable, and useful services" (p. 199).

The recovery perspective has its roots in the service user movement of the 1970s and 1980s. In contrast to clinical recovery, which highlights the absence of symptoms and outcome, recovery builds on a broader understanding of mental health and rebuilding a life with dignity (Borg & Davidson, 2008; Kogstad et al., 2011; Price-Robertson et al., 2017; Roberts & Boardman, 2013; Tew et al., 2012). Recovery is described as an individual journey (Anthony, 2003), and a social process where improvement occurs in relation to other people in given surroundings (Onken et al., 2007; Topor et al., 2006). Recovery takes form in social and historical contexts (Borg & Davidson, 2008) and has various dimensions, such as rediscovering oneself or experiencing new qualities in life (Kogstad et al., 2011). Because recovery in this context is understood as a non-linear process and not as an outcome, the term "recovery processes" is often used (Davidson et al., 2010). Some studies also describe how turning points relating to specific incidents, moments, or encounters may have decisive importance for the recovery process (Kogstad et al., 2011; Mancini, 2007; Song & Shih, 2009). A turning point is defined as "a time or event when one took a different direction from that in which one had been traveling" (Clausen, 1998, p. 189). It is not possible to see how these events connect to life choices until afterwards (Pillemer, 2001).

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Although the recovery approach is gaining more ground in the mental health field, it is not often encountered in suicide prevention work. However, Sellin et al. (2017) interviewed 14 hospitalized persons at risk of suicide about their experience and understanding of the recovery phenomenon. They found that recovery was about "reconnection with oneself while struggling between life and death" (p. 204), concluding that the purpose of recovery is to experience the ability to deal with one's own life. This study aims to further explore the recovery processes of people who have attempted suicide. Their experiences may contribute important knowledge on what is perceived as being helpful, and what should be given priority in future suicide prevention work.

Method

Participants

The participants were seven women and one man (aged 26–65 years) who previously had attempted suicide; two of them once, the others three or more times (one more than ten times). Four of the participants were single and four were in a relationship. At the time of the interview, it was between 18 months and five years since the participants' last suicide attempt, and none of them were undergoing treatment in specialist mental health care. We recruited the participants by publishing an announcement on the Facebook pages of the Norwegian *Mental Helse* (Mental Health) organization, searching for people willing to share their experiences of their recovery after suicide attempts. The inclusion criteria were that: participants were more than 18 years of age, their last suicide attempt was 18 months to five years ago, and they were no longer receiving treatment in mental health care. Eligible people were encouraged to contact the first author by e-mail or telephone.

Interview procedure

In this explorative qualitative study, we conducted individual semi-structured interviews. The first author conducted the interviews in the period 2018–2020. In accordance with the participants' own wishes, two interviews were conducted in a meeting room at their place of study, two in their homes, and two interviews were conducted in a meeting room at the first author's workplace. Due to the COVID-19 pandemic, the last two interviews were conducted via Zoom. The interviews lasted from 56 minutes to two hours and eight minutes, with an average of approximately one and a half hours. The opening question was "Please tell me the story about your recovery process following your last suicide attempt," thereby underlining that it was up to the participants to decide what and how much they wanted to share. The interview guide had four main themes: (1) What could have prevented the suicide attempt (s)?; (2) Reflections on the recovery process (e.g. what was helpful after the suicide attempt(s)?); (3) How can we best prevent suicide? (e.g., if you had been in charge of national suicide prevention for one day, what would you do?); and (4) Lived experience (e.g., in what way do you think service user participation may contribute to suicide prevention efforts?). The main themes were used to elaborate and further explore the participants' reflections on their recovery process. In line with Brinkmann and Kvale (2015), the interviewer asked follow-up questions such as "could you please tell me more about…" and "have I understood you correctly in that…" to clarify the participants' statements and reflections. The interviews were recorded and transcribed verbatim.

