Psychiatric care of people at risk of committing suicide

Narrative interviews with registered nurses, physicians, patients and their relatives.

Anne-Grethe Talseth

Umeå 2001
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AKADEMISK AVHANDLING

som med vederbörligt tillstånd av Rektor vid Umeå universitet för avläggande av medicine doktorsexamen kommer att offentligen försvaras i Aulan, Vårdvetarhuset, lördag den 10 februari 2001 kl 09.00

av

Anne-Grethe Talseth

Fakultetsopponent: Professor emeritus Jan Beskow, Institutionen för klinisk neurovetenskap, Göteborg
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Narrative interviews with registered nurses, physicians, patients and their relatives

Anne-Grethe Talseth, Department of Nursing and Department of Clinical Sciences, Division of Psychiatry, Umeå University, Umeå, Sweden

ABSTRACT

The aims of this thesis are to illuminate the meaning of being cared for and treated by nurses and physicians, as narrated by psychiatric suicidal in-patients; the meaning of taking care of and treating patient at risk of committing suicide, as narrated by nurses and physicians; and the meaning of being met and having one’s suicidal relative taken care of by health personnel, as narrated by relatives. Narrative interviews were conducted with 42 adult patients at risk of committing suicide in an in-patient psychiatric unit, 19 RNs, 19 physicians, and 15 relatives at a hospital in Norway. The tape-recorded and transcribed interviews were interpreted using a phenomenological hermeneutic method.

Nurses’ relations to patients at risk of committing suicide were illuminated via the dimension ‘Distance–Closeness’ (I). The relation of the suicidal patient to the nurses was illuminated via the dimension ‘Confirming–Lack of confirming’ (II). The relation of physicians to patients was illuminated via the dimension ‘Power to–Power over’. (III). The relation of suicidal patients to physicians was illuminated via the dimension ‘Participating approach–Observing approach’ (IV). Results from the relatives’ experiences of being met by health personnel of suicidal patients reveal that the context of being met was characterized by ‘being helpless–powerless’, and that the meaning of the experiences of ‘being met’ was reflected in six themes: ‘Being seen as a human being’; ‘Participating in an I-Thou relationship with personnel’; ‘Trusting personnel, treatment and care’; ‘Being trusted by personnel’; ‘Being consoled’; and ‘Entering into hope’ (V).

The interpreted meanings of the experience of being cared for as a person at risk of committing suicide were illuminated as confirmation, communion, consolation and hope. Threaded through these meanings is the relation with self and others. Thus, the essence of the results that emerged from this study indicates the presence of a relational view of the care received by people at risk of committing suicide.

Key words: Psychiatric care, in-patients at risk of committing suicide, registered nurses, physicians, relatives, narratives, phenomenological hermeneutics, confirmation, communion, consolation, hope.
Psychiatric care of people at risk of committing suicide
Narrative interviews with registered nurses, physicians, patients and their relatives.

Anne-Grethe Talseth
To all the psychiatric patients at risk of committing suicide and their relatives I have met. You have taught me what is most important— to always look for the human being.
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IV. Talseth AG, Norberg A, Jacobsson L. The meaning of suicidal psychiatric inpatients’ experiences of being treated by physicians. *Journal of Advanced Nursing*, accepted for publication.


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INTRODUCTION

Life is full of challenges: at work, at school and in relations to family and friends, we meet expectations and make demands on ourselves. At times, we are confronted with situations, which seem impossible to cope with. Life can sometimes feel so meaningless and painful that a person sees no possibility of continuing it and, therefore, chooses death. Suicide is perhaps the most lonely and impersonal act performed by a human being in that it objectifies and destroys the self. At the same time, there are few actions that impact so dramatically on all the people involved.

Suicide poses the questions of our responsibility for other people’s lives and the right to choose death. How do we react when a person declares, “I have the right to commit suicide, and you have no right to stop me”, and if our religious beliefs forbid suicide, how will this affect our reactions towards the person? Throughout history suicide has fallen very much into the domain of taboos and, even today it confronts us with one of the last taboos, recognition of our own death.

Suicide has been studied from various perspectives. The proliferation of research in this area indicates the extent of the problem of suicide in our world today. As a background to this dissertation, statistical, medical, psychosocial and existential perspectives are reviewed in addition to research on experiences of health personnel, patients and relatives’ involved in the psychiatric care of patients at risk of committing suicide.
Statistical perspectives on suicide

In the 1980s, the World Health Organisation (WHO) developed a document entitled “Health for all by the year 2000”. WHO/EURO specified this broad goal under 38 targets, one of which was to reduce the rising trends in suicide and attempted suicide\(^1\),\(^2\) (target 12). Suicidal behavior is identified as a major public health problem in many countries in Europe. The Multicentre Study on Parasuicide, aimed at providing reliable epidemiological data, revealed great variations in suicide rates within 13 European countries. The first years of monitoring, 1989-1992, revealed an attempted suicide rate of 186 for females and 136 for males per 100 000 inhabitants, with substantial differences between countries (Schmidtke \textit{et al.} 1996).

The Norwegian National Plan for Suicide Prevention was developed in 1994 (Department of Health and Social Security 1994) to follow up the WHO/EURO plan. In 1995, the suicide rate in Norway was approximately 12.6 per 100 000 inhabitants, and approximately 547 individuals died that year as a result of suicide (Statistical Central Bureau 1995). There has been a relative increase in suicide for people aged 15-24 years. Hansen \textit{et al.} (1997) reported that the highest suicide rate, however, was for males over 80 years of age. The average population suicide ratio of males to females was 2.8:1. In the case of suicide attempts, the incidence was approximately three times as great for females as for males. The mortality rate for psychiatric patients in Norway was thus unsatisfactorily high, and males especially constituted a high-risk group

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\(^1\) In this thesis the terms attempted suicide and parasuicide are used synonymously.

\(^2\) Attempted suicide/parasuicide is understood to mean a conscious and deliberate act, carried out by an individual in order to harm himself and which the individual could not be certain to survive, but where the harm does not result in the death of the individual (Rettersøl 1995).
Medical perspectives on suicide

Practitioners are educated and trained to see the world through the theoretical lens of their particular practice (Kleinmann 1988, pp. 2-5), which for health care practitioners, is often a bio-medical model. In bio-medical terms, suicide can be explained as the result of an alteration in biological structure and function. Theories related to genetics and neurophysiologies are new ways of explaining suicide. Genetic research by Edmonds et al. (1998) and Roy et al. (1997) showed emerging trends in the frequency of suicide in families. Significantly low concentrations of the neurotransmitter 5HIAA, a metabolite of serotonin, in the cerebrospinal fluid was found in psychiatric patients who had attempted suicide and suffered major depression (Drevets et al. 1999, Nielsen et al. 1998, Virkkunen et al. 1996).

In a number of psychological autopsy studies, more than 90% of the deceased could have been diagnosed as suffering from a psychiatric disorder (Shaffer et al. 1996, Marttunen et al. 1991 Beskow 1979, Barraclough et al. 1974, Robins et al. 1959). Depression has been found to be the strongest risk factor in adolescent suicide (Shaffer et al. 1996, Brent et al. 1993a, Marttunen et al. 1991). Feelings of hopelessness also seem to predispose people to commit suicidal actions (Keller & Wolfersdorf 1993, Schlebusch & Wessels 1988,) are closely correlated with depression (Iancu et al. 1999, Asarnow et al. 1987) and may be a better marker for suicidal action than depression (Negron et al. 1997, Beck 1986). Another study showed that depression, previously attempted suicide and feelings of hopelessness are the most powerful clinical predictors of future suicide (Malone et al. 2000). Elderly patients with severe depression, poor social support, and a history of serious suicide attempts have a high suicide potential (Alexopoulos et al. 1999). Research has shown a relationship between psychosis and rates of suicidal behavior; especially among patients with major depression and schizophrenia (Radomsky et al. 1999), and that a change in the environment may trigger
suicide in people with schizophrenia (Funahashi et al. 2000). For example, a study in England and Wales reported suicide risks concerning psychiatric inpatients with depression in the first week of admission to (Copas & Robin 1982), and soon after discharge from psychiatric care (Goldacre et al. 1993). According to Michel (1997) depressive states have to be assessed carefully and treated adequately in order to prevent suicide. One argument is that suicide among people with mental illness is, principally, the end result of a serious mental illness, and as such cannot be prevented any more than can death associated with other serious illnesses (Gralnick 1993).

Physical illness is also a risk factor in suicide. A European study (De-Leo et al. 1999) has shown that of 1269 people who attempted suicide one in two suffered from an acute or chronic disorder, 42% of these rated their somatic problem as a factor precipitating their suicide attempt, and 22% judged it to be a major factor. Similarly, a study by Horte et al. (1996), showed a correlation between the suicidal act and serious physical disease. A Swedish study revealed that of 100 psychiatric patients who committed suicide, two-thirds had one or more somatic disorders that restricted their daily activities (Gustafsson 1999a, p. 9).

Substance abuse and depression also represent a high-risk profile for suicidal actions (Shaffer et al. 1996, Brent et al. 1993b, Kovacs et al. 1993). A study by Hawton et al. (1982) has shown that adolescents, who had taken overdoses, also suffered recent and current physical illness. Diabetic adolescents even use insulin to harm themselves (Kaminer & Robbins 1988).

In a retrospective US study, Buzan and Weissberg (1992) reported that most patients who committed suicide were under-diagnosed and under-treated by physicians. Another study in the US (Murphy 1975) showed that 49 out of 60 patients who committed
suicide had been under the care of 71 physicians six months or less prior to the suicide. Twenty-seven of the 49 patients had talked about suicide, and 21 had histories of attempted suicide. The results of a study by Jegesy et al. (1995) in Hungary indicated that most of the suicide victims contacted a doctor and received some treatment immediately before death. A Swedish study showed that 79 of 271 male inpatients had received psychiatric care during the six months preceding their death (Beskow 1979). Another Swedish study showed that 57% of 104 people who committed suicide had been in contact with psychiatric care services within a year before their suicide (Åsgård 1990). A total of 16% of those attempting suicide in Norway in 1994 were reported to have received help from a psychologist or psychiatrist (Rossow & Wichström 1997).

A Swedish study has shown that the suicide risk is particularly high during the first year after attempted suicide. Both old and young males who have once attempted suicide are at high risk of committing suicide (7% and 10% respectively), and older females are at higher risk than younger ones (6% vs. 2%) (Nordström et al. 1995). It has been noted that more specific procedures for follow-up care of parasuicide patients need to be developed (Möller 1989). Much has been written about determining risk factors in order to predict suicide. It is apparently not possible, however, to predict with any precision which patients will commit suicide (Rygnestad 1997, Newman et al. 1992, Goldstein et al. 1991) or to predict repetition of suicidal action (Hjelmeland et al. 1998).

**Psychosocial perspectives on suicide**

It is very complicated to explain and understand suicide other than in such extreme situations as war, torture, mortal disease etc. While people may be predisposed to self-harm because of situations in their childhood, suicide can be triggered by current life situations such as loss, stress or a desperate need to gain control over one’s own life.
Wagner (1997) suggested that familial sexual abuse is one of the best-documented risk factors in suicide and suicidal behavior. Other risk factors include the recent ending of an interpersonal relationship coupled with feelings of hopelessness, helplessness, worthlessness, and insomnia and the inability to keep a job (Hall et al. 1999).

Studies have described a correlation between unemployment and suicidal behavior among adolescents (Heikkinen et al. 1994, Hawton et al. 1993,). Hjelmeland and Bjerke (1996) found that the proportion of unemployed people among 2,068 parasuicide patients in Sør-Trøndelag, Norway, remained fairly stable from 1988 to 1993, while the rates of unemployment increased in the general population.

Sexual problems have received little direct attention in relation to suicidal behavior. Remafedi et al. (1998) showed that gay and lesbian adolescents have an increased rate of suicidal attempts, and most likely also of suicide. A probable explanation for this is social stigmatization.

Studies also point out the influence of socio-economic status in relation to suicide. While Durkheim (1978/1897, p. 130) found that the suicide rate was higher in the higher socio-economic classes, more recent research in the US showed suicide attempts to be more prevalent in lower socio-economic classes (Lewis et al. 1988).

