Longing for understanding - in the struggle between living and dying. Experiences in the aftermath of suicidal crises.

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Abstract

The aim of this study was to explore the experiences of being suicidal and the encounter with health care personnel. The research question was: How did the suicidal patient experience the encounter with health care personnel? Data were collected, analysed and interpreted using a hermeneutic approach. Qualitative research interviews were used to collect data. Participants included ten people: four women and six men; aged 21-52 years. With the exception of one person, they had all experienced one or more suicide attempts.

The study requires ethical considerations in planning, interviews as well as in the analysis process. Through a thematic analysis, three key themes emerged: 1. Experiencing and not experiencing openness and trust, 2. Being met and not met by someone who address the matter, 3. Being met on equal terms versus being humiliated. Results in this study may indicate a lack of willingness and courage to listen to what the suicidal person say, and to trust him or her.

Key words
Attempted suicide, patient experiences, suffering, attitudes, health care personnel, hermeneutics

Introduction

Being suicidal is to be in a condition of suffering[1-2] as the result of important needs not being met. Serious suicide attempts arise from intense psychological pain which is experienced as unbearable.[3] Hopelessness is considered to be the central emotion associated with suicidality.[1, 3-4] The perception of being 'trapped in a cage', the lack of a way out, the lack of belief that something or someone can help you, and a reduced ability to solve problems on one's own[5] exacerbate the perception of hopelessness and helplessness. According to Joiner,[6] suicide is a result of the link between the wish to die and the capability to carry out a self-destructive act.

There seems to be a fundamental relationship between past and future suicidality.[6] Maybe the way health care personnel understood and meet an individual after a suicide attempt can make a difference and either strengthen hope for life or increase the wish to die. This hypothesis entails not only ethical responsibility in the encounter with suicidal patients, but also opportunities for prevention of suicide.

The health care personnel's understanding of suicidality is observable in attitudes and responses in the form of language and extralingual behaviour. According to Gadamer[7] all understanding is derived from a prior pre-understanding. By examining our own pre-knowledge, health care personnel are able to be conscious of their own notions and

attitudes and thereby be better able to manage the responses that are expressed through verbal statements, revealed emotions and actions.

The literature review in electronic databases as Academic Search Premier, Cinahl, Medline, PsykInfo, Swemed+ showed a limited number of studies investigating experiences following suicide attempts or associated with being suicidal. Shame has been singled out as an important theme in the aftermath of suicide attempts.[8-10] The attitude and behaviour of health care personnel have been reported as alleviating feelings of shame, but they have also been shown to be exacerbative.[8] To be met with respect, to be listened to, confirmed, given proper time and attention, all of these were reported to be helpful.[11-13] For some patients, the lack of confirmation appears to have contributed towards a perception of having been a burden to others, and also towards new suicide attempts.[14] Life does not necessarily change after an unsuccessful suicide attempt; some patients continue to wish to die.[9, 15] The need for consolation[15-16] and for changed life conditions[9, 17] is described. Finally, responsibility for family or other closely related persons is cited.[10, 15, 18]

Suicide is a public health problem worldwide. There is a lack of knowledge based on experiences from those people who have survived suicidal attempts. The aim of this study was to investigate patients' experiences in the aftermath of suicidal crises and what appears to have helped them. The research question was: *How did the suicidal patient experience the encounter with health care personnel?*

Theoretical perspective

Human dignity is the foundation of humanism.[19] A holistic view comprises seeing a person as a unity of body, soul and spirit, and responsible and active in the interaction with his or her surroundings.[20-21] The experience of being a whole person, valuable and unique, is central to Eriksson's theory of health.[19, 22] Suffering is part of being a human being, and is thereby also a term in the vocabulary of healthcare. Eriksson's theory[20, 22] goes into depth in terms of the ontological dimension of suffering and therefore seems to be a relevant framework for interpretation in the present study. Suffering described as 'life suffering' is related to human existence; 'suffering from disease' is related to the consequence of physical illness, while 'suffering in absence of care' is related to the consequences of lacking care and treatment.[20, 22] To properly encounter a person in a state of suffering demands the ability to suffer together with the person, in what Eriksson[22] terms ‘suffering's drama’; the confirmation of suffering, time and space for suffering, and the road forward towards reconciliation.