Analysis

We analyzed the data by means of systematic text condensation (STC). STC is a descriptive four-step approach with an explorative ambition (Malterud, 2012). First, the first and third author read the transcripts to get an overarching impression of the data. Then, the first author reread the transcripts and identified preliminary themes in the material (e.g., caring health personnel, good helpers, new insight, say no to medication, friendship, and practical help). Second, the first author identified meaning units (text fragments with information about the research question) and labeled them with a code (e.g., good relations, fellowship with others, get a job, identity outside the mental illness). Then, the first author sorted meaning units within one (or more) of the preliminary themes from step one, and discussed the coding, labeling and sorting with the other authors. According to Malterud (2012), it is necessary to be flexible in the analysis process, and for this reason names and features of the code groups from step one was changed during step two of the analysis. Third, we sorted all meaning units within a code group into two to three subgroups, made a condensation for each subgroup and illustrated them with an authentic extract. Fourth, we developed and refined the final descriptions over time by re-reading the transcripts to ensure that they were grounded in the data (Malterud, 2012). Guided by a hermeneutic tradition, which emphasizes interpretation of meaning (Kvale et al., 2009; Malterud, 2011), we developed four themes.

Ethical considerations

The Regional Committee for Medical and Health Research Ethics (Norwegian abbreviation REK) approved the study (ref. no. 6053). Due to the COVID-19-pandemic, REK approved conducting the last two interviews via Zoom. Prior to the interviews, all participants received a letter informing them about the study. When meeting them face to face, the interviewer repeated this information. The participants signed an informed consent form and were told that they could withdraw from the study at any time without needing to provide a reason. At the end of the interview, the interviewer asked the participants how they felt about the interview and encouraged them to get in touch if the interview had evoked distress. A mental health nurse was also available. It may be challenging to be interviewed on a sensitive topic like suicide via Zoom. However, both participants gave positive feedback on this experience. None of the participants needed follow-up after the interviews. We treated the data confidentially and in such a way that the participants are not identifiable. We refer to all the participants with fictional female names for anonymity reasons. The authors have no relationship with the participants.

Findings

The participants described different but crucial turning points in their recovery processes. This is illustrated and elaborated on in four themes: (1) Feeling acknowledged, understood, and cared for by professionals; (2) Experiencing belonging and closeness to significant others; (3) Taking control over one's own life through realization and confrontation, and (4) Establishing a new everyday life. The experiences that led to a turning point made it possible for the participants to be active agents in establishing a new everyday life.

Before the themes are presented, a brief description of the participants' background is given to contextualize the recovery processes. Several of the participants talked about problematic relationships during their upbringing, mentioning physical and mental abuse, parents with drinking problems, and much quarreling. Others talked about experiencing bullying and exclusion in school. They had in common the experience of broken trust and challenges in close relationships. Elise said: "…so relationships, feeling safe and confident has not been my strong side, and …I have walked around more or less afraid all my life." All the participants had been in contact with professionals (psychiatric nurse, psychologist, doctor, or psychiatrist, either through an outpatient clinic or during hospitalization) in connection with suicidal ideation and suicide attempts, but the importance of these for the recovery process varied. Several talked about negative experiences with the mental health care system, particularly when it came to diagnosis and medication, which had exacerbated an already difficult situation. Due to the harmful experiences, it was even more difficult to open up and find words for their emotions and perceptions when encountering new people.

Feeling acknowledged, understood, and cared for by professionals

When the participants met professionals who were curious about their stories, who built alliances, who were willing to come to a shared understanding on the background of the suicidality, and who would go an extra mile for them and showed genuine care, the participants felt acknowledged, understood, and cared for. These perceptions led to lifesaving turning points for some of them and were vital for their recovery processes.

Johanne talked about how the encounter with a psychiatric nurse was important for her. This nurse was interested in Johanne's everyday life, how she was doing and what she had done since the last time they met. Johanne described this as much more meaningful than the innumerable meetings with doctors who wanted to diagnose her and prescribe medication. Like Johanne's story, other participants described meetings with professionals who were mostly interested in assigning diagnoses and prescribing medication. This left the participants feeling unacknowledged and they found it difficult to develop a trusting relationship. Such a focus was not helpful in the recovery process, rather it had the opposite effect and was perceived as an extra burden.

Anne also had several negative experiences of professionals and talked about the absence of predictability, rejection, conflicts, and instances where "there was no chemistry." However, the encounter with a psychologist in the outpatient clinic who was curious about Anne's story was very important for her:

> …with the new therapist I gained more hope because she was the first who started to doubt that my diagnosis was correct, maybe it's something else, what is this about? She was much more curious about me, not just rubber stamping me and signing me off.

