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Experiences that inspire hope – Perspectives of patients in the aftermath of suicide attempts

Abstract

Background: Suffering in a suicidal crisis includes feelings such as despair, loneliness, anxiety, fear, shame, guilt, and hopelessness. This study highlights the experiences of patients in the aftermath of suicide attempts. The **research question** was: What do suicidal patients see as meaningful help in care and treatment situations?

The **methodology** is inspired by Gadamer's hermeneutics, where the parts are understood in light of the whole, and the whole is understood in light of the parts. Qualitative interviews were employed.

Participants and research context: Ten persons, four women and six men 21-52 years old, were informed and asked to participate by specialists in psychology at two emergency psychiatric wards and by one crisis resolution team. Nine of the participants had experienced one or more suicide attempts using drugs and alcohol. Forced hospitalization prevented one of the ten participants from attempting suicide.

Ethical considerations: Before the participants signed an informed consent form, the interviewer met all participants to provide the written information, talking about the interview. A meeting to terminate contact was arranged after the participants had read their own interviews.

Findings: Three themes were generated by the methodology we applied: 1) Experiencing hope through encounters, 2) Experiencing hope through the atmosphere of wisdom, 3) Experiencing a ray of hope from taking back responsibility.

Discussion: The findings are discussed in the light of Eriksson's suffering theory and Lindströms theory about psychiatric care, as well as earlier research and theories about suicidality.

Conclusion: The study reinforces possibilities that hope in suicidal patients can be inspired in encounters with health care personnel and within caring cultures. Through dialogue and cooperation patients' safety and ability to cope with suffering is created, and thereby the hope and will to struggle for life.

Keywords: Attempted suicide, suffering, patients experiences, encounters, psychiatric care, caring cultures, hope, hermeneutics

Introduction

The suicidal suffering includes feelings such as despair, loneliness, anxiety, fear, shame, guilt and hopelessness. The feelings become unbearable at the time when persons are unable to endure the pain[1] in suffering. Hopelessness is found to be a more crucial risk factor than depression.[2] According to Joiner,[3] the risk of suicide increases when persons' experience a low degree of belongingness and feel that they are a burden to others. More than 800 000 people die from suicide every year and the number of attempts with the intention to die is many times greater.[4] A history of multiple suicide attempts is one of the main factors in risk assessment[3]

One characteristic of suicidal patients' is the lack of a belief that someone or something can help them.[5] This means to be caught in a deep loneliness. The patients needs to meet professionals who become involved in the patient's suffering. This is what Cutcliffe and Barker[6] call "engagement as the means to inspire hope". Patients need to meet health personnel who in their care and treatment become involved in their suffering and focus on the sufferer's dignity, need to belong and hope for life.

By searching databases such as Medline and Cinahl, fifteen studies were reviewed based on relevance to this study's research questions. The findings concern mainly factors in the relationship between patient and health personal. The relations factor has been shown to trigger suicide attempts, but can also facilitate a type of communication that prevents further suicide attempts.[7] Encounters with health personnel both alleviate and increase suicidal suffering.

Wiklander et al.[8] showed that being met with respect and kindness in the aftermath of attempted suicide was seen as an alleviation, while moralizing was perceived as increasing their shame. Reported shame is associated with not coping with life or a feeling of having failed in their suicide attempt.[8-9] No definitive connections have been established between the tendency to feel shame and attempted suicide.[10] To be understood, listened to, respected, trusted and confirmed are perceived as important to moving forward after a suicidal crisis.[11-14] In addition, being met with openness and direct questions helps the patient to talk about the real context of the suicidal suffering.[13] Jordan et al.[15] showed that young men struggle with becoming a man and that meaningful care may help to meet challenges in life.

Relations in social networks are seen as having a central role in continuing life in suicidal crises. What was of most help to half of the patients when they suffered worst in their crisis, was their social network, according to Eagles et al.[16] Nevertheless, several of these patients had not talked about their despair with someone in their network. Lakeman and FitzGerald[17] pointed out the importance of establishing links with other people to strengthen the will to continue to live. Intervention in the private network by someone who becomes involved in the patients' suffering was cited as a significant resource after an attempted suicide.[18]

Hope emerged as something relational, interpreted as defined and undefined hope for life and for death by Herrestad and Biong.[19] In a study by Talseth et al., two sub-themes: "communicating hope to the patients" and "communicating hopelessness", were tied to the main themes "Confirming" and "Lack of confirming". Suicidal persons long for closeness and fear being abandoned. On the other side they struggle to open up for an inner dialogue about their own

needs.[20] Struggling to find a solution which could alleviate suffering has been shown to be central in a suicidal crisis. [9, 17, 21] A turning point in life could help persons go to continue living, but it might also exacerbate suicidality. [21] In a study where the attempted suicide was 2-6 years in the past, a main finding was the persons' struggle to accept their own worth in life. The authors claim that the knowledge gained from this study can be used as a guide to strengthen the self-image of the patients, and to inspire hope in a process of improvement.[22] Through a literature review, Lakeman[23] described some key themes and stated that the findings in the research about pain, suffering and alienation are consistent.

Since the existing research about patients' experiences of care and treatment in suicidal crisis is rather scarce, we found it valuable to carry out a study to strengthen the knowledge from the patients' perspective, in order to guide health care personnel.

The *aim* of this study is to develop knowledge on what alleviates the suicidal suffering after having survived a suicide attempt. *The research question* is: What do suicidal patients see as meaningful help in care and treatment situations?

Theoretical framework

The study builds on a multi-dimensional view of human beings[24], their health and suffering, and is inspired by the theories of Eriksson[24-27] and Lindström.[28-29] Eriksson's concept, life suffering, encompasses the total life situation in that it touches upon our existence and significance as human beings. To not feel that one is seen by others is, according to Eriksson,[26] perhaps the deepest form of life suffering, which at some point may become intolerable. Human beings seek

a feeling of belonging in a fellowship built on trust and reciprocity, and in which one has the freedom to make one's own decisions.

Lindström distinguishes between the person's needs, his innermost longings and problems, in her theory about psychiatric care.[28] The person's ability to long for something emerges through desires and hopes. According to Lindström,[28] hope is grounded in people's belief in something in existence, and hope relates to the person's will. Hope in this study is seen as a movement towards betterment in the struggle for life, which is affected in relationships.

Suffering can create a feelings of hopelessness, and therefore human beings need hope that can alleviate suffering.[26] To not validate the suffering of the patient is to question his/her credibility and dignity,[28] and to inflict suffering in care.[24, 27] Through authentic relationships, caring cultures[28-29] are created that can alleviate suffering, inspire hope, and strengthen the will to live.

Methodology

Hermeneutics as a methodology inspired by Gadamer,[30] forms the basis for the interpretation of opinions related to reaching a deeper understanding of the subject matter. Hermeneutic knowledge development involves a quest towards understanding experiences in a different way, rather than understanding them better.[30] Understanding is brought about in a dialogue between the reader and the subject matter described in the text,[30-31] which in this study deals with patient experiences after a suicide attempt, through an oscillation between the theoretical and the empirical. The researcher's prior experience may present an obstacle to understanding, but is, according to Gadamer,[30] a pre-condition for a different kind of understanding. In this study, the

first author's understanding emanates from meetings with suicidal patients in mental health care - experiences that are judged to have influenced the dialogue