Methodology

Hermeneutics is a methodology in the human sciences with a particular relevance to the field of qualitative research. In particular, Gadamer's hermeneutics on understanding and what occurs in us when we understand[7] has been an inspiration during the process of collection, analysis and interpretation of data.

In Gadamer's theory,[7] prejudices are understood as positive conditions for understanding. Understanding is a circular movement between reader and text. A hermeneutic approach is

characterized by sensitivity and openness to what unfolds in the text, out of which new questions are created.[7] Sensitivity and openness are crucial elements for creating understanding and developing new questions in the encounter between people, reflecting precisely the interview situation. Through an understanding and interpretation process, we seek to create a deeper meaning related to a topic at hand – in the present study, the question of experiences after suicide attempts.

The first author's pre-understanding is marked by lengthy clinical praxis and education in mental health care and by further research about suicidality. In this study, we maintain that pre-understanding has led to a deeper understanding about suicidal patient experiences – or understanding in another way, according Gadamer.[7]

Participants

Four inclusion criteria were used in selecting the participants. The participants must 1) have been considered seriously suicidal, but in the event of a suicide attempt, the interview needed to take place no earlier than two weeks afterwards, 2) not be psychotic, 3) be able to verbalize his/her experiences, and 4) have access to a therapist at least two weeks after the interview.

Ten people participated in the study after being asked and informed by specialists in psychology at three emergency psychiatric units and one crisis resolution team.
The participants consisted of four women and six men aged 21–52 years. Nine had made suicide attempts prior to the interview, and one of them had tried four times during the previous month. Four of the interviewees had made one or more attempts in the past. All had used drugs as the method in the attempted suicides. Five revealed that they had consumed alcohol prior to or concurrently with taking the drugs. One of the ten had not attempted suicide, but was prevented from carrying out a carefully planned suicide by being hospitalised.

One of the participants was married, and four had children. Six had a broken girlfriend- or boyfriend relationship in the recent past. Five had a job or were on sick leave, and five were receiving a disability pension. Seven participants lived in their own homes, one in an apartment with assistants. Two participants were staying temporarily with parents.

Interviews

The data were collected by semi-structured interviews,[23-24] which lasted between 90 and 110 minutes. Interviews were formatted as conversations based on an interview guide[23] that the interviewees were given to review in advance, to ensure that the interviewee had conveyed what he considered to be of importance. The opening question proved to be a good start for the participants to tell about the suicidal event. Other main questions were as follows: What do you think about the attitudes and the way you are met by personnel? Is there anything you would like to be changed in the way the personnel approach suicidal persons – if so, what?

The contact with the participants, which started with a preliminary conversation and ended when the interviewee had read the interview text, lasted an average of one month. For two persons, the contact extended over about three months.

Analysis and interpretation

A thematic analysis was carried out to identify, analyse, and refer themes. The process has been explained through six phases, inspired by Braun and Clarke. [25]

The first phase consisted of a painstaking effort to transcribe the interviews as an aid to enhancing our familiarity with the data. The second phase consisted of a naive reading of all the interviews, to generate initial codes or themes based on the interviewee's own understanding.

In the third phase, the data were reviewed with respect to the research question, searching to identify themes. Relevant texts were coded and copied into a new document. Informative statements that could elucidate the research question were selected. From these statements, some important elements appeared as 'potential themes'. From these, five themes emerged as the study's 'thematic map'(table 1).