Runeson and Beskow (1991) described 19 people who committed suicide and suffered borderline disorder and had problems such as a family history of substance abuse in the home, employment and financial problems, lack of a permanent residence, and early parental absence.
Physicians in Norway have a higher suicide rate than the general population or other academics. Little is known about the reasons for this. The risk factors found included being female, living alone and suffering from depression (Hem et al. 2000).

**Existential perspectives on suicide**

A human being almost always has the possibility to choose death. When someone commits suicide, people around them are stricken with guilt. Suicide evokes guilt in others because it raises the haunting question of what one could have done to prevent it. Suicide, in and of itself, makes one reflect upon life. When we meet suicide in our personal surroundings, we are suddenly made more aware of our own mortality and inability to control our lives.

Similarly, Marcel writes that suicide results from a struggle with the most fundamental of questions, the meaning of life (Marcel 1950, p. 139). He talks about the need to “explore the inner world of suicide on the part of those creative individuals whose talents lead them to explore, understand, and communicate the deeper dimensions of the human being who struggles with captivity, absurdity, loneliness strangeness and hopelessness” (Randall 1992, p. 21). In his work, Marcel examines various relationships, including life-hope, suicide-hopelessness, hope-despair, as well as various kinds of suicide, including mental suicide, *i.e.*, cynicism, (emanating from experiences such as loneliness, alienation, strangeness and hopelessness) (Marcel 1967, p 229), incarnate suicide, *i.e.* physical suicide which is a radical rejection of being (Marcel 1979, p. 194), and collective suicide, *i.e.*, spiritual suicide; it is technology which sets the stage for the reduction of life to a series of techniques and for the resulting loss of faith and transcendence (Marcel 1950, p. 28). For Marcel, as well as Camus (1967, p. 6), there is only one essential starting point for any genuine philosophical thought: suicide, that is “…the relationship between individual thought and suicide” (Randall 1992, p. 19).
Health personnel’s, patients’ and relatives’ perspectives on suicide

Most studies about personnel, patients and relatives pertaining to suicide are based on structured interviews and questionnaires. Care for a patient at risk of committing suicide is a tremendous challenge for health personnel as well as for the patients’ relatives. Health personnel in hospitals often meet people who have expressed a wish or even attempted to commit suicide, and fear that the patient at risk in this respect may make renewed attempts while hospitalized (Becker-Fritz 1987). Anyone at risk of committing suicide may be hospitalized in a psychiatric hospital if considered a danger to themselves and/or are suffering from mental illness (Department of Health and Social Security 1961). Pallikkathayil and Morgan (1988) emphasized a conflict between the professional duty to save human life and the human right to control one’s own destiny, which engenders insecurity.

Health personnel in Swedish medical emergency rooms tend to exhibit more unfavorable attitudes towards a patient at risk of committing suicide than psychiatric staff (Samuelsson et al. 1997a, Suokas & Lönnqvist 1992). A study in the US showed that physicians were less willing to treat the older suicidal patient than younger patients. The physicians were more likely to feel that suicidal ideation on the part of the older patients was rational and normal (Uncapher & Arean 2000). Waern et al. (1999) described elderly patients who were open about their suicidal feelings, whereas doctors seldom discussed the topic. Medical personnel are often the first professionals to meet a patient at risk of committing suicide in hospital. Physicians have a right and duty to intervene to prevent suicide. This meeting might affect the willingness of patients at risk to receive other types of professional help. A study by Beskow et al. (1996) of ten physicians employed at a psychiatric hospital in Sweden described some aspects of the meeting between the psychiatrist and the patient at risk of committing suicide. The
psychiatrists' previous personal experiences, competence in understanding and discussing existential questions, and their ability to communicate using everyday language were of great importance for establishing contact with the patient. The quality of this contact was found to be decisive for establishing the validity of the suicidal risk assessment.

Maltsberger and Buie (1974) described feelings of malice and aversion among psychotherapists in the treatment of a patient at risk of committing suicide and understood these feelings as countertransference: repression, turning against one's self, reaction formation, projection, distortion, and denial. Such feelings of countertransference on the part of the therapists may reduce their recognition ability and add to the danger of suicide. Wolk-Wasserman (1987) reported that patients at risk of committing suicide evoked feelings of guilt, incompetence, anxiety, fear, anger, hopelessness, helplessness and a sense of failure in therapists (Richards 2000). It has been suggested that negative reactions from clinicians toward patients exhibiting suicidal behavior may be related to the stigma of losing a patient (Fremouw et al. 1990).

Inpatient suicides have marked effects on therapists. Research has shown that there are three phases therapists pass through after a suicide on a ward: first, disbelief, bewilderment and a sense of loss of control; second, overwhelming feelings of anger, guilt, anxiety, depression and doubt about their own judgment; and, third, an opportunity for growth (Cotton et al. 1983). Therapists who have lost patients through suicide also expressed self-blame and self-doubt (Valente 1994a). Brown (1987) reported that psychiatrists who had experienced patient suicide felt that the impact was "severe" or "strong", and that it had a "major effect" on their development as physicians. A suicide can be even more devastating when it occurs while the psychiatrist is still in training (Chemtob et al. 1988). According to Grad et al. (1997), the most frequently reported
reactions among therapists after losing a patient were increased caution in their treatment of other patients and more talk with colleagues and supervisors. There was agreement among the therapists that support is important both professionally and personally and that therapists need to be offered help in order to be able to work through the trauma of a patient suicide.

Mental health nurses belong to a profession that requires them to save lives, and yet they may experience interpersonal conflicts in keeping someone alive who does not want to live (Whitworth 1984). When nurses become angry, patients may interpret it as a personal rejection (Lewis et al. 1986). Nurses at an emergency department in the US reported that they sometimes felt angry when in contact with a suicidal patient at risk of suicide (Pallikkathayil & Morgan 1988). Goldney and Bottrill (1980) showed that there was a considerable incidence of non-sympathetic attitudes on the part of nurses in an initial contact with the patient at risk of committing suicide. According to McLaughlin (1994) and Samuelsson (1997) older and more experienced nurses seem to have more positive attitudes toward suicidal patients than younger less experienced nurses.

A study in Sweden showed that female psychiatric nurses tended to be more sympathetic towards a person who had attempted suicide than male nurses, and the personnel who worked in psychiatric emergency or short-term care had more positive attitudes than personnel who worked in psychiatric intermediate or long-term care (Samuelsson 1997). A study in England by Hemmings (1999) has shown that attitudes among nursing and medical staff in an emergency team revealed a high degree of ambivalence, frustration and distress towards self-harming patients. It has also been reported from the US that older nurses and nurses with higher qualifications are more often willing to accept a patient’s right to commit suicide than younger nurses and those with fewer qualifications (Alston & Robinson 1992).
Head nurses’ reactions to patients at risk of committing suicide have been described as a kind of process: ‘naivety, recognition, responsibility and individual choice (Hamel-Bissell 1985). The ‘naivety phase’ is characterized by shock, lack of understanding, avoidance and denial. During the ‘recognition stage’ of fear, anxiety, helplessness and confusion, there is overlap with the previously mentioned feelings. The ‘responsibility phase’ entails feeling responsible, guilty and angry. When they reach the ‘individual choice phase’, the nurses see the patients as being responsible for their own lives, and learn to accept the fact that some patients choose to die. A study in North Wales by Midence et al. (1996) has shown that when nurses lost patients due to suicide, some felt sad, shocked, fearful, angry and guilty while others seemed less affected. There was a lack of support for the nursing staff during the post-suicide period.

Very few studies are available from the perspective of those who have been at risk of committing suicide. In Sweden, the overall patient satisfaction with psychiatric care has been reported to be high (Höglund 1992). Suicidal patients may be extremely sensitive and vulnerable. They may feel helpless, worthless and guilty (Lewis et al. 1986), and they often communicate their suicidal intentions either verbally or non-verbally to health personnel and relatives (Wolk-Wasserman 1986, Bernstein 1978-79, Kovacs et al. 1976). Valente (1994b) described the results of an analysis of the suicide messages of 25 male psychiatric inpatients who committed suicide. Most of these patients sent a clear message in advance, communicating suicide as their only solution to life’s traumas. Studies have shown that people who have attempted suicide are very willing to talk about their life crisis and express feelings of isolation arising from lack of communication with professional staff (Dunleavey 1992, Pallikkathayil & McBride 1986).
Results of a study in Ireland by McLaughlin (1999), using content analysis of semi-structured interviews with 20 psychiatric nurses and 17 suicidal inpatients, reported that both patients and nurses believe that the most important skill in psychiatric nursing is communicating with patients about their difficulties. In this study, patients suggested that nurses should spend more time helping patients to solve their difficulties; both nurses and patients indicated that situational factors interrupt their time together.

In a Swedish study the relatives of patients who committed suicide reported that their first contact with psychiatric care was negative. They received limited information about medical treatment; questioned the competence of the personnel; felt that the patient’s suicidal behavior was not taken seriously; and had not been allowed to participate in patient care and treatment (Åkerberg et al. 1994). These results are quite similar to those from a study in England by Solomon et al. (1988) who found that communication between families and psychiatric hospital staff was relatively poor, e.g. the staff neither provided information to help them understand what was wrong with the patient, nor information about treatment programs and the patient’s progress. These families also felt that the hospital had responded poorly in terms of providing practical advice and emotional support. A Canadian study by Thompson and Weisberg (1990) showed that 100 families received more help than they originally wanted in some areas, e.g. diagnosis and handling their own feelings. In other areas, however, they received less help than they wanted, especially in learning how to improve relations with the patient and to obtain information about follow-up plans. Most of the relatives felt that psychiatrists were the most important source of information.

According to a Swedish study by Magne-Ingvar and Öjehagen (1999), information from partners, adult children, siblings and friends of those who attempt suicide would be helpful in the psychiatric assessment of patients. These people themselves said that they
wanted individual counseling and/or counseling together with the patients in order to resolve the circumstances of the suicide attempt. Relatives of people who have committed suicide are at high risk of developing medical problems. Many enter the healthcare system during the first year after the suicide of a loved one (Van Dongen 1991), and are at increased risk of committing suicide themselves (Ness & Pfeffer 1990). Information from relatives is noted as being of special importance in assessment of suicide risk, e.g., in neurological patients (Kallert 1994).

In an Australian study family and friends of 15 people who committed suicide in Australia were interviewed in order to elicit their perceptions of the support given by health personnel to the people prior to their death. The study showed that the families believed there was inadequate support, that information and education were uncoordinated and sparse, and health personnel displayed negative attitudes towards patients at risk of committing suicide (Nirui & Chenoweth 1999).

Very little literature pertaining to research about the lived experience of patients at risk of committing suicide, their relatives or health personnel has been found.

In Canada, Moore (1997) interviewed 11 adult inpatients (aged 64-92 years) about their experiences of being suicidal. A hermeneutic interpretation revealed that these participants felt they were ‘uncared for and powerless’ to relieve their tremendous personal suffering and, moreover, lack of caring on the part of healthcare staff further reinforced their feelings of powerlessness (Moore 1997).
Suicidal psychiatric inpatients in Sweden were asked to narrate their experiences of care. The importance of being well cared for and experiencing understanding and confirmation was emphasized; conversations with the staff were seen as essential to the process of healing and the desire to go on living (Samuelsson 1997b).

**RATIONALE FOR THE STUDY**

The rationale for this study is based on my reflections after reviewing the published literature and my experience as an RN with specialist training in psychiatric nursing. The literature related to suicide raises several concerns. First, according to epidemiological data, suicide is an increasing public health problem in Norway as well as in other parts of Europe. Second, there is an abundance of research pertaining to the ‘outer world’ of suicide as reported from statistical, biomedical and sociological literature, and very little research into a lived experience perspective. It seems important to me to grasp a more in depth understanding of this experience so that meaningful care can be provided.

The real world of health personnel can be seen as a web of activities. As a psychiatric nurse, I believe a central activity for health personnel involves entry into relationships with patients. The patient is ill and knows best how the illness affects him or her. It is a moral imperative for health personnel that they understand what is best for the patient. In dealing with patients at risk of committing suicide, health personnel are challenged, not just concerning what they should do, but also concerning being present, attentive and thoughtful. In my experience, it is not sufficient for health personnel to understand the life situation of the patients at risk of committing suicide against a background of theories or models, nurses and physicians must also look for the meaning of the lived experiences from patients themselves and their relatives. The challenge here is to
illuminate the meaning of the everyday ordinary, or the difficult extraordinary, which
the health personnel talk about in terms of their day-to-day life in a psychiatric hospital.
Since the reviewed literature revealed very few phenomenological hermeneutic studies
on suicide from the perspective of patients, their relatives and health personnel, such an
investigation was undertaken for this study.