Anne had earlier experienced being "stamped" with a diagnosis she believed was incorrect. According to the quotation, however, it appears that what was crucial was the psychologist's curiosity about her as a

person and her story, and them together arriving at a shared understanding of her situation. For some of the participants, a shared understanding meant that it was an agreement between their personal experiences and the diagnosis given. Moreover, it appears that a shared understanding of what was behind the suicidality made it easier for some of the participants to move forward in the recovery process. Also, Anne felt that she had forged an alliance with the psychologist, and thus experienced that she had somebody fighting for her.

> And that she was quite open to letting me control my own treatment. She was very much like that, letting me be in control, I think in so many ways. In a way she said straight out that she was breaking the rules for me so I would be allowed to have what I needed. What I needed was contact with her outside the appointments.

It appears that the psychologist went an extra mile to satisfy Anne's needs, thus empowering her and building a foundation for a trusting and safe relationship. Anne described this as decisive for her recovery process.

In the participants' descriptions of significant professionals, care and empathy were also critical qualities. Dina said for example: "Of course I wanted someone to care about me. That someone cared whether I lived or not…." For her, care and observation were not the same. She felt that observation was something the staff did for their own sake, whereas what she needed was care. After several years in psychiatry and countless hospitalizations there were only two episodes Dina could recall where she felt that someone "actually cared." One of these episodes came immediately after one of her suicide attempts in the psychiatry ward:

> But he [the social educator] just got to the point. And there was something in his body language and his whole demeanour that showed me he really cared about how things were for me and how it was to lie there (participant described method). Like none of the others had ever done. And I think that I actually never tried again while he was there.

Dina experienced the social educator's demeanor and reaction as genuine care. After earlier suicide attempts, when hospitalized, she had been dismissed with statements like "Do you really think that you would manage to kill yourself that way?," an approach she felt was the opposite of care. Because Dina felt that he cared, she would not consider attempting another suicide on his watch. The following quotation illustrates how Dina reflected on the possible consequences of her attempted suicides, and that she wanted to shield people who cared about her.

> It's really… one of my big quandaries was: who would find me? People will, in a way, have to carry that with them the rest of their lives. What I decided was that it wouldn't be on his watch (…). Because he cares.

Experiencing belonging and closeness to significant others

Relationships to a friend, a partner, or others, were important for the participants' recovery process. In Dina's words: "I think that perhaps we all need to be part of a flock." For Dina and Eva, the attachment to other patients had given them an experience of belonging, feeling that they shared the same experiences, were able to solve problems together, but also have fun and laugh. For Kathrine, her belonging to her group of friends was most important for the recovery process "… sure, but we [her friends] had to [talk about everything]. Because if we don't talk about everything, we don't have a chance." She talked about how she and her friends would be there for each other, and that was where she would go for comfort when she needed it. Some of the participants also described getting a boyfriend or girlfriend as meaningful. Elise told about a boyfriend who "came into my life at a point when I truly needed it." The relationship did not last, but because of it she had new experiences and discovered that she mastered things more than she expected she would. This was important for Elise because she was no longer "the one who always sat at home." Together with her boyfriend she experienced and used other aspects of herself, with her resources and abilities becoming visible and important, making this a relationship that positively affected her identity and gave her strength.

Ida described two very important relationships for her recovery process. One was to a person in the same situation who she felt she could talk to about everything. The other was to God. Ida talked about how she reached a point where she had given up, but just before she was going to take her own life, she was stopped by a man who gave her a greeting from God. This incident caused Ida to experience a revelation from God: "… I must take care of my life … because God has told us to love yourself, love your neighbour as yourself, but then you must first love yourself." This was a turning point for Ida. She found that God made her strong, capable of taking care of herself and able to face her challenges.

Taking control of one's own life through realization and confrontation

The negative experiences in the encounter with the mental health care system led to the experience of losing control and becoming a passive participant in one's own life. The participants had experienced that their problems were not understood and taken seriously. Several said that what was supposed to be helpful was not that at all, and at a point in time they came to realize that a change would be necessary if they were to live: "And then I remember that I thought now something's got to give, or I'm going to die" (Elise). This realization often led them to confront someone or something they felt impeded their recovery process. Through a process of realization and confrontation the participants took back control over their own lives. Several described this as a crucial turning point in the recovery process.