The fourth phase involves a review of themes to check for support in the data materials, and to determine whether some themes had been missed in earlier phases. In the fifth phase, the themes was defined and named in a 'final map', comprising three themes. This process is visualized in columns on the right hand side of table 1. 'Producing the report', as Braun & Clarke[25] termed the sixth and last phase of a thematic analysis, includes the presentation of results and discussion. The discussion in this study is carried out in respect of the previous research and the theoretical perspective for which Eriksson[22] is the main reference.

Table 1

Process towards 'Defining and naming themes', inspired by Braun & Clarke

Potential themes	Thematic 'map'	Themes
Being met with sufficient knowledge about the psyche Feeling trampled on when you are depressed People with resources can be depressed, too. When they forced me, the fear increased Feeling trust vs. longing for trust Openness as "two-way" communication	1.An attitude of openness and trust versus lack of openness	1.Experiencing and not experiencing openness and trust
To get direct questions and responses Longing for talk about the difficult things They do not explore the issues Some of them know how to address the issues To get the time I needed	2. Getting close to or not	2. Being met and not met by someone who address the matter
The suicide attempt - just a cry to get help? Feeling difficult to talk about the suicide attempt Feeling shame and guilt about what I have done Can I do it again?	3. To talk about the suicidal event or not	
Being met as an equal human being Getting help that feels genuine Getting help when you need it Being forced and controlled	4.Being met on equal terms	3.Being met on equal terms versus being humiliated

Be talking <u>to</u> - not about, not down to Being met with confirmation versus moralizing		
A 'poor-little-you' attitude - it feels humiliating	5. To pity someone	

Ethics

The study was recommended by the Regional Ethical Committee for Research, Southern Health Region in Norway, and the Privacy Protection for Research of the Norwegian Social Science Data Services. Before the interviews, the participants signed an informed consent and received information related to confidentially, the right to withdraw, and how information from the interviews should be used. The information was repeated verbally by the researcher. Length of meetings and interviews varied according to the interviewee's wishes, situation, and condition.

Practice-oriented research requires sensitivity to what happens in the interview situation; described by Hummelvoll[26] as a caring attitude motivated by the principles of beneficence and non-injury. The attitude was expressed in situations that illustrated that ethical responsibility takes precedence over the research interest. For example, some participants wanted more time than others to talk with the researcher, including after the interview, perhaps because they had not talked about some of the themes before. A caring attitude required giving the patient the time he or she needed to tell their story, letting participants decide. In addition, transcription entailed ethical considerations of confidentiality. It was necessary to exclude special events and descriptions to protect the participants, in agreement with the participants themselves. For the same reason, the presentation of the results also entails ethical considerations.

Results

Through the analysis process, three themes emerged; these are understood as significant attitudes related to the suicidal patients' encounter with health care personnel. The themes are introduced through summaries and selected statements.

Experiencing and not experiencing openness and trust

The participants appear as persons who have struggled for a long time and tried to cope with various problems on their own. The decision to ask for help appears to have been difficult to make. The participants described sensitivity in terms of the way they are understood and met: "*When you are down, it doesn't take much to get you further down; I never felt so degraded before"*, one of them said after a meeting about sickness benefits.

The participants expressed disappointment at being met by personnel who had insufficient knowledge: *"I don't think they know enough about the psyche",* one of them says, referring to a situation at the emergency ward. Symptoms such as shortness of breath and the feeling of being suffocated were met by: *"If it's not worse than <u>this</u>, you should come back tomorrow then we might examine you".* This man said that his anxiety, a feeling of loneliness, despair and a

feeling of being worth nothing at all, increased after such meetings. One of the participants referred to her doctor's response when she talked about her suicidal ideation:

"You see, there's no point in trying to take your own life, one doesn't get any help by doing that, you see, if you take an overdose, you will be brought by ambulance to the hospital; then you'll have your stomach pumped, and you'll be sent home and told to get in contact with your doctor." He might share attitudes like that with his colleagues, and he may have these attitudes in private, but when a suicidal patient is visiting his office, he should <u>not</u> say such things.