PURPOSE AND AIMS OF THE STUDY

The overall purpose of this thesis is to increase the understanding of the meaning of
caring for and treating patient at risk of committing suicide as experienced by suicidal
patients and their relatives, RNs and physicians in a psychiatric setting. The specific
aims of this thesis are as follows:

- To illuminate the meaning of RNs’ and physicians’ narrated experiences of taking
care of and treating patient at risk of committing suicide (I, III).
- To illuminate the meaning of the experiences of being cared for and treated by
mental health nurses and physicians as narrated by patients at risk of committing
suicide (II, IV).
- To illuminate the meaning of relatives’ narrated experiences of being met by
health personnel (V).

METHODOLOGICAL FRAMEWORK

A phenomenological hermeneutic method inspired by Ricoeur (1982, 1976, 1967) was
used in the interpretation of the interview texts. The word phenomenology comes form
the Greek words ‘phainomenon’ (that which reveals itself) and ‘logos’ (reason,
discussion), and means reason or discussion about that which reveals itself (Honderich
1995, p. 659). Phenomenology is the systematic study of phenomena by returning to the
things themselves, to a person's lived experience of being in the world and, most importantly, phenomenology focuses on the meaning of such lived experience. Through phenomenological reduction, a distance from naturalistic 'naivety' is created and this reduction increasingly signifies a return to "the primordial evidence of the world" (Ricoeur 1967, p. 12).

'Hermeneutics' is derived from the Greek word 'herméneuein' meaning to interpret, and 'herméneutike' (techné) is the art of interpretation (Honderich 1995, p. 353). Ricoeur (1982, pp. 101-128) describes phenomenology as a prerequisite for hermeneutics, and hermeneutics as a prerequisite for phenomenology. According to Ricoeur the task of hermeneutics is not to understand the intention of the author but the meaning of the text itself (Ricoeur 1976, p. 92). What has to be understood and assimilated in a text is the world the text opens up, beyond the situation of the reader and the author (cf. Ricoeur 1976, pp. 34-37). The reader opens up her/himself to possible modes of being in the world which the text discloses (Ricoeur 1982, p. 177).

Understanding of a text is always governed by a pre-understanding (Ricoeur 1982, p. 108). Awareness and critical reflection of the interpreter's pre-understanding occur directly or indirectly through discourse with other people. The unconscious part of the interpreter's pre-understanding consists of a part of her or his own culture, language, history, which though taken for granted still influence the interpretation of the text (cf. Malterud 1996). This subjectivity can only be counteracted by the application of a strict method of interpretation (Ricoeur 1976, pp. 92-94).

My experiences as an RN specializing in psychiatric nursing, contribute to my pre-understandings of taking care of people at risk of committing suicide. I have worked as an RN in a psychiatric hospital, and provided care for patients who had thought about,
expressed a wish or even attempted to commit suicide. In my clinical practice, I have experienced feelings of anger, guilt, frustration and sympathy in relation to patients at risk of committing suicide. I have also experienced fear that patients would make renewed suicide attempts while hospitalized or even commit suicide. I simultaneously felt that I had to respect the fact that the patients wanted to commit suicide and felt that I had the right and duty to intervene and prevent patients from successfully committing suicide. I have never experienced suicide in my psychiatric practice, either in my family or in my immediate social network. Being with a patient at risk of committing suicide is one of the most challenging, demanding, and painful human situations with which I have been confronted.

MATERIAL AND METHOD

An overview of the status of papers comprising this thesis is supplied in Table 1.
Table 1. Overview of the status of Papers I-V

<table>
<thead>
<tr>
<th>Paper</th>
<th>Focus of the study</th>
<th>Participants</th>
<th>Data and data collection dates</th>
<th>Method of interpretation</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>Nurses’ experiences of caring for patients at risk of committing suicide</td>
<td>19 RNs</td>
<td>Narrative interviews 1992</td>
<td>Phenomenological hermeneutic</td>
<td>Published</td>
</tr>
<tr>
<td>II</td>
<td>Patients’ experiences of being cared for by nurses</td>
<td>21 patients</td>
<td>Narrative interviews 1994-1995</td>
<td>Phenomenological hermeneutic</td>
<td>Published</td>
</tr>
<tr>
<td>III</td>
<td>Physicians’ experiences of treating patients at risk of committing suicide</td>
<td>19 physicians (10 RP)³</td>
<td>Narrative interviews 1996-1997</td>
<td>Phenomenological hermeneutic</td>
<td>Accepted for publication</td>
</tr>
<tr>
<td>IV</td>
<td>Patients’ experiences of being treated by physicians</td>
<td>21 patients</td>
<td>Narrative interviews 1996-1998</td>
<td>Phenomenological hermeneutic</td>
<td>Accepted for publication</td>
</tr>
<tr>
<td>V</td>
<td>Relatives’ experiences of being met by mental health personnel</td>
<td>15 relatives</td>
<td>Narrative interviews 1996-1998</td>
<td>Phenomenological hermeneutic</td>
<td>Manuscript submitted</td>
</tr>
</tbody>
</table>

Research setting

The research setting was a psychiatric hospital in Tromsø, Norway, which is part of Health Region V in the north of Norway. The hospital is the central hospital for the counties of Troms and Finnmark, with a population of 225 000 and an area of 74 618 sq. km. The hospital provides care for people with severe, acute and long-term psychiatric illnesses. In 1997 there were 848 admissions and a total of 34 644 inpatient days in the Psychiatry Department and 8 713 consultations in the Adult Psychiatry Outpatient Clinic.
Participants

Purposive samples of RNs, physicians, patients, and patients’ relatives were selected. Table 2 gives an overview of participants and selected wards at the psychiatric hospital.

Table 2. Overview of participants and selected wards at the hospital

<table>
<thead>
<tr>
<th></th>
<th>Long-term ward (n=2)</th>
<th>Critical care ward (n=3)</th>
<th>Sub-emergency ward (n=2)</th>
<th>Psychogeriatric ward (n=1)</th>
<th>Outpatient department ward (n=1)</th>
</tr>
</thead>
<tbody>
<tr>
<td>RNs</td>
<td>X</td>
<td>X (2wards)</td>
<td></td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Physicians</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Patients</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Patients' relatives</td>
<td>X (1 ward)</td>
<td>X</td>
<td></td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

Registered nurses (RNs) (I)

From a list of names of 24 RNs specialized in psychiatric nursing, telephone contact was made with a purposive sample of 19 RNs. All the RNs verbally gave informed consent to participation in an interview. The interviewees were 15 women and four men, varying in age from 25 to 45 years. The RNs had worked in the hospital for 2.5 years to 20 years. Each chose the time and place for the interview: 17 chose their own place of work and two selected my office.

Physicians (III)

From a list of names of 30 physicians a purposive sample of 19 physicians was selected to participate in an interview. Information about the project was communicated by letter. After 14 days, the physicians were contacted by telephone to arrange an appointment time. All the physicians gave written informed consent to participation in the study. The interviewees comprised 10 men and nine women, between the ages of 31 and 55 years.

3 Specialists in psychiatry
The physicians had worked with psychiatric patients from six months to 25 years. Ten of them, six men and five women, had specialist training in psychiatry and from six months to 25 years of clinical experience. All the physicians chose to be interviewed in their own offices.

Patients at risk of committing suicide (II, IV)

Two groups of patients were interviewed: 21 patients were interviewed about being cared for by mental health nurses and 21 other patients were interviewed about being treated by physicians. Interviews about relations with mental health nurses were conducted in 1994-1995. Nine men and 12 women with an age range 25-63 years participated. The interviews about relations with physicians were conducted in 1996-1998. Ten men and 11 women who ranged in age from 23 to 78 years participated.

Before beginning the interviews, I scheduled three separate meetings to provide information about the project and to gain co-operation in arranging the interviews with the patients and their relatives. The first meeting included the head nurse, the deputy head nurse, and senior nurses in the department. The second meeting included each of the senior medical officers. The final meeting involved health personnel on six wards. All parties responded positively to these meetings.

The selection criteria for all patients were: hospitalized for more than one week prior to the interview with expressed having thoughts about, wishing to or even attempting to commit suicide. All patients were fluent as regards both speaking and understanding Norwegian. The chief physicians informed the patients verbally and in writing about the project, obtained permission to disclose their names, and, an appointment was scheduled with each patient and their primary contact nurse. During this appointment with each patient and her/his primary contact nurse, I provided information about the study and
answered questions. The patients did not know me, and the intention behind having the primary contact nurse present was to provide a secure setting for the patients, and make it possible for them to ask the nurses questions about the study after the meeting. At scheduled times, an interview was then conducted with each patient, in total 42 interviews. All interviews were conducted in a meeting room on the ward, at a time set by the patients and the primary contact nurse.

Patients' relatives (V)
Twenty-three psychiatric in-patients at risk of committing suicide were contacted and their permission requested to contact their relatives. Eight of these patients did not consent to such contact. The patients said they had no contact with their relatives, or they did not want to burden their relatives with being interviewed. Fifteen patients consented to the contact with relatives. Seven of those 15 patients who participated in the patient interviews about their experiences of being treated by physicians were also requested to grant their permission for a relative to be contacted. The procedure for contacting the remaining eight patients was the same as described above under 'Patients at risk of committing suicide'.

The fifteen patients who consented to the contact with their relatives decided which relatives should be contacted; wife, husband, parents, daughter, son and sister-in-law. These relatives were informed by letter about the project, and they were sent the patient's declaration of informed consent for contact to be made with their relatives, and a form for their own declaration of consent. If a reply was not received within 14 days, the relatives were contacted by telephone. All relatives contacted were willing to take part in the study, and gave their informed consent in writing. The relatives were eight females and seven males. The interviews were conducted in various places as requested
by the relatives: three in the home of relatives, six in my office and six in the meeting room on the psychiatric ward.

**Narrative interviews**
The data collection for Papers I-V was based on narrative interviews (Mishler 1986, pp. 53-59). The purpose was to obtain descriptions of the lived experiences of the participants in order to interpret the meaning of the phenomenon 'psychiatric care of people at risk of committing suicide'.

Interpretation of narratives has been used in nursing research in psychiatric care. For example, Hellzén (2000) interpreted nurses’ and patients’ narratives about care for people with mental illness and provocative actions, Olofsson (2000) interpreted nurses’, patients’ and physicians’ narratives about coercion, and Pejlert (2000) reported nurses’, patients’ and their relatives’ narratives about care of people suffering from long-term schizophrenia. Other nursing researchers have used interpretation of narratives, such as Gilje (1993) who studied narratives about patients’ lived experiences of nurses’ presence in a hospital; and Totka (1996) who reported stories from pediatric practice to illuminate nurses’ boundaries in their own practice.

This study concerns the limit situations of suffering, guilt and death (cf. Jaspers 1994, pp. 96-104). Narrative interviews were chosen as I saw narrative interviews as being particularly useful when traumatic and sensitive events in a person’s life are at issue (cf. Riessmann 1993). Narratives constitute an important part of the participant’s identity (cf. Bjerg 1986, pp. 43, 94) and provide a way to understand the meaning of their lived experiences (cf. Coles 1989, p. 7). When narrating, interviewees put into words what they want to talk about, and telling about their own experiences may have a kind of healing effect (Brody 1987, pp. 5-13).
Narratives disclose the complex interplay between cognition, emotion, volition and action (Tappan 1990) and are fundamental in formulating and communicating human life experiences (Polkinghorne 1988, p. 15). It is a form, which people spontaneously use to find meaning in their world (Hydén 1995). The narrative is the interviewees’ interpretation (reconstruction) of what happened (Sandelowski 1991, Carr 1985, pp. 74-77).

The audio-recorded personal narrative interviews lasted from 30 to 90 minutes, and were transcribed verbatim by me. I conducted all the interviewees. I asked questions of: RNs and physicians about their experiences of caring for and treating a patient at risk of committing suicide; patients at risk of committing suicide about their experience of being cared for and treated by mental health nurses and physicians; relatives about their experience of being cared for by health personnel. I elaborated sequences, which were unclear or that I did not understand, by asking questions such as: What did you feel? What did you think? What did you do then? The questions helped the interviewees to continue their stories, which in turn led to new questions. The questions often resulted in a new narrative phase, which in turn led to a new questioning phase. The interviews had a spiral-like structure.