Eva's realization came when an acquaintance took his own life, and she consequently experienced the pain of being a bereaved person. Maria described a more internal process. For her it was decisive to "listen within herself" to determine what she actually thought and felt: "… and then I listened within myself, asking in a way my heart or my soul, or yes, within, but what is it I want? And then I sensed that, yes, I want to live."

Maria's internal process also meant to make a settlement with thoughts she had about herself. The big turning point came when she realized that much of what she had believed and thought about herself was not true:

> I had for example the idea that I was the black sheep of the family. And then I simply asked—well now, is that really true? And with all these statements that had been swirling around in my head, I found out that none of it was true. And, yes, that was really a big turning point.

An experience of inadequate help from the mental health care system also led many of the participants to come to the realization that they would need to assume responsibility for themselves. For Dina, such negative experiences were so serious that she said: "Because I have eventually come to learn that regardless how bad it is, I must for God's sake make sure that I'm never again hospitalized in an emergency ward. Because I don't know if I could survive that." It appears that Dina had arrived at the realization that the place that was supposed to make her feel safe and provide care and support when life dipped to its lowest point, had completely opposite effect.

Several of the participants also came to realize that their medication did not help. Johanne felt that medicine only made things worse, while Ida claimed that psychiatry was drilled on diagnostics and medication. Her experience was that medication had dulled her senses. She said: "It′s better to cry and shout out for a week than taking that junk [medication] really. Honestly."

The participants' realizations led to confrontations. For Ida, assuming control over her own life became not just a rejection of medicine and the mental health care system, but also a rethinking of her relationships. She had had a difficult childhood and upbringing, and many of the challenges in the family followed her into adult life. For her, it was crucial to sever ties with some of her family members to avoid more suicide attempts. Maria also rejected the medicine she was prescribed. Consequently, she felt more in contact with her emotions and what she really wanted, and she developed another perspective on who she was and how important she was to others:

> I really believe that the medicine did something to my emotional life, and that's not good, because we need emotions. Therefore, it was really an epiphany moment for me to discover that the kids loved me. That the power of love was exceedingly strong.

Dina too rejected her medication, and she made the choice to avoid the mental health care system altogether, finding that this choice had kept her alive over the subsequent five years. She described it as the "absolutely safest path to the goal." It may also appear that Dina's choice to reject medication and the mental health care system, made her confront her identity as a patient. She said: "I think that getting rid of the patient identity is also quite a major part of it … I do not allow myself to enter that role in a way … I do not cling to those thoughts anymore."

Establishing a new everyday life

The participants' challenges had caused them to drop out of a social life when it came to friends, education, job, and home. But having experienced a lifesaving turning point they wanted to gradually establish a new everyday life. Moreover, for some, establishing a new everyday life was an important part of the recovery process.

For most of the participants this amounted to having the opportunity to study and/or work. The exception was Johanne who received disability benefits due to her challenges. Johanne, however, talked about how a social worker had been important for her. The social worker had contributed practical assistance in

connection with a student loan and her financial situation. Eva had also received some practical help which she described as very useful. NAV (the Norwegian Labor and Welfare Organization) had helped her to apply for a job and get her finances in order. For both Johanne and Eva, it was important to receive help in dealing with practical matters, which enabled them to establish a new everyday life. Statements from the participants reveal that education and work contributed to creating a necessary everyday structure and the possibility of using one's resources, while also accessing a network and providing a sense of belonging. Elise stated: "for me it has like helped, totally, to have a reason to get up in the morning", while Kathrine talked about how much it had meant to her to get a new job:

> And now I see that: okay, I have a job. I feel it's great to go to work. Like, I go to my job too early because I want to go to work. And colleagues who I talk to after work and meet after work …

Kathrine job appears to be important to her for several reasons: she is doing something she thinks is fun, she has found something that motivates her, and she has acquired a larger network. For Anne, Elise and Dina, studying was important because they found an arena where they were able to use their abilities, resources, and experiences. Anne and Elise wanted an education where they could make a difference. Establishing a new everyday life appears to be important because it provides the opportunity to be active in one's life, experience mastering and apply oneself to something that is perceived as meaningful.