She described the response as depriving her hope. Some time later she carried out the suicide attempt. She did experience, however, that the personnel at the emergency ward and the emergency unit demonstrated a belief in her and her opportunities for the future, and that gave her renewed hope.

The participants described situations of disappointment because their information was not considered to be important. They expressed a longing for dialogue and a desire to be met with trust. A woman told the psychologist about a sexual assault she had experienced in the past. She suggested this event might have some connection with her current relationship to men, which in the past had led to loss, despair and grief. Then the psychologist said *"no", he did <u>not</u> think there was any connection.* The participant went home with a feeling of disappointment and hopelessness because her suggestion had not been deemed worthy of consideration.

The fact that pressure oftentimes restricts the possibility for dialogue was described in particular by two younger participants. Several persons experienced fear of hospitalization and force used against their will as a threat. One of them explained that only after some time, she was able to tell the therapists at a crisis resolution team about difficult feelings and thoughts. While treated in a polyclinic unit, she was unable to express thoughts and feelings to the therapist, who, the participant thought, appeared to panic. Then the therapist said: *"We can see that you are so sick, if you don't get yourself out of this, then you'll have to be hospitalized by force, perhaps in another place."* The participant described how this response increased her fear of what might happen: "*and then you close up even more".*

Another participant, a young man, described how he was treated with understanding and care when he was admitted to an emergency ward after taking an overdose of Paracet: "*They listened. They said that they were here for me. And that this would be solved, as long as you'll get the help you need. Actually, they gave me a good, warm feeling".* This interviewee described how the psychiatrist evaluated him before he was discharged from the emergency ward:

They asked me directly. The psychiatrist made everything clear. What about friends, safety, family, a place to live? He wanted to know if I had all the safe elements required to manage the next days. If I hadn't had all this, they would have admitted me to hospital.

The same participant told about his doctor who gave priority to him, spent time with him, medicated him and contacted the emergency team at the local psychiatric centre. The emergency team was "*a support there and then",* as he put it. He explained:

They were very concerned about whether or not I was suicidal. Our talks showed that I was not. During my last appointment, I told them: now you can't help me anymore; I'll call you if I need to. They were more closely involved with my case, whether I would try to commit suicide in the time afterwards, the weeks afterwards…

The participant was more eager to solve the problems because he still felt despair and was so depressed. He told how his sister helped him to see that he was in a crisis of identity, and his family paid a psychologist who could help him to find his way to a better life.

The theme is to be understood as the participants' longing to be confirmed in their suffering, loneliness, despair and hopelessness. Are the patients met by a willingness to listen carefully to them; do they perceive that their experiences are taken seriously by the health care personnel?

Being met and not met by someone who address the matter

The participants described it as absolutely positive that they were asked directly about thoughts and plans for a suicide attempt. Beyond this, the descriptions were characterized by the participants' longing for a response that would help them talk about the difficult questions and the issues.

For some of the participants the suicide attempt resulted in their first encounter with psychiatric health care personnel. Several of them were hardly accustomed to talking about feelings and thoughts. Most of the participants found talking about their thoughts about suicide and the attempt itself to be very personal: "*It's not something you talk about with just anyone …"* Also because it is a "*sort of taboo subject"*, as one man said. They would have liked more time for conversation; they sought to find a connection between past and present, like this woman, who told about her thoughts of suicide at the age of fifteen: "*Maybe I should just walk straight out into the street; then a tractor-trailer might hit me and it would be over".* Sixteen years passed before she carried out the suicide attempt in desperation and "*as a cry for help"*, she said. During several of these years she got treatment which helped her to a certain extent. At any rate, the suicide attempt led her to a treatment that she perceived as helpful in finding a new way to think about herself and her own life and opportunities.