Forty-two psychiatric inpatients at risk of committing suicide narrated that they had thought about, wished to or even attempted to commit suicide and about their lived experiences of being treated and cared for by physicians and mental health nurses. Table 3 reports the frequency of patients who narrated stories of attempted suicide and suicidal thoughts.
Table 3. Frequency of patients who narrated stories of attempted suicide and suicidal thoughts

<table>
<thead>
<tr>
<th></th>
<th>Attempted suicide</th>
<th>Suicidal thoughts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients’ narratives</td>
<td></td>
<td></td>
</tr>
<tr>
<td>related to nurses</td>
<td>10</td>
<td>11</td>
</tr>
<tr>
<td>Patients’ narratives</td>
<td></td>
<td></td>
</tr>
<tr>
<td>related to physicians</td>
<td>11</td>
<td>10</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>21</strong></td>
<td><strong>21</strong></td>
</tr>
</tbody>
</table>

Nineteen RNs and 19 physicians narrated their lived experiences of caring for and treating patients who had thought about, attempted and even committed suicide. Table 4 reports the frequency and type of suicidal actions or thoughts mentioned in the narratives of RNs and physicians.

Table 4. Frequency of RNs and physicians who narrated suicidal actions or thoughts

<table>
<thead>
<tr>
<th></th>
<th>Completed suicide</th>
<th>Parasuicide/Attempted suicide</th>
<th>Suicidal ideas?/Suicidal thoughts</th>
</tr>
</thead>
<tbody>
<tr>
<td>RNs</td>
<td>1</td>
<td>8</td>
<td>10</td>
</tr>
<tr>
<td>Physicians</td>
<td>5</td>
<td>5</td>
<td>9</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>6</strong></td>
<td><strong>13</strong></td>
<td><strong>19</strong></td>
</tr>
</tbody>
</table>

Fifteen relatives (1 wife, 5 husbands, 2 fathers, 4 mothers, 6 parents, 1 daughter, 1 son, 1 sister-in-law) narrated their lived experiences of being met by mental health personnel. Four relatives narrated their experiences of patients with suicidal thoughts and 11 relatives had narrations about patients who had attempted suicide.

Interpretation

As the interviewer, I was a co-producer of the text. The interviews were audio taped and transcribed verbatim. The interview transcripts provide a distance from the dialogue situation between the interviewees and myself. The interview text in this study was read both by my co-researchers and myself. What we interpreted was thus tape recorded.
speech, in that way our method differs from the method described by Ricoeur (1976). Our method is being developed for nursing research at Umeå University, Sweden and the University of Tromsø, Norway (e.g. Lindseth et al. 1994, Rasmussen 1999, p. 46, Söderberg 1999, p. 23).

In the interpretation of the text, my co-researchers and I asked what the text said semantically, and what possibilities it opened up; and these possibilities were then further reflected on. At the same time, in the interpretation of the text, each of the informants was remembered, and the informants were “present” as a silent party in the interpretation of the interviews.

In this study the interpretation of the narratives about psychiatric care situations in this study focuses on the meaning of the interviewees’ lived experience of the psychiatric care of people at risk of committing suicide, i.e. each narrative contributes aspects to the phenomena of the meaning of caring for and treating suicidal patients being respectively treated and cared for.

Recognition of my own pre-understanding necessitated my setting aside assumptions, such as “what I read is self-evident from what I think and know”, or “I knew of this experience”. This awareness of the need to liberate myself from prejudice and dogma was necessary in order to gain a deeper understanding of the meaning played out in the text (Ricoeur 1967, pp. 348-357). According to Kemp (1988), Ricoeur says, that the moral pre-understanding of narrative includes a competence to use it in a meaningful way. My ability to meet the phenomena with as little prejudice as possible reduced the possibility of judging the informants. I had to be aware of the informants’ self-respect and did not judge the actions or opinions that they have talked about in the interviews (cf. Vehviläinen Julkunen 1993).
The interpretation is a dialectic process in three phases: first there is a movement from understanding (naive reading) to explanation of the text (structural analysis), and then a movement from explanation to understanding (critical comprehension) (Ricoeur 1976, pp. 92-94).

**Naive reading**

Each interview was read several times with an open mind in order to gain an overall impression and an initial overall grasp of the meaning of the text as a whole, which provided ideas for the forthcoming analysis.

**Structural analysis**

In this study a thematic structural analysis was conducted. The structure of the text was examined in various ways in order to explain what the text said. The text was divided into meaning units *i.e.* one or more sentences or whole paragraphs connected by their meaning content. The meaning units were condensed, compared and organized into sub-themes, themes and main themes.

**Critical comprehension**

A critical in-depth interpretation was developed from the results of the naive reading, the structural analysis, the researchers’ questions and pre-understanding, an affinity for the participants, the literature and re-reading the text as a whole for the purpose of gaining a deeper understanding of what the text as a whole indicated. The process of interpretation is spiral, the whole is understood by explaining the parts, and the parts are included in the perception of the whole. The aim of the interpretation is to create something new out of something already given.
The interpretation of the interview text refers to aspects of being in-the-world. This interpretation is accomplished with the interpreter’s interpretation of her- or himself, “..., the subject from now on understands himself better, in a different way or only now begins to understand himself” (Ricoeur 1991, p. 54). The interpretation of the text becomes assimilated into self-understanding, and a new discourse on one’s own possibilities occurs (Ricoeur 1982, p. 177). The interpretation in the last instance is self-reflection, which means that the meaning of the text can only be revealed through self-understanding, which leads to receiving a new mode of being in the world from the text itself (Ricoeur 1976, p. 94).

Ethical considerations
The Regional Committee for Medical Research Ethics Health Region V and the Data Inspectorate approved the study. The interviewees were informed both in writing and verbally about the study, and gave their informed consent to participation in the study. The interviewees were guaranteed confidentiality, including anonymity in the publication of the results. They were also told that they could withdraw from the study at any time without risk of any negative consequences. I did not have any responsibility for the care and treatment of the patients, nor a working relationship with the health personnel on the wards. Since my relationship with the interviewees was as a researcher only, no one should have felt coerced into participating in the study.

Prior to the interviews, I had not read the patients’ medical records, received reports or talked to staff in order to obtain information. Such background information about patients’ histories could have influenced my pre-understanding. However, as I wanted to meet the patients on equal terms i.e. without them knowing anything about me, I did not want information about them. Also, when I informed the patients that I did not have any information about their lives, they immediately looked into my eyes, smiled and relaxed.
I openly allowed each interviewee to present themselves in their own way. As I did not have any prepared pre-formulated interview questions and interviewees knew that I did not know anything about them, it was possible for unique elements to be expressed in the interviews, as Mishler (1986, p. 118) says, my objective was “to empower respondents to encourage them to find and speak in their own ‘voice’ ”.

According to Lögstrup (1971) it is the tone or spirit in communication, which is the fundamental phenomenon of ethical life. The tone of the dialogue determines whether it is good and trusting or artificial and false, and the tone that was stuck in the relation between the interviewees and myself was decisive of whether we were open or closed with each other (cf. Storaker 1992). I felt that the interviewees were interested in telling me about their lived experiences related to suicide. They were also interested in my questions and reactions to what they narrated. We became engaged in understanding each other, in the communication we expressed, saw, heard and perceived more than we realized (cf. Watzlawick 1978). In my efforts to understand what was said, I took residence in the narration – ‘indwelling’ i.e. through identification with the interviewees, I could understand something of what they were talking about (cf. Polanyi 1968). Recognition of the interviewees also evoked recognition of my own feelings such as anger, despair and grief (cf. Fog 1994, p. 42, Van Manen 1990, p. 84). In these situations, I sat in silence for a short time to reflect upon my feelings, and then continued to focus my attention on the interviewees i.e. what the participant said and how he/she said it, what he/she did and how he/she did it. There was a risk that I could have become enmeshed with the interviewees if I had had difficulty separating my own experiences from those of the interviewees when conducting the interviews (Sandelowski 1986).

The dialogues were open and trusting, and vigilance was required with regard to the interviewees’ “untouchability zone” (Lögstrup 1983, p. 171), this is the dialectic
movement between respect and openness as a condition for communication. I had to respect the limits set by the interviewees and this made it necessary for me to know my own boundaries in relation to anxiety and defenses (cf. Fog 1994). Engaging oneself as an interviewer about suicide is emotionally demanding. It was important for me to understand the emotions evoked during the interviews by sharing them with my research team and colleagues. At the same time, I had to make sure that the interviewees or the situation were not “lost” in favor of my own passion for the research project (cf. Gadamer 1986).

One important task for me during the dialogue was to observe signs of discomfort in the interviewees expressed through their nonverbal communication, e.g.; anxiety, mumbling, crying, pauses or silence. Unease was observed in most interviewees. I assessed whether or not the dialogical interview should continue based on three aspects: comfort level of the interviewees; own and the interviewee’s boundaries; and my own limits regarding an emotionally charged topic (cf. Morse 1991, p. 62). However, it was never necessary to interrupt or abandon any of the interviews. When the dialogue was over, there was silence. Van Manen (1990, pp. 99-114) reports that a good dialogue ends in silence: as dialogue decreases gradually with a series of increasingly frequent pauses, and in silence there is reflection around the dialogue. Silence was regarded as an expression of confidence and communion between the interviewees and myself, and as reflection on what we had talked about.

My aim concerning the interviews was to understand the meaning of caring for and treating a patient at risk of committing suicide as experienced by RNs and physicians, a patients at risk of committing suicide and their relatives. After the interview, interviewees said they had gained a new perspective on their situation. They said that hearing themselves talk about the experience was quite different from thinking about
their lived experiences. For interviewees, Hutchinson et al. (1994) assert that one’s own narrations can have a sort of healing effect and give a new insight as shown in a study involving people with aids (Grossman 1995), and survivors of murder victims (Cowles 1988). This means that participation in a research project such as this may have benefit the suicidal patient therapeutically (cf. Morse 1988, p. 215).

According to Lewis et al. (1986) a patient at risk of committing suicide often feels helpless, worthless and guilty. Therefore, I contacted the wards 2-3 days after the interviews were completed to obtain an impression of the well-being of the patients at risk of committing suicide. It was reported that the interviewees had not suffered any adverse effects from the interview, but such a possibility cannot be excluded (cf. Beskow et al. 1991).

RESULTS

In the following the results from each paper will be described, and the themes and sub-themes from each paper are shown in Tables 5-9.

Paper I

Paper I focused on the meaning of RNs’ experiences of taking care of psychiatric inpatients at risk of committing suicide. Two main themes were formulated which described the meaning of nurses’ caring for patients at risk of committing suicide: Distance and Closeness. A distance relationship with patient at risk of committing suicide meant feeling compassion without being able to imagine oneself in the patient’s situation. Nurses were guided by their consideration of the principles of treatment of disease. Nurses felt responsible and guilty when patients had suicidal thoughts and attempted suicide. Nurses did not meet the suicidal thoughts and the feelings of the patients and therefore avoided confronting their own anxiety and despair. Nurses failed
to make contact with patients, who did not respond to their care, thus making nurses feel incompetent, helpless and unable to help in the way they wanted to.

A close relationship with patients meant that nurses were aware of their own feelings, such as sadness, loneliness, and despair, and did not need to flee from encounters with patients at risk of committing suicide. Primary contact nurses gained confidence in the patients and made them responsible for their own agenda. They listened to patients, helped them to verbalize their feelings and focused their care on the patients' needs. Table 5 presents the meaning of taking care of patients at risk of committing suicide as narrated by RNs, organized under themes and sub-themes.

Table 5. The meaning of taking care of patients at risk of committing suicide as narrated by RNs organized under themes and sub-themes.