Discussion

The aim of the study was to interview people who had attempted suicide but who were no longer being treated by the mental health care service to explore what they had experienced as important for their recovery. The findings show that the road to recovery was complex, and that the perception of lifesaving turning points was crucial. In retrospect, when the participants told their stories about their recovery, they managed to see which events and incidents had led to lifesaving turning points. Such turning points were connected to reflections on relational and/or internal matters and to the establishment of a new everyday life.

The participants' descriptions can be understood in light of the recovery perspective. Recovery is individual (Anthony, 2003), but also occurs in relation to other people (Onken et al., 2007; Topor et al., 2006), takes form in different contexts (Borg & Davidson, 2008) and comprises different dimensions (Kogstad et al., 2011). Several of the participants emphasized the experience of being acknowledged, understood, and cared for by professionals as significant, while others described the importance of experiencing belonging and closeness to significant others. For some, these relational experiences led to lifesaving turning points. The importance of good relationships in recovery processes, with professionals, family, and friends, is well known (Borg & Kristiansen, 2004; Topor et al., 2006). Nonetheless, professionals and people with lived experience still call for relational approaches and interpersonal engagement in suicide prevention efforts (Espeland et al., 2021; Vandewalle et al., 2021).

A characteristic of effective patient-practitioner relationships is a therapeutic alliance where mutual collaboration is essential (Michel, 2021). According to Jobes and Ballard (2011), a therapeutic alliance is established when professionals have an empathetic approach, see suicidality through the eyes of the patient and allow the patient to narrate their story. When professionals explore and endeavor to understand what lies behind suicidality, they contribute to imparting hope (Berglund et al., 2016; Cutcliffe & Barker, 2002; Vatne & Nåden, 2018). Østlie et al. (2018) found that the therapist's and patient's shared understanding of the suicidality is a vital part of a working alliance where change processes can occur. To achieve a shared understanding, the therapist must adopt "a wide listening perspective" (Østlie et al., 2018, p. 161). If the patients felt that the therapist did not have "a wide listening perspective," they would then see the alliance as weak, and there would be no changes in patient suicidality over time. The anxiety of therapists, either due to the possibility of a patient's suicide, or due to fear of reactions from their supervising authorities, undermined their ability to listen (Østlie et al., 2018). Furthermore, therapists who had a theory that the patients' suicidality stemmed from mental disorder or stable personality traits had greater challenges when it came to arriving at a shared understanding (Østlie et al., 2018). Schön et al. (2009) claim that the social aspect does not only contribute to recovery, but that recovery is achieved through social processes, and that the quality of the relations is decisive, regardless of whether this applies to professionals, family, friends, or other patients. In keeping with Kogstad et al. (2011), we found that supporting and loving relationships are fundamental for recovery to take place.

Even if several of our participants talked about having positive experiences of their relations with professionals, many of them also criticized the emphasis on medication, and felt they were losing control, becoming passive participants in their own lives. Our findings also indicate that these negative experiences were often an impediment to recovery. When suicidal persons do not experience adequate support from professionals, and their suicidality is not acknowledged, this may lead them to withdraw and keep their thoughts and feelings about suicide to themselves (Hagen et al., 2018). Attachment to professionals, protection from oneself and the suicidality, together with control over one's own life are important for suicidal people to feel safe when hospitalized. If these needs are not met, they may feel unsafe, their suicidal thoughts and feelings may increase and for some this may trigger a new suicide attempt (Berg et al., 2017). However, our findings showed different perspectives. For some of the participants the negative experiences in the encounter with the mental health care system provided the impulse for change and led to a turning point where they arrived at the decision to take control over their own lives. This is in keeping with the study by Mancini (2007), where the participants stated that resisting institutional labels and suppressive treatment environments was vital for the recovery process.