To address the issues of the case can be time-consuming. The time it takes to establish a close relation varied among the participants, and for some, this was explained as "bad chemistry" between the involved parties. The feeling that they were being coerced was described by some participants as one factor preventing the patients' from verbalizing their situation, like this young woman's' account:

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I was sitting, let's say, for two and a half hours; this has happened several times, I suppose … they were not in a hurry, they just sat down. They understood that in a way, not because I didn't want to say anything, but because I couldn't. Therefore, they didn't force me …

In some situations 'getting close' may be about looking behind words and appearances. A man explained that he stopped seeing his therapist after ten appointments, because "*I felt*

that I couldn't get close to him, or he couldn't get close to me, I suppose". When health care personnel merely see the patient's positive resources, the symptoms might be exacerbated. A woman said: "*when you suffer so much, it's so disheartening when people just say: "Really, are you depressed? No, I don't think so"… People with lots of positive resources can be very depressed, too".* She perceived the response as increasing her suffering rather than alleviating it.

The caregiver's ability to identify the stage in the suicide process may also be important for getting close to the patient. Several persons said that suicidal thoughts arose already in early childhood, or in adolescence. One of them told about his mourning over the loss of his biological parents, a psychological sore that had never been treated: "*I have been carried this with me for 26 years, and through the years, more things have accumulated, and then finally it was too much".* Another young man told about his decision to take his life and his suicide plan following a period of hearing commanding voices and of being seriously depressed. When the therapist asked him directly about suicide plans, he found it impossible to deny his plans, even though he was determined not to reveal anything about them. A man said that his doctor tried to get close to him when he told about his suicidal thoughts:

He stopped writing on his machine and looked at me directly, and asked: "What do you intend to do?" Then I told the doctor that I'm not so stupid as to sit here and tell that I'm planning to take my own life, I said, because I know that they have ways to hospitalize people by force, and things like that. Then there was no more talk about it. But he was very clever in following me up, he was indeed.

Four months later, the participant made suicide attempts four times in five weeks. As soon as the suicide thoughts became an obsession, it was more difficult to talk about them; because, *"naturally, you're afraid to reveal what you have been 'toying' with in your thoughts",* he said.

The participants were longing to talk about their suicidality. They had talked with only a few persons, if any at all, about the *event*, a word they used to refer to the suicidal attempt. Some of them mentioned the suicide attempt as a shameful and cowardly act which was embarrassing to talk about. Some also referred to their own environment, where suicide was understood as "*a wrong and cowardly act. What I have done seems unreal,* one said, *so I'm actually talking about something I try to reject, that could not have happened".* Especially one of the participants talked about his struggle to understand the event, which included two attempts to end his own life on the same night by means of drugs:

What I did…was it a cry for help? But after all I had a feeling of being angry, of being annoyed at myself because I hadn't succeeded. So it's as if I haven't managed to collect my thoughts into one answer.

For him, an aspect seemed to be missing – that of not having talked more about the suicidal attempt. *"It's like three wheels are spinning",* he said. He could talk about physical suffering; however, suicide still seemed to be a taboo subject to him: "*you're really a 'loser' when you try to commit suicide".*

Some of the participants described that they felt they were *falling between two stools*. A woman told about several suicide attempts and her reactions after hospitalization during which she lay in a long-lasting coma. To her mind, memories returned along with the loneliness as the result of *falling between two stools,* she said. "*I had so many hallucinations, it was terrible, I had so much pain, there were so many questions, there was so much to cope with, so many traumas, indeed, things suddenly appeared, real things then, but I had no one to talk with about this".* In this situation, none of the health personnel took the responsibility to support her in the struggle for life.

This theme is to be understood as a longing for an encounter with personnel having the knowledge, willingness, courage and responsibility to explore the suicidal person's suffering. Supporting the individual to be able to reconcile himself after having carried out a suicide attempt is possibly an area of knowledge that we have not sufficiently expored.