<table>
<thead>
<tr>
<th>Distance</th>
<th>Closeness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Compassion without emotional identification</td>
<td>Compassion with emotional identification</td>
</tr>
<tr>
<td>Mistrusting patient</td>
<td>Trusting patient through contact</td>
</tr>
<tr>
<td>Feeling responsible for patient’s actions, feelings of guilt</td>
<td>Feeling responsible for making patient’s agenda</td>
</tr>
<tr>
<td>Being rejected by patient</td>
<td>Being rejected by patient, temporarily</td>
</tr>
<tr>
<td>Rejecting patient</td>
<td>Listening to patient</td>
</tr>
<tr>
<td>Focusing on nurse</td>
<td>Focusing on patient</td>
</tr>
</tbody>
</table>

**Paper II**

Paper II focused on the meaning of the experiences of being cared for by mental health nurses as narrated by inpatients at risk of committing suicide. Their contact with nurses revealed the themes *Confirming* and *Lack of confirming*. Patients who described *lack of*
confirming on the part of the nurses communicated feelings that nurses did not care about the patients, and the patients felt ignored through not having their basic needs acknowledged and met. They felt that the nurses listened to them with prejudice, implying that they were only concerned with the patients’ symptoms and the effect of the medicines. Patients felt worthless as human beings and began to consider ways to take their lives while on the ward. In contrast, confirming meant feeling that the nurses repeatedly showed consideration and care for the patients. The patients thought of themselves as valuable people when nurses listened in a non-judgmental way to what they had to say. Such contact with nurses promotes hope in patients. Table 6 presents the meaning of being cared for by mental health nurses as narrated by inpatients at risk of committing suicide, organized under themes and sub-themes.

Table 6. The meaning of being cared for by mental health nurses as narrated by inpatients at risk of committing suicide, organized under themes and sub-themes

<table>
<thead>
<tr>
<th>Lack of confirming</th>
<th>Confirming</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overlooking patients’ basic needs</td>
<td>Attending to patients’ basic needs</td>
</tr>
<tr>
<td>Not seeing patients</td>
<td>Seeing patients</td>
</tr>
<tr>
<td>Not having time for patients</td>
<td>Having time for patients</td>
</tr>
<tr>
<td>Leaving patients</td>
<td>Being with patients</td>
</tr>
<tr>
<td>Listening to patients with prejudice</td>
<td>Listening to patients without prejudice</td>
</tr>
<tr>
<td>Not being open to patients</td>
<td>Being open to patients</td>
</tr>
<tr>
<td>Denying patients’ feelings</td>
<td>Accepting patients’ feelings</td>
</tr>
<tr>
<td>Communicating hopelessness</td>
<td>Communicating hope</td>
</tr>
</tbody>
</table>
Paper III focused the meaning of physicians’ experiences of treating suicidal psychiatric in-patients. Two main themes were constructed: *Power over* and *Power to*. A *power over* relationship with patients at risk of committing suicide meant listening to patients while focusing on the disease. The physicians were not open to the patients; they neither saw nor participated in the patients’ articulated experiences. Physicians decided what they would talk about, and rejected any other topics offered by the patients. The physicians mistrusted the patients who felt rejected by the physicians. The physicians avoided interacting with the patients or facing their own lived experiences concerning death. The physicians focused on protecting the patients from self-harm and were worried about their professional judgment and reputation. A *power to* relationship with patients meant that the physicians were open, in contact with patients and listened to the patients’ narratives about their suffering. The physicians trusted the patients, and recognized their own lived experiences concerning death when the patients talked about suicidal thoughts and actions. The physicians also had the impression that the patients trusted them. When a patient committed suicide, the physicians experienced grief. Table 7 presents the meaning of treating patients at risk of committing suicide as narrated by physicians, organized under themes and sub-themes of *Power over* and *Power to*. 
Table 7. The meaning of treating patients at risk of committing suicide as narrated by physicians organized under themes and sub-themes of Power over and Power to

<table>
<thead>
<tr>
<th>Power over</th>
<th>Power to</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Communicating with patients</strong></td>
<td><strong>Deep communication with patients</strong></td>
</tr>
<tr>
<td>Listening to patients with focus on disease</td>
<td>Listening to patients’ own narration about their lived experience</td>
</tr>
<tr>
<td>Not taking part in patients’ expressed experiences</td>
<td>Taking part in patients’ expressed experiences</td>
</tr>
<tr>
<td>Not being open to patients</td>
<td>Being open to patients</td>
</tr>
<tr>
<td>Rejecting patients</td>
<td>Caring about patients</td>
</tr>
<tr>
<td>Not being in contact with patients</td>
<td>Being in contact with patients</td>
</tr>
<tr>
<td>Distrusting patients</td>
<td>Trusting patients</td>
</tr>
</tbody>
</table>

| Not accepting one’s own mortality | Accepting one’s own mortality |
| Not acknowledging one’s own lived experiences about death | Accepting one’s own lived experiences about death |

| Not accepting one’s own vulnerability | Accepting one’s own vulnerability |
| Preventing of the patients’ death | Feeling responsible for patients’ life |

| Not accepting one’s own fallibility | Accepting one’s own fallibility |
| Feeling guilty of patients’ death | Grieving patients’ death |

| Worrying about one’s own professional reputation | Worrying about helping the patient out of difficulties |

| Being rejected by patients | Being trusted by patients |

**Paper IV**

The fourth paper focused on the meaning of being treated by physicians as narrated by inpatients at risk of committing suicide. Two main themes were constructed: *Participating approach* and *Observing approach*. Patients who described a *participating approach* meant that physicians spent time with them, even if they had a busy schedule. Patients regarded themselves as valuable people when the physicians interacted with them and gave them the opportunity to talk about their lived experiences. ‘Real interest’
was expressed by physicians through questioning and appropriate direct eye contact. The
patients felt they were taken seriously and were trusted when the physicians understood
or tried to understand what they said about their suffering. These experiences led to
patients gaining a new understanding of their own situation, and, medication also
seemed to help. Patients who said that the physicians had an *observing approach* when
they did not take the time to be with patients. This was described when patients had no
real contact with the physicians, and the physicians made decisions about patients’ lives
without consulting them. Patients did not understand the language the physicians used,
and felt that they neither listened nor understood what they were talking about. The
patients said that it seemed as if the physicians were always in authority and had the
‘right’ answer regarding their life situation, which denied patients their own feelings.
The patients felt rejected, and it was difficult for them to trust their physician. The
patients said that physicians neither took patients’ opinions into account nor included the
patients in planning their treatment. Physicians were preoccupied with medical
interventions and concerned only about their own success. Table 8 presents the meaning
of being treated by physicians as narrated by in-patients at risk of committing suicide,
organized under themes and sub-themes of *Observing approach* and *Participating
approach*. 
Table 8. The meaning of being treated by physicians, organized under themes and sub-themes of *Observing approach* and *Participating approach*

<table>
<thead>
<tr>
<th>Observing approach</th>
<th>Participating approach</th>
</tr>
</thead>
<tbody>
<tr>
<td>Leaving patients to themselves</td>
<td>Being with patients</td>
</tr>
<tr>
<td>Not choosing time for patients</td>
<td>Choosing time for patients</td>
</tr>
<tr>
<td>Not coming into contact with patients</td>
<td>Coming into contact with patients</td>
</tr>
<tr>
<td><strong>Listening to patients with prejudice</strong></td>
<td><strong>Listening to patients without prejudice</strong></td>
</tr>
<tr>
<td>Physician explaining patients’ disease</td>
<td>Patients’ narrating their own lived experiences</td>
</tr>
<tr>
<td>Having the ‘right’ answer for patients</td>
<td>Not having the ‘right’ answer for the patients</td>
</tr>
<tr>
<td>Denying patients their feelings</td>
<td>Accepting patients’ expressed experiences</td>
</tr>
<tr>
<td><strong>Mistrusting each other</strong></td>
<td><strong>Trusting each other</strong></td>
</tr>
<tr>
<td>Being rejected by physicians</td>
<td>Being trusted by physicians</td>
</tr>
<tr>
<td>Distrusting the physicians</td>
<td>Trusting the physicians</td>
</tr>
<tr>
<td><strong>Not respecting patients’ integrity</strong></td>
<td><strong>Respecting patients’ integrity</strong></td>
</tr>
<tr>
<td>Deciding patients’ agenda</td>
<td>Patients being involved in their own agenda</td>
</tr>
<tr>
<td>Implementing medical treatment</td>
<td>Being of health and support for patients</td>
</tr>
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**Paper V**

Paper V focused on the meaning of the experiences of being met by mental health personnel as narrated by relatives of inpatients at risk of committing suicide. The interpretation proceeded by organizing data into three parts based on temporality: experiences prior to admission; experiences during hospitalization; and, experiences at time of discharge. The meaning of the experience of being met was reflected in six themes: *Being seen as a human being*; *Participating in an I-Thou relationship with personnel*; *Trusting personnel, treatment and care*; *Being trusted by personnel*; *Being consoled*; and *Entering into hope*. Table 9 presents the meaning of being cared for by
health personnel as narrated by relatives of in-patients at risk of committing suicide, organized under themes and sub-themes.
Table 9. The meaning of being met by health personnel as narrated by relatives of patients at risk of committing suicide organized under themes and sub-themes

<table>
<thead>
<tr>
<th>Being met</th>
<th>(\Rightarrow)</th>
<th>Being seen as a human being</th>
</tr>
</thead>
<tbody>
<tr>
<td>Being acknowledged</td>
<td></td>
<td>Not being acknowledged</td>
</tr>
<tr>
<td>Being heard</td>
<td></td>
<td>Not being heard</td>
</tr>
<tr>
<td>Being kind</td>
<td></td>
<td>Being impolite</td>
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<tr>
<td>Needs being anticipated</td>
<td></td>
<td>Needs being denied</td>
</tr>
<tr>
<td>Being understood</td>
<td></td>
<td>Being misunderstood</td>
</tr>
<tr>
<td>Feeling secure</td>
<td></td>
<td>Feeling insecure</td>
</tr>
<tr>
<td>Being approachable</td>
<td></td>
<td>Not being approachable</td>
</tr>
<tr>
<td>Being respected</td>
<td></td>
<td>Not being respected</td>
</tr>
<tr>
<td>Being confirmed</td>
<td></td>
<td>Disconfirmed</td>
</tr>
</tbody>
</table>

| Participating in I- Thou relationship with personnel                     |                  |                            |
| Giving of self                                                          |                  | Being selfish              |
| Being open                                                              |                  | Being distanced            |
| Giving information                                                      |                  | Not giving information      |
| Receiving information                                                   |                  | Not receiving information   |
| Being patient                                                           |                  | Being impatient             |
| Co-operating                                                           |                  | Not co-operating           |
| Being close                                                             |                  | Avoiding contact            |
| Being understood                                                        |                  | Not being understood        |
| Being included                                                          |                  | Being excluded              |
| Being available                                                         |                  | Being unavailable           |

| Trusting personnel, treatment and care                                   |                  |                            |
| Having confidence in treatment                                          |                  | Lacking confidence in treatment |
| Trusting personnel                                                      |                  | Mistrusting personnel       |
| Relying on care                                                         |                  | Not relying on care        |
| Being cared for                                                         |                  | Not being cared for         |
| Having confidence in personnel                                          |                  | Not having confidence in personnel |

| Feeling trusted by personnel                                           |                  |                            |
| Working together                                                        |                  | Not working together        |
| Feeling close                                                           |                  | Feeling distant             |
| Having confidence                                                       |                  | Lacking confidence          |
| Needs being met                                                         |                  | Needs not being met         |
| Being available                                                         |                  | Not being available         |

| Being consoled                                                          |                  |                            |
| Feeling relieved                                                        |                  | Feeling stressed            |
| Feeling relaxed                                                         |                  | Feeling tense               |
| Feeling welcome                                                         |                  | Feeling isolated            |
| Feeling comfortable                                                     |                  | Feeling uncomfortable        |
| Being present                                                           |                  | Not being present           |

| Entering into hope                                                      |                  |                            |
| Accepting patients’ condition                                           |                  | Not accepting patients condition |
| Desiring partnership with personnel                                      |                  |                             |
| Moving on with a dignified life                                         |                  |                             |
The meaning of care and treatment for patients at risk of committing suicide as narrated by RNs, physicians, patients and patients’ relatives was made visible through the dialectics of the results presented in Papers I-V and the literature.

First an overview of the comprehensive understanding of Papers I-V will be presented in order to clarify the perspectives of RNs, physicians, patients and patients’ relatives before reflections on the whole study are presented and an overall comprehensive understanding is formulated.