Recovery may be described as a personal process which implies finding "a new sense of self" (Kogstad et al., 2011). Even if this is a personal process, Davidson and Strauss (1992) maintain that the development of an active sense of self occurs in a social context where significant others contribute positively or negatively. Ida's story reflects such a perspective. She made personal choices and took control of her own life. At the same time, Ida's actions cannot be understood in an individual perspective because autonomy and setting boundaries are interpersonal acts that only have meaning in a relational context (Price-Robertson et al., 2017). Taking control over one's own life can refer to both personal and social circumstances (Mancini, 2007; Mezzina et al., 2006), and may be understood as an existential dimension of recovery processes: "Philosophically, an existential dimension means that human beings are free and make choices that also imply responsibility" (Kogstad et al., 2011, p. 484).

Bandura's (2001, 2006, 2018) theory of human agency may also shed light on the theme "Taking control over one's own life." According to Bandura (2006), individuals are agents who are not only a product of their circumstances, but who also consciously influence their circumstances, and he states that "to be an agent is to intentionally make things happen by one's action" (p. 2). Bandura (2006) posits four core characteristic qualities of human agency: intentionality, forethought, self-reactiveness, and self-reflectiveness. Self-reflectiveness, the ability to reflect on oneself and one's own thoughts and feelings, is the most characteristic core quality (Bandura, 2006, 2018). The ability to reflect about themselves was clearly stated by several of the participants as part of their realization that a change was necessary if they were to survive. In keeping with Bandura (1991), it appears that turning points motivated some of the participants to take part in changing their circumstances. Personal efficacy, the faith in one's own ability and power to effect change, impacts personal goals and how we motivate ourselves and tolerate challenges and adversity (Bandura, 2006).

Our findings may indicate that the mental health care system′s emphasis on medication contributed to some the participants' feeling of passivity, while self-reflectiveness and a realization that change was required provided them with a belief in their own ability and empowered them to make changes. Several of the participants mentioned how they confronted situations that were not helping them by, for example, discontinuing their medication, shunning the mental health care system, or severing ties with family members. In keeping with Bandura (2006, p. 164), the participants stopped being "onlookers" in their own lives and chose rather to actively change their circumstances. Our findings suggest that the participants became active agents in the design of a new everyday life, which in itself was an important dimension in the recovery process. Education and work were especially highlighted as important because they gave them a reason to get up in the morning, provided a structure in everyday life, gave them the opportunity to use their resources, provided a network and supported a sense of belonging. Studies and work appeared to be more important than before the suicide attempts. According to Mezzina et al. (2006) and Tew et al. (2012), studies and employment are important resources which can help people to step away from the status of "illness" and the patient identity. Reestablishing one's everyday life means taking control over one's life, reconstructing one's identity and being socially included (Mezzina et al., 2006; Tew et al., 2012). Our findings are in keeping with Tew et al. (2012), who maintain that social inclusion is very important because it touches on both the subjective sense of belonging and the feeling that one is a co-citizen in the community.

The study has some strengths and limitations. The opening question in the interviews was "Please tell me the story about your recovery process following the last suicide attempt." As this was an open question, the participants could decide what they wanted to emphasize when describing their recovery process, and in this way, we were able to explore the experiences, thoughts, and perceptions of the participants (Malterud, 2011). This approach is appropriate when exploring issues that are multifaceted and complex (Malterud, 2011). Part of what we have illuminated in this study is indeed how complex recovery processes can be, and that recovery does not occur in a vacuum. This is a relatively small qualitative study. However, the data material was rich, and the number of participants is not decisive when the aim is to explore participants' experiences (Malterud, 2011). Malterud (2011) asserts that external validity is to look at which settings our findings can apply beyond the research context. Even if the findings cannot be generalized to include everyone who is or has been suicidal, they have external validity when they point out the importance of first-person knowledge in suicide prevention work, both in terms of clinical activities and developing guidelines and action plans. All but one of our participants are women and we did not focus on gender related issues in our analyses of the data. This could be explored in future research.

Our findings point out how both relational and internal experiences may contribute to turning points in the recovery process. For some of the participants the relational circumstances were most important, while others placed more emphasis on internal reflections. The turning points made it possible to establish a new everyday life, which was meaningful per se. This indicates that suicide prevention efforts must embrace relational and individual processes and must be adapted to individual needs. Moreover, in line with Webb (2010) and Scarth et al. (2021), the findings suggests that first-person knowledge should be highlighted and given an important role in the design of suicide prevention efforts.

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