Being met on equal terms versus being humiliated

The participants told about episodes when they felt confirmed and even understood. Some also told about situations that generated annoyance and aggression that increased their fear of losing control. Especially two younger participants described a 'pity you'- attitude as personally humiliating. One of them described his reactions in this way:

In principle I don't think they meant anything bad by it. Well, I can see that in a very vulnerable situation, then things are experienced in a special way. To pity someone – feel sorry for someone – I don't' like that. I felt that they pampered me, talked to me like I was a child, and … a little sort of, "poor little you". That patronizing attitude, that poor-little-thing attitude, annoyed me.

He described how a young therapist met him in a very different way. Usually the patient spent time in his own room, but when the therapist was on duty, the participant spent more time in the living room, eating and conversing:

She wasn't … yes, 'pitying' again then. We were two people talking together on equal terms, not prisoner and jailer. She was simply so fantastic ….and it was as if I could talk with her without feeling that, - what shall I say – she would divert the conversation, no matter what.

The same participant described how his experience of being forced and controlled increased his feeling of being humiliated. The humiliation of being hospitalized by force when his suicidal plans became known is illustrated by several circumstances, such as the examination of his luggage, having his trouser belt taken away, and someone running into his room without warning when he was about to go to sleep. His experience of being interviewed and evaluated by a "*quite violent psychiatrist, whom I didn't like at all, who almost examined me",* intensified his feelings of being humiliated, he said. When they asked him about his suicide plans, he did not reveal them because he wanted to move into another unit where he did not expect to be controlled in the same way.

Diversion from the topic at hand rather than talking about the matter was another staff tactic that seemed to increase the participants' feeling of being humiliated and annoyed. To

get leave from the hospital was experienced as a power struggle: "*It was a struggle to get leave, when I was supposed to be discharged. They just used a lot of excuses and devices to lead the conversation in a different direction, to avoid allowing me leave".*

Diversion of conversation and being talked about are described in connection with medication, too. A woman told about a conversation in which she asked for Lithium, a medicine that she had understood – and hoped –relevant for her. The doctor said *"no, nothing had ever been said about Lithium … no, about yesterday, no, everything turned out so wrong", and then she started talking about something else".* The participant perceived this as a professional conflict concerning diagnosis and medication. She also described her reaction at being talked about when she was present at a meeting with her psychologist and the therapist at the ward where she was hospitalized:

When she talked about me, she looked at my psychologist. I was sitting next to her and, I just wanted to move myself in front, and …, but then, I just thought, I can't. I had no strength and it was like I had lost so much energy, my ray of hope, and belief in the system (after the meeting with theme Lithium). *So I just decided to get out of this, sort of, and thought to myself that okay, let them just give me whatever they have decided to give me.*

She explained how this sequence diminished her trust in the personnel and her will to fight to get the treatment she needed to live her life.

Meeting someone on equal terms is a situation whereby the parties accept each other's inherent value. Can unconscious prejudices and trust issues reduce the professionals' ability to give time and space to suffering, and to meet the patient as an equal individual?

Discussion

The results of this study showed that encounters with health care personnel frequently lacked something that patients longed for in the aftermath of a suicide attempt: the wish to be trusted, understood, and confirmed in his or her suffering. The theme *Experiencing and not experiencing openness and trust* is understood as the suicidal person's longing to be seen as a whole individual, including contrasting aspects such as strengths and weaknesses, courage and fear, hope and hopelessness, the will to live and the wish to die. The statement "*really, are you depressed"* exemplifies that persons, who outwardly seem to act appropriately, can inwardly experience a feeling of not being confirmed in their suffering. Suffering by absence of care[22] can be triggered by unawareness and ignorance. Lack of confirmation can increase the feeling of loneliness and emptiness, and overshadow the hope of progress. Lindström[21] maintains that confirmation is the most active nursing act affecting the patients' progress.

According to the results, the suicidal persons' fear of forced hospitalization can hinder their openness. "*Then you close yourself, even more",* as one of the participants said. Both patients and personnel's understanding derives from their prejudices. One of the participants associated hospitalization in the emergency ward with the 'restraining straps' that have marked the history of psychiatry. To create time and space to suffer all the way out, as Eriksson[22] states, where the patient can share his fear, anxiety, loneliness, despair and hopelessness, but also his longings, wishes and dreams, calls for courage to be in the

patient's world, according Lindström.[21] It is about creating trust and stimulating hope; an ethical requirement in the work with suicidal persons.