Data collection for Papers I-V was based on narrative interviews. I asked RNs and physicians questions about their experiences in taking care of and treating patients at risk of committing suicide. I asked patients about their experiences of being cared for and treated by mental nurses, as I thought that patients would not be able to differentiate between RNs and ENs. I also asked physicians, and patients’ relatives about being met by health personnel. I did not ask patients at risk of committing suicide about their meaning in life or why they thought about or attempted suicide.

**Paper I**

Registered nurses met patients in a fluctuation between *closeness* and *distance*. At the *closeness* pole they tried to be open to patients’ situation and meet them where they were. Registered nurses, felt they were helpers. They focused their care on patients’ needs. They confirmed, and were in communion with patients. At the *distance* pole, RNs cared for patients within a distant relationship. They focused on the principles of treatment of the disease. They were not in contact with patients, and nurses felt
incompetent and guilty. They were not in communion with patients nor did they confirm them.

**Paper II**

Patients being met by nurses alternated between a *confirming* and *lack of confirming* relationship. At the *confirming* pole, nurses attended to patients' basic needs, cared about them, listened and respected them and fostered their hope. Patients thought of themselves as valuable people. Being confirmed, in communion with nurses, patients received consolation and hope. At the *lack of confirming* pole, nurses ignored the patients' needs. Patients felt they were not seen, welcomed or connected with the nurses, and they even thought about suicide. Being disconfirmed, for patients, involved the absence of communion and lack of consolation. Patients felt helplessness.

**Paper III**

Physicians met patients in an alternation between *power to* and *power over*. At the *power to* pole they tried to be open to the patients' situations and meet their needs. Physicians accepted suicide as a human reaction, and worried about patients. They grieved when patients committed suicide. They confirmed patients and were in communion with patients. At the *power over* pole physicians looked to causality and explanations for the patients being at risk of committing suicide and they lacked deep contact with the patients. Physicians distanced their own feelings of mortality and vulnerability, worried about their own professional reputation, and felt guilty. They disconfirmed patients, and did not engage in communion with patients.
Paper IV
Patients felt met in a way that varied between a participating approach and an observing approach from physicians. At the participating approach pole, physicians were present with patients, listened and trusted them, and respected their integrity. Patients felt cared about and regarded themselves as valuable human beings. Patients were confirmed and in communion with the physicians. At the observing approach pole, patients were left to themselves and felt they were not trusted by the physicians. Patients felt they were let down and lacked value as people. Patients felt disconfirmed, which involved a sense of lack of communion with physicians.

Paper V
Relatives felt that they were met by healthcare personnel when they felt they were seen as human beings and ways in which they could participate and feel trust were opened. In communion with personnel, relatives felt consoled as feelings of helplessness and powerlessness diminished and they entered into hope.

These results indicate the desire for confirmation, communion, consolation and hope. These results in essence of provide a relational view of suicide. Threaded through all the meanings of these results is relation with self and others.

Marcel’s (1982, pp. 11-37) differentiation between problem and mystery can shed light on a relational view of suicide. According to Marcel, problems can and should be solved, but we can only relate to mysteries and dwell in them. Mystery, first and foremost includes a view of self and others as unique human beings. When viewing suicide as a mystery, the person at risk of committing suicide may be viewed as a mystery – as a human being with a unique lived experience. A mystery cannot be reduced to details and analyzed, because a mystery is lived (Marcel 1965a, p. 110), as
Marcel (1948, p. 11) says, "I cannot place myself outside it or before it ... I am inside it in a certain sense, it envelops me and it comprehends me.” No doubt, it is always logically and psychologically possible to degrade a mystery into a problem (Marcel 1965a, p. 127). The diagnosis and treatment of the patient at risk of committing suicide belong to the realm of problems. The outer view of suicide, focuses on problems and looks to causality and explanation of suicide (III). This view may affect the view of the person at risk of committing suicide in that he or she is regarded as a problem – as a statistic, a genetic defect, a neurotransmitter imbalance or a family system dysfunction. Solely objective understanding encourages this view. In some respects, the results of this study indicate that the personnel were occupied with problem solving, e.g., implementing medical treatment (III), deciding about care plans (I), and focusing on tasks (II, IV), while patients wanted to be involved in their own care and relatives (V) wanted to receive information and be involved in the care of the family member.

How one sees suicide, then, may also transfer to how one views a person at risk of committing suicide. The perspective of suicide as a mystery leads to a fuller and deeper understanding of the complexity of the meaning of the experience of suicide. A relational view of suicide means a longing for confirmation, communion, consolation and hope (I-V).

Good relationships among personnel, patients and their relatives occur when the personnel value the patients, their relatives and themselves as human beings. Confirmation is amongst the most significant aspects of life. Confirmation means giving the other person the following messages: “To me, you exist! - We are relating! - To me, you are significant! - Your way of experiencing your world is valid” (Cissna & Sieburg 1981, p. 259). All human beings want to be confirmed for what they are, and even for what they can become (Buber 1957, pp. 102-103). This means that we must be present
as the people we are with the others. Making the other present means imagining what he or she perceives, feels and wishes at this very moment. The results presented in Papers I-V show that patients at risk of committing suicide, their relatives, RNs and physicians want confirmation as human beings. It has been noted that psychiatric patients are victims of disconfirmation (Laing 1961, pp. 89-93, Heineken 1982). Marcel (1982, p. 12) says that people are depersonalized through meeting mistrust from other human beings, as one patient (IV) said, “Do I mean so little as a patient that it is a matter of exchanging three words with me and writing them down and then hurrying away? I started to speculate about how in Heaven’s name am I to get help. Do I have to deal with this myself? I became depressed.”

Watzlawick et al. (1967, pp. 83-85) view confirmation and disconfirmation as underlying dimensions of communication expressed through messages such as: “This is how I see myself in relation to you”, rather than “This is what we are talking about”. This means that messages given by RNs and physicians define a confirming or disconfirming relationship between personnel, patients at risk of committing suicide and their relatives. Patients said that when the staff listen to their narratives about their lived experiences and spend time with them, they feel confirmed as valuable persons (II, IV), as one patient (IV) said, “I felt very privileged, simply because he showed that he had all the time in the world for me. That made me so at ease and comfortable in conversation with him”. Registered nurses and physicians also mentioned these aspects as important in their relation to people (I, III). Through confirmation we become more secure and stable in our self-esteem. According to Watzlawick et al. (1967, p. 84), confirmation is probably the greatest single factor ensuring mental development and stability. Suicidal psychiatric inpatients in Sweden emphasized the importance of being well cared for and experiencing understanding and confirmation; conversation with health personnel was seen as essential to the process of healing and the desire to go on
living (Samulelsson 1997b). Laing (1967, p. 58) says that confirmation between people might be equated to love. Drew (1986) illuminates the importance of confirmation for patients’ feelings of hope, comfort, confidence and assurance in a somatic setting. Paulson et al. (1999) show the importance of confirmation, i.e., that nurses’ and physicians’ ways of being evoke feelings of confidence and being cared for among inpatients.

According to Hegel (1977, pp. 111-119) confirmation leads to a strengthening of the self-consciousness of the person being confirmed. Hegel emphasizes that the formation of self-consciousness takes place within a dialectic of recognition. It is through the other person’s recognition of me, that my self-consciousness is formed. Self-recognition takes place within a dialectic of recognition in every new situation, and constitutes a mode of being. When personnel receive recognition from patients at risk of committing suicide and from patients’ relatives, this confirms their self-consciousness and they identify themselves as competent members of a staff. When physicians (III) and RNs (I) confirm patients (II, IV) and relatives (V), the possibility opens up for the patients and their relatives to confirm the personnel, and, when physicians and RNs disconfirm patients and their relatives, it is likely that the patients and their relatives may disconfirm the personnel in return. Hellzén et al. (1995) note that nurses felt confirmed through confirming patients.

Confirming and being confirmed involve giving and receiving and openness. In order to engage in this reciprocal dimension, presence interwoven with availability is necessary. Through presence, something appeals to patients at risk of committing suicide, their relatives and the personnel. This appeal presupposes an openness to receiving, what Marcel (1965a, p. 23) calls a state of availability. Presence for a human being can only be offered and received as a free gift; thus, presence cannot be separated from
availability. It is something that cannot be claimed, demanded and forced (Marcel 1967, p. 153) Presence reveals itself immediately, for example through a smile or a look from the personnel to the patients, who thus become available to each other (cf. Marcel 1948, p. 26), as one patient (II) said, "When I experience the nurse looking into my eyes without staring, that means that she is following what I am saying". In being present, patients at risk of committing suicide, physicians and RNs became aware that suicide and death concerned them and thus recognized their own mortality. As one physician (III) said, "I have a very modest attitude toward my patients: it could have been my sister, it could have been anyone at all. It could have been me!" Presence involves a reciprocity, which is excluded from any relation of subject to object (Marcel 1948, p. 40). The presence of another person forces me to see things through his or her eyes (cf. Marcel 1982), and ‘to enter into the depth of one’s self’ means here, fundamentally, to get out of self (Marcel 1950, p. 131). When the presence of health care personnel really makes itself felt, it can refresh the physicians’ and nurses’ inner being, i.e. presence reveals physicians and nurses to themselves; it makes health personnel more fully themselves (cf. Marcel 1950, p. 205). My response to the other’s appeal gives me my personality and makes me what I am (Marcel 1965b).

In the midst of presence, trust can be experienced. In very difficult situations when one is faced with life and death decisions and is very vulnerable, trust is important. Trust was a common theme in this study. Patients at risk of committing suicide (IV) stated that the staff has to show that they are worthy of being trusted. As one patient (IV) said, "To make it possible for me to trust someone, it must be a person who has known me for a long time, or a person I suddenly got a lot of confidence in. There must be a feeling of being able to rely on someone, and that person must prove that it’s possible". According to Lögstrup (1971, p. 19), "It is characteristic of human life that we naturally trust one another". If there is trust among people, there is no need to argue about it, it is a given.
However, if a person does show mistrust, it would not be strange to ask, “Why are you so suspicious?” Trust does not need a reason, but mistrust does. In this sense, trust is a characteristic of human life. This implies that we cannot live our lives without trusting others. A metaphor, used by Lögstrup (1971, p. 15), is that we always put something of our lives into the hands of the other. We decide what to do in a given situation to serve the other in the best possible way. Life cannot flourish if we isolate ourselves in suspicion and reservation, if we do not venture outside ourselves, and if we do not put something of our lives into the hands of others.

Through trust we open ourselves to genuine dialogue, which goes from one openhearted person to another equally openhearted person (Buber, 1965, p 7). Dialogue involves participation, and participation is lived through receiving and giving. Marcel (1950, p. 117) emphasizes that to feel is to receive, to gain direct access to the other person’s reality. The personnel listened to the patients’ lived experiences and acknowledged their suicidal thoughts and feelings (I, IV). They accepted and became aware of the patients’ and their relatives’ suffering and despair regarding the death-life crisis (cf. Buber 1965, p. 10). While relating, patients at risk of committing suicide felt confident (II), when RNs (I) and physicians listened to them and were open and available (III). In relating with patients, RNs seemed to be in touch with their own feelings of sadness, loneliness and despair and did not need to flee when confronted with patients at risk of committing suicide (I), and physicians acknowledged their own lived experiences of death (III).

Patients at risk of committing suicide felt welcomed, which may be identical to receiving. As one patient (IV) said, “He (physician) had a calm and balanced voice. He was not stressed but was relaxed. I felt calm myself, and I felt safe. I felt welcome”. Receiving another human being involves allowing her or him to participate in a certain reality (Marcel 1982, p. 91). Receiving is a way of being in communion and does not
require physical contact. Patients being in communion with personnel means sharing affective state rather than sharing cognitive interpretation (cf. Söderberg et al. 1999). Communion belongs to the realm of being, a reciprocal love and a unity, where people become we (Benzein 1999, p. 40). Communion can occur at the level of thinking (Marcel, 1982 p. 12), as one patient (II) said, “I mostly stayed in my room. I cannot remember how many hours she (nurse) spent with me in the mornings and early afternoons, without saying too much”. This kind of contemplation is a possible only for somebody who is sure of his or her grip on reality (Marcel 1950, p. 123). Contemplation must be considered a mode of participation, a turning inward of one’s awareness of the outer world (Marcel 1950, p. 131). The personnel are with patients at risk of committing suicide and gain understanding of the patients’ life situations. This wordless communication may be identified with what Buber (1965, p. 4) has called “silence which is communication”.