Suicidality creates a rational fear in the helper[1], which can generate essential action. At the same time, fear can prevent the ability to be there for the individual [21] and to give time and space for reconciliation of suffering[22] in his or her struggle to live. To be in openness and trust, the helper must examine his own prejudices and reactions, in order to move towards better understanding.[7] Sometimes knowledge about signs and criteria in connection with a psychiatric diagnosis might influence health care personnels' understanding, in such a way that can hinder an attitude of openness. Understanding the suicide attempt as a 'cry of pain'[27] with focus on an inner condition instead of a 'cry for help' with a focus on behaviour, could make a difference in the way personnel respond to the suicidal person.

Clinical assessment of suicidal risk is a demanding task[28] that requires openness and trust between patient and health personnel. Some of the participants in this study were still suicidal and had suicide plans without revealing them to the personnel. Others said that they were happy that they still were alive and were eager to solve their life problems. Establishing a good therapeutic relation is very important in the process of assessing the risk of suicide. In the clinical framework 'Collaborative Assessment and Management of Suicidality',[28] the core elements are a strong therapeutic alliance and a close collaboration between therapist and client about the understanding and treatment of suicidality. Maybe this approach could be helpful to achieve better dialogue between suicidal patients and personnel. A misjudgement may result in irrevocable consequences, for both the patient and his relatives. Also, a suicide may cause pain to the helper as well, – grief, a sense of incompetence, fear of colleagues' reactions.[29] There will always be the possibility of an erroneous assessment of a suicidal patient and his/her situation. The thought of the consequences of an erroneous assessment can create a fear that diminishes the ability of the caregiver to be present for the patient. Thus the patient may experience an absence of care[20] that can intensify the feeling of being separate from the other, the sense that no one can help,[5] and the feeling of being a burden to others.[6] Finally, the loneliness can be so painful that suicide is seen as a last resort.[10, 30] According to Cutcliffe & Stevenson[31] the health care personnel's tasks are to prevent suicide by reflecting a mirror image of the outside world, to guide the suicidal person back to the world, and to help and support him or her to continue life. In this study, openness and trust is understood as a premise before the patient can accept guidance and support from another.

An open and caring attitude and ample time, seem to be important so that the suicidal person can explore and come to grips with his life suffering, as reflected in the theme *Being met and not met by someone who address the matter*. Despite increased knowledge about the importance of openness, professionals in psychiatric health care also tend to think that suicidality should not be talked about.[32] This study proved instead that there is a longing and a desire for a better dialogue, as also Talseth et al.[16] state. There is a need to speak about the event after a suicide attempt, despite the fact that this is difficult for the patient. Reconciliation can mean to articulate feelings of shame and guilt after the attempted suicide, and to understand the event in light of one's own life story.[10] The suicide attempt can be seen as a trauma that needs focus in the emergency conversation, as this study corroborates.

To get 'close to' a suicidal person requires the interest, will, courage and desire that presence will give consolation and help the patient endure suffering. According to Eriksson[22] compassion, in the meaning of suffering with another person, calls for courage to take responsibility and to devote oneself. To devote oneself means to dare to come to grips with issues without knowing where they will lead.

To talk about the suicide attempt is to talk about behaviour. To talk about suicidality is to talk about suffering. To be able to describe suffering related to suicidality, we need an expanded vocabulary,[1] which would perhaps benefit from a more frequent use of metaphors. To be 'close to' someone can encourage a patient to face suffering.[21] The challenge is to approach the heart of the matter in a respectful manner, that includes an attitude of openness and trust.

To identify risk and protective elements during a risk assessment is to find out the suicidal person's relationship with these elements. Having family members does not always mean receiving support. Several of the participants did not tell their parents, brothers and sisters or other family members that they had carried out a suicide attempt. Identifying protective elements can produce concerns that require time to address. Invitations to share without any stress, with ample time – a scarcity in many treatment environments – are resource-demanding. Taking responsibility can mean providing sufficient time, which in light of the results in this study seems essential in achieving what Eriksson[22] describes as reconciliation.

To be suicidal is to be in a crisis[3] where an individuals' coping capacity is reduced. Being unable to cope with their own circumstances of life and having to ask for help, or even being involuntarily treated, will affect the patients' sense of dignity and confidence. The theme *Being met on equal terms versus being humiliated* illustrates how one's own values and prejudices can be expressed and can either relieve or cause suffering to persons in a vulnerable situation.

The participants described some traits that are characteristic of depression, such as worthlessness,[1] and their own sensitivity to other peoples' attitudes and statements. As one interviewee said: "*when you're down it, doesn't take much to get you further down".* Depression could make the person more vulnerable to dignity violation.

Equality is a basis of the therapeutic relationship and implies that both parties recognize each other's value. In the encounter with patients in a suicidal crisis, it is no less important to be aware of the value of equality. A 'poor-little-you'-attitude, as described by two of the participants, is not experienced as sympathy or compassion but as a patronizing attitude. Eriksson[22] points out that the health care personnel`s own suffering can reduce their ability to express sympathy. For example, the encounter with young suicidal people might affect some persons strongly, because they are naturally concerned about their own children and this could invoke fear and anxiety, and reduce the caregiver's ability to provide time and space for the patients' suffering.

The sense of humiliation, also described by Wiklander,[8] is connected with absence of dialogue about subjects that concern the participants, such as leave from hospital, drugs and so on. Diversion might be a strategy that protects the helper against his own fear and anxiety, but for the patient it can exacerbate frustration and cause further suffering. The fact that the personnel share their own concerns with the patients might enhance the patients'

ability to be open to exploring risk and protective elements. The personnel's willingness to open the 'inner door' in their own mind[33] will better meet the longing for understanding that could make equality possible.

Methodical considerations

Through the interviews, participants constructed narratives of their suffering, recounted in the conditions and the stage at which they were when the interview took place. Every interview contained new themes or variants of the other themes. After ten interviews, the material was considered ample to answer the study's research questions. The conversations prior to and after the interview provided supplementary information that expanded understanding of the texts from the interviews. Creation of contact, trust and mutually proper dialogue between researcher and participants is crucial for the quality of qualitative data.

Subjectivity can sometimes be a source of error, but can also provide opportunities. The data have been interpreted by the first author and under the influence of her pre-knowledge, but in dialogue with the second author. Other readers might see other themes in the material, based on their reading of the texts from their own perspectives. The study represents no definitive truths about experiences of suicidality, but it can serve as a contribution to expanded and nuanced understanding.

Conclusion

This study shows that encounters with health care personnel do not necessarily help the suicidal patient in the struggle for continued life, but can reinforce suffering and reduce hope for a better life. The participants in the study shared some experiences that could help to further understand how to meet the suicidal patients' longing for understanding. Being met with openness and trust appeared to be important. The suicidal patients' suffering could be about loneliness, shame, guilt and so on. It was deemed hard to get close to and share difficult thoughts and feelings without being trusted. Being met on equal terms is a matter of course in theory but not in praxis. An attitude of openness and trust is a premise for meeting someone on equal terms.

A caring attitude, characterized by openness, trust, getting close to the patient, and treating the patient with equality could all be helpful in order to better co-suffer and encounter the suicidal patient. Vulnerability to dignity violation will generally be very high in suicidal patients. Therefore, a conscious attitude towards own pre-understanding is of the utmost importance in the conversation. There appears to be a need for studies that investigate how suicidal persons experience conversations with personnel about suicidality, a necessity for the dialogue in caring and treatment.

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Conflict of interest

The authors declare that there is no conflict of interest.

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