In communion we dare to share the suffering of the person affected by tragedy, without making any attempt to change her or him (Söderberg et al. 1999). In communion with the personnel relatives felt consoled (V). Consolation means a shift of center from the sufferer to the in-between, to experiences of belonging, and feeling at home with others. Feelings of being relaxed and calm open the way for consolation that belongs to the realm of mystery (cf. Norberg 2000).

Consolation is experienced through presence and availability, which inspire hope. Emotional closeness with a suffering person implies giving up tranquillity and overcoming one’s fear of remaining vulnerable, as one RN (I) said, “I could recognize some intense feelings within myself, such as loneliness, failure and helplessness”. This emotional closeness demands an ability to be emotionally touched, as Pahuus (1993, p. 94) expressed, “one cannot help but to act, to aid or to console, when meeting an
unhappy or distressed human being”. Being consoled is a kind of healing, i.e. making whole a divided personality (Duclow 1979). When a relationship is re-established within oneself and with others, healing has occurred (Quinn 1989). It was a good life for relatives (V) when they experienced a sense of belonging and feeling at home (cf. Zingmark et al. 1995). Relatives felt at home in the hospital when they were with the family member at risk of committing suicide, laughing, relaxing and enjoying each other. Relatives were consoled through being with their loved ones and when personnel showed that they cared about them and made them feel at ease, secure and at home.

The dialectic of the dimensions of confirmation, communion and consolation was explicated and revealed as longings and desires. The lack of relation with self and other among patients at risk of committing suicide, their relatives and the personnel can be illuminated by Laing’s (1961, p. 108) argument, “to disclose oneself to the other is hard without confidence in one’s self and trust in the other”. Lack of trust can be reflected in the personnel’s (I, III) and the patients’ (I, IV) rejection of each other. It might be the patients who initiate rejection, to avoid being rejected by personnel. To reject feels easier than being rejected. However, when patients at risk of committing suicide experience being rejected, their suffering and hopelessness increase.

Hopelessness emerges from alienation which is a consequence of the personnel being unavailable (II), and suicide is a consequence of feeling that one does not belong, which in turn evokes despair (Randall 1992, p. 15), as one patient (II) said, “I feel I am just biding my time, and that they have stored me away here. I feel that there is no way out for me. I feel that everything is hopeless”. Hopelessness means to be morally or spiritually homeless (Marcel 1973, p. 84) which can be linked with mental and spiritual suicide (see Introduction, p. 13). According to Randall (1992, p. 10) Marcel has stated, “if death is the ‘springboard’ for hope, then that form of death described by the term
suicide gives rise to the most desperate hopes because the despair which counsels suicide is the most overpowering hopelessness possible”. It is well documented that experiences of hopelessness imply risk of suicide (Malone et al. 2000). Hopelessness can involve experiences of powerlessness. The personnel have power in relation to patients at risk of committing suicide and their relatives, and this power has to be used in a responsible and creative way, as power to instead of power over (cf. Fromm 1974, pp. 291-296). Power has its own fragility. We can use power over another person either in our own or the other’s best interest (cf., Lögstrup, 1971 pp. 19, 155). It seems that feelings of being helpless, worthless, guilty and powerless are common among inpatients at risk of committing suicide (Moore 1997, Lewis et al. 1986). A psychological autopsy study in Sweden showed that 80 % of 100 consecutive people who had committed suicide had experienced a threatened or actual separation from parents, spouses and children (Gustafsson 1999b). This can be understood as separation from significant others involves absence of confirmation, consolation and communion, and this promote hopelessness in people. Powerlessness further complicates the patients’ vulnerability since being ill, in and of itself, threatens their self-esteem (cf. Fitzgerald Miller 1992, pp. 50-81).

Physicians (III) and RNs (I) belong to professions that require them to save lives. They reported that they felt responsible and guilty when patients committed suicide. They also experienced reproach at the thought of patients taking their lives. Physicians and RNs were confronted with the limit situations of suffering and death (cf. Jaspers 1994, pp. 96-104). The threat of death has always awakened and increased people’s consciousness of guilt (Tillich 1956, p. 52). Physicians (III) and RNs (I) reproached themselves greatly for their professional judgments, as one physician said, “I thought, ‘What were we up to?’ seeing as we could assess things so differently the next day. That I could be so naïve! I reproached myself dreadfully, I still do”.

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In confirmation, communion and consolation, hope becomes possible. Hope is the fundamental experience of courage, faith, love, strength and endurance (Randall 1992, p. 20). Without communion, hope diminishes. Hope corresponds to Marcel’s mystery of communion, which involves seeing the other as ‘we-ness’ (cf. Marcel 1982, p. 34). In communion, the personnel inspire hope through being available and present for patients and relatives. In communion, ‘we-ness’, is established through a bond, a unity, between one and the other, and the other “ceases to be him and becomes thou” (Randall 1992, p. 235), and appears as someone to love. According to Randall (1992, p. 235), Marcel indicates that when love for another is experienced, openness occurs as one’s “outer defenses fall at the same time as the walls separating me from the other person fall”. As these boundaries diminish, one realizes that “the horror of suicide is that the action could have been yours or mine” (Vråle 1993, p. 27). Hope is an essential issue in all health care, as one patient (II) said, “I have to hear the same thing over and over again, to have it confirmed that things are not hopeless, that there is still hope and that I do not have to think about giving up”. Benzein (1999, p. 32) found that one dimension of the lived experiences of hope is a confirming relationship, from which communion and consolation emerge and form the possibility of hope.

**METHODOLOGICAL CONSIDERATION**

This study concerned psychiatric care of patients at risk of committing suicide from the perspectives of patients, relatives, nurses and physicians in the same hospital. The method applied has affected the result of this study. First, the sampling was purposeful as is often the case in qualitative research. The informants were selected on the basis of their lived experiences of the research phenomena, and their ability to describe the
experience so that the data contain depth and breadth (Maunsbach & Dehlholm-Lambertsen 1997, Malterud 1996).

Second, in the interviews, the interviewees talked about situations that occurred from three days to six years ago in psychiatric care. The narratives are the interviewees’ reconstruction of what happened (Sandelowski 1991, Carr 1985, pp.74-77), and often within a framework they have later learned about (Repstad 1987). This does not have to be seen as a problem as long as the interviewees narrated from their own memory. In the act of remembering, the interviewees activated an embodied impression of a situation. It seems reasonable that RNs and physicians selected narratives related to their professional competence and responsibility; to ask people to narrate their experiences has been found to be a useful method for providing new insights (cf. Vitz 1990).

Third, in the collection of data, I was the instrument. My psyche may represent a systematic source of error. After each interview I asked myself about the interview process and whether the information gathered was trustworthy. One question was: “How did I function as an interviewer?” After each interview I asked the interviewees how they felt about the interview. The interviewees’ experiences could provide an insight into the connection between my self-understanding as an interviewer and my experience of the interview situation, and the interviewees’ views. The interviewees responded that the interview time had passed quickly, that they had achieved new understanding and they felt it was good to talk to someone (cf. chapter: Ethical consideration during interviewing). None of the interviewees made negative statements. The statements corresponded to my experiences of having good contact with patients and commitment in the dialogues. In particular, the patients at risk of committing suicide expressed good feelings about sharing information with me.
Fourth, I conducted one interview with each interviewee. For me to be able to “create” the dialogues that were as good as possible, I had to be sensitive to each person who was interviewed (cf. Fog 1994). My proximity to the interviewees both strengthens and threatens the validity of the results (cf. Sandelowski 1986). I can never be certain of the extent to which my pre-understanding and opinions interfered with my understanding of what the interviewees said. Only, when I have recognized the significance of where I stand in the research process is critical reflection possible (cf. Malterud 1996). I had psychiatric knowledge, i.e. knew about the social culture in the hospital, and could meet health care personnel as a fellow specialist with a common professional language. Knowledge of the field also gave me the necessary prerequisite for understanding patients at risk of committing suicide, their relatives, RNs and physicians. This insight and understanding on my part made it easier for the interviewees to talk about their experiences, and also made it possible for me to ask questions that helped the interviewees in their narrations about the meaning of their experiences of psychiatric care. My sensitivity was a prerequisite for examining and understanding the narratives, and it produced an ample overview of the topic, and strengthened the trustworthiness and validity of the interviews. However, the interviewees may have tried to please me by narrating what they thought I wanted to hear (Lorensen 1998, p. 171). The interviewees’ narratives seemed trustworthy; the interviewees told me about both positive and negative aspects of their experiences, which connected with the practical aspects in the narratives.

Patients at risk of committing suicide and their relatives are particularly vulnerable, and for this reason I did not initially interrupt when they narrated something outside the subject of the interview e.g. childhood and family life. I listened attentively to what they said and assessed when an interruption could refocus the interview and further elaborate the topic of interest. This way of guiding them was necessary because too little control
on the part of the researcher can lead to untrustworthy data (cf. Kvale 1997). I did not try to entirely eliminate the influence of leading questions, but considered different types of leading questions and their influences upon the answers given (Kvale 1996). For me, the decisive thing was whether the questions helped the interviewees’ narrations and were relevant regarding the topics the interviewees talked about.

Fifth, the use of audiotape recorders has been challenged, and may have a constraining influence on the interview situation (Banaka 1981, pp. 100-101, 153). Before starting the interviews, interviewees mentioned that tape recorders could be bothersome, but they seemed to forget about them as the interviews proceeded (cf. Beskow et al. 1991). If someone felt uncomfortable, I was prepared to turn off the audiotape, however, no such instance occurred.

Sixth, in the interpretation process, I read the text repeatedly, asked questions about the text which were pursued, developed and tested against other interpretations in a process which Ricoeur (1976, p. 203) calls probability logic. A text has multiple but not infinite meanings and can, thus, be interpreted in various ways. The present interpretation is only one of several possibilities (Ricoeur 1976, pp. 71-88). The validity logic moves us between the two extremes of dogmatism and scepticism. It is always possible to argue for or against an interpretation, question an interpretation, question it, and to mediate between interpretations (Ricoeur 1976 p. 203). The interpretation of the interview text was followed in sequence from the first paper to the fifth paper. I tried to bracket the ‘forestructure of understanding’ after each paper to avoid bias before beginning the interpretation of the second paper, and so on. I knew most of the RNs and physicians quite well as individuals, and it is difficult to say if this made a difference to the process of interpretation. For me, the interpretation in study V seemed easier, because I knew the method better, and had experience of how to use it. The method of interpretation was
also being developed during the time I completed this thesis (cf. Rasmussen 1999, p. 67, Pejlert 2000, p. 64).

My co-researchers ensured the trustworthiness of the interpretation by reading and re-reading the narratives, critiquing my thoughts and verifying that the results were grounded in the data, as Ricoeur (1982, p. 164) says, "...what the interpreter says is a re-saying which reactivates what is said by the text". The interview text was examined in order to explain it. The text was divided into meaning units, condensed and organized into themes. Examples of the analyses are presented in tables in the papers, which enhance the auditability of this study (cf. Burns, 1989, cf. Sandelowski, 1986).

A major threat to validity is the "holistic fallacy" that tends to make data look more patterned, regular or congruent than they actually are (Sandelowski 1986). In this study, not all the data in the interviews were interpreted. During the course of the interviews, the patients at risk of committing suicide and their relatives talked, for example, briefly about childhood, the journey to the hospital, family life, their own children etc. After careful consideration, this type of data was deemed not to be relevant and was not included in the interpretation. Apparently excluding these data did not reduce the quality of the interviews for the study (cf. Kvale 1996).

This study ensures strength in relation to transferability, as narrative interviews give an in-depth understanding of the phenomenon under study. Because of the many details in the data, there is a high content validity (Sandelowski 1986), but nothing can be said about the relative or absolute distribution of the phenomena in a background population. The results of the study were congruent with results from previous research indicating credibility (Delholm-Lambertsen & Maunsbach 1997). According to Sandelowski
(1993) data reduction, which grasps the "essence" of a phenomenon may enhance the validity of qualitative research.

The results from a qualitative study are credible when people who have the same kind of experience can immediately recognize the descriptions or interpretations as their own (Sandelowski 1986). The results of phenomenological hermeneutical studies mainly consist in opening up a world, i.e. the meaning of the results in this study can only be revealed through self-understanding, which leads to accepting a new mode of being in the world from the results (cf. Ricoeur 1976, p. 94). This study reveals the possibilities of interpreting lived experiences, and provides a basis for reflection about psychiatric praxis.

CONCLUSION

Registered nurses and physicians were asked to narrate their experiences of caring for and treating patients at risk of committing suicide; patients were asked to narrate their experience of being cared for and treated by nurses and physicians, and patients’ relatives narrated stories about being cared for by health care personnel. The participants narrated their experiences as a relation with self and others. They talked about the same phenomena: confirmation, communion, consolation and hope. It appears that these phenomena are basic needs for human beings. When health care personnel confirm, are in communion with, console and promote hope in patients at risk of committing suicide and their relatives, the latter receive these as gifts. These gifts can make it possible for patients to continue their lives, i.e. meeting basic human needs gives meaning to their lives. When patients and relatives did not have these basic needs met as they expected when admitted to the psychiatric hospital, their burden of suffering was increased by the
health care personnel. This could increase the risk of suicide on admission to and discharge from a psychiatric hospital.

The interpreted meaning of the experience of being cared for as a person at risk of committing suicide was illuminated as confirmation, communion, consolation and hope. Threaded through these meanings is relation with self and others. Therefore, the results of this study in essence point to a relational view of the care of people at risk of committing suicide. It is significant that a new paradigm is emerging in contemporary suicidology called the ‘phenomenology of suicide’ (Funahashi et al. 2000, Jobes 2000, Dawkins 1996). Jobes (2000) claims that this new paradigm contributes to more effective assessment and treatment of suicidal conditions. This study supports and confirms this paradigmatic perspective and opens up a dialogue about a relational view of the phenomenon: Psychiatric care of people at risk of committing suicide.
SUMMARY IN NORWEGIAN

Psykiatrisk behandling og pleie til pasienter som er i fare for å ta sitt eget liv, basert på narrative intervjuer med sykepleiere, leger, pasienter og deres pårørende.

I de fleste forhold i livet - i familien, blant venner, på arbeidsplassen og i skolen - blir det stilt krav og forventninger til oss, og vi stiller krav til oss selv. Noen ganger står vi overfor situasjoner som kan virke umulig å mestre. Livet kan i noen av disse situasjoner oppleves så vanskelig, meningsløst og smertefult at enkelte ikke ser noen annen utvei enn å begå selvmord. Å forklare eller forstå selvmord, som ikke kan tilskrives ekstreme situasjoner i forbindelse med krig, tortur, dødelig sykdom eller lignende, er komplisert. Som regel er det mange faktorer som spiller inn når en person velger å ta sitt liv. Noen faktorer skriver seg fra barndommen, andre er utløsende og henger sammen med den aktuelle livssituasjonen.

Selvmord har opp gjennom tiden vært studert fra ulike perspektiver. Det er mye medisinsk og sosioligisk forskning som søker å gi forklaringer om selvmord. Mine erfaringer som spesialsykepleier i psykiatri tilsier at det ikke er tilstrekkelig å forstå pasienten på bakgrunn av teorier eller modeller. I møte med en pasient som er i fare for å ta sitt liv og deres pårørende blir helsepersonalet utfordret, ikke bare på den måten de handler, men også ved å være nærværende.

Den overordnede målsettingen i avhandlinga er å belyse erfaringer som sykepleiere og leger har i relasjon til pasienter som har hatt tanker om, ønsket, forsøkt eller tatt sitt liv. Jeg vil dessuten belyse de erfaringer pasienter som er i fare for å ta sitt liv og deres pårørende har i relasjon til leger og sykepleiere. Studiene er ikke fokusert på å forklare hvorfor de handlet som de gjorde, heller ikke søke å forklare hva som skjer med pasienten, de pårørende, sykepleieren og legen ut fra de situasjonene de forteller om. Arbeidet har fokus på forståelsen av "fenomenet" 'å være pasient', 'å være pårørende', 'å være sykepleier'og 'å være lege', d.v.s hva som skjer i interaksjonen mellom partene i utøvelse av psykiatrisk behandling og pleie til pasienter som er i fare for å ta sitt eget liv.

Avhandlingen består av fem delarbeider. Den bygger på narrative intervjuer med personer på et psykiatrisk sykehus i Norge. Intervjuene er foretatt på ni avdelinger; to langtids-, tre akutt-, to korttids-, en psykogeriatrisk- og en poliklinisk avdeling. Narrativer eller fortellinger er en grunnleggende form for å uttrykke og kommunisere menneskelig liv og erfaringer, og er den form som mennesker spontant anvender for å skape mening og sammenheng i sin verden. Å be mennesker fortelle om sine erfaringer er en velegnet metode for å forstå betydningen av erfaringene som deltagerne i dette prosjektet formidler. Det fortolkende fokus på fortellingene var ikke intervjuersonene som individer, men det de fortalte om.
Intervjupersonene var: 19 spesialsykepleiere i psykiatri (15 kvinner og 4 menn, 25-45 år, som hadde arbeidet i sykehuset 2,5-20 år), 19 leger (9 kvinner og 10 menn, 31-55 år, som hadde arbeidet i sykehuset 1/2-25 år), 42 pasienter (23 kvinner og 19 menn, 23-78 år, som alle hadde vært innlagt minst en uke før intervjuene ble gjennomført) og 15 pårørende (1 hustru, 5 ektemenn, 6 foreldre, 1 datter, 1 sønn, 1 svigersøster). Intervjuene varte 30-60 minutter og ble tatt opp på lydbånd.

Det første studiet viser hva det innebærer for sykepleiere å pleie pasienter som er i fare for å ta sitt liv, belyst gjennom to temaer Nærhet og Distanse. Nærhet til pasienten fremkommer når sykepleieren: uttrykker medfølelse; viser tillit til pasienten; opplever seg ansvarlig for at pasienten utfører sitt program; lytter til pasienten; opplever å bli akseptert; og har fokus på pasienten sine behov. Distanse til pasienten oppstår når sykepleieren: uttrykker medfølelse uten emosjonell identifikasjon med pasienten; har mistro til og kontrollerer pasienten; opplever seg ansvarlig og skyldig når pasienten forsøker eller tar sitt liv eget liv; ikke har kontakt med pasienten; avviser pasienten; opplever seg inkompetent og hjelpeløs i den måten de ønsker å pleie pasienten.

Det andre studiet med intervju av pasienter, viser hva det innebærer for pasientene å bli pleiet av sykepleiere, belyst gjennom to temaer Bekreftelse og Fravær av bekreftelse. Pasienten opplever Bekreftelse når pleieren: tilgodeser grunnleggende behov; ser pasienten; har tid til pasienten; er sammen med pasienten; lytter til pasienten uten fordommer; er åpen for pasienten; respekterer pasientens følelser; frembringer håp i pasienten. Pasienten opplever Fravær av bekreftelse når pleieren: overser de grunnleggende behov; ikke ser pasienten; ikke har tid til pasienten; overlater pasienten til seg selv; lytter til pasienten med fordommer; er ikke åpen for pasienten; fornekter pasienten’s følelser og frembringer håpløshet i pasienten.

Det fjerde studiet viser hva det innebærer for pasienten å bli behandlet av legene, belyst gjennom to temaer *Observerende tilnærming* og *Deltagende tilnærming*. Pasienten opplever *Deltagende tilnærming* fra legene når de er: Sammen med pasienten, som innebærer å ha tid og komme i kontakt med pasienten. Lytter til pasienten uten fordommer, som innebærer å lytte til og akseptere pasientens erfaringer, og ikke har det ‘riktige’ svaret. Har tillit til hverandre. Respekterer pasientens integritet, som innebærer at pasienten deltar i behandling og pleie og de opplever at de har fått støtte og hjelp. Pasienten opplever *Observerende tilnærming* fra legene når de: Ikke er sammen med pasienten, som innebærer at de ikke bruker tid og ikke kommer i kontakt med pasienten.
Ikke lytter til pasienten, som innebærer at legen forklarer pasientens sykdom, ikke aksepterer pasientens erfaringer, og har det ‘riktige’ svaret til pasienten. Har mistillit til hverandre. Ikke respekterer pasientens integritet, som innebærer at legen bestemmer hva som skal bli gjort og iverksetter medisinsk behandling.


Når helsepersonalet bekrefter, er i et felleskap med-, trøster og fremmer håp, blir det mottatt som en ”gave” av pasientene og deres pårørende. Denne ”gaven” kan gjøre det
mulig for pasientene å velge livet, for å bli møtt i sine grunnleggende behov gir livet mening. Når pasientene og pårørende ikke blir møtt, som de hadde en forventning om da de kom til sykehuset, øker lidelsen. Dette kan bety at mangel på bekreftelse fra-, fravær i et felleskap med-, fravær av trøst og håp fra helsepersonalet kan være med til å øke risikoen for selvmord i den tiden pasienten er innlagt i sykehuset og like etter utskrivelsen.
ACKNOWLEDGMENTS

This study was carried out at the Department of Nursing, Umeå University, Umeå Sweden and Tromsø College, Sciences of Health, Tromsø, Norway. I want to express my gratitude to all the people from whom I have received help, support, advice, love and encouragement. In particular I would like to thank:

The patients at risk of committing suicide and their relatives, the nurses and the physicians at the psychiatric hospital for so kindly and generously participating in the research project. Thank you for showing interest in the study and sharing your experiences and ideas.

I would like to convey my special gratitude to my supervisor Professor Astrid Norberg for her help in completing this work, for her support, encouragement, advice and criticism and also for sharing her vast knowledge, wisdom and sympathy. I am grateful to you for sharing the laughter and problems, giving me inspiration. Thank you so much for believing in me.

My co-writer Professor Lars Jacobsson for always giving me ideas about how to structure my results. Thank you for sharing your knowledge and humanity with me.

Assistant Professor Fredricka Gilje, North Dakota, for giving structure to the result, for gentle correction of the language, your faithfulness, encouragement advice and criticism.

Assistant Professor Berit Lundman, for your support, especially with reading and checking references.

My co-writer Associate Professor Anders Lindseth (Papers I, II) thank you for listening to me in the first part of the project.

Ms Inga Greta Nilsson, department secretary at the Department of Nursing, Umeå for always being kind, friendly and patient and for helping me with endless practical problems.

All the staff and colleagues at the Department of Nursing, Umeå for always welcoming me kindly and for sharing of laughter and problems. Ms Åsa Hörnsten, thank you so much for making my tables readable and Ms Patricia Shrimpton, Umeå University, for revising the English in parts of the thesis.

Anne Simonsen, the Director of the Red Cross Nursing School, Tromsø, Norway. Thank you for letting me be me, for pushing and supporting me in my vision of nursing. Thank you for believing in me.

Lotte Fribakk, the unitnursing officer at a psychiatric hospital in Bodø, Norway. Thanks for sharing your knowledge, wisdom and sympathy, and disclosing how challenging and complex psychiatric care is.

Karin Blix Flage, supervisor in psychiatric care in Tromsø, Norway. Thank you so much for giving me an insight into what psychiatric care is; which implies that I had to be led through the painful difficult process of confronting my own desires, needs and frustrations.
Colleagues at Tromsø College, Faculty of Health Sciences, Tromsø, Norway Special thanks to Else Hasselberg for supporting me and sharing my ups and downs at work, encouragement and stimulating discussion.

Kirsti Silvola and Torbjørg Guttormsen, Norwegian National Plan for Suicide Prevention, Fifth Health Region, Norway. Thank you for standing by my side, for the sharing of tears, laughter, problems and discussion. Thank you for never ceasing to say to me: “This is important work, carry on!!”

Ole Solnørdal, my husband. I would express my deepest love and gratitude to you for being with me throughout the process. This dissertation would never have been realized without your love, companionship, help, support, encouragement and reminding me that life is more than doctoral studies. Our children, Morten and Mette, who have grown up with a constantly studying mother, thank you so much for your “being”, and for your love and support. Thank you so much to my dear mother, Alisa, for your loving support, concern and encouragement. Also thanks to my mother and dead father Mauritz-Arne, for giving me the gift of self-esteem so that I could carry through this work. Thanks to the rest of the family and friends for concern and support and believing in my ability to “move mountains”.

I am grateful for the financial support from Tromsø College, Tromsø, Norway, Norwegian Board of Health (Norwegian National Plan for Suicide Prevention) and Psychiatric Research Centre for Finnmark and Troms (PFFT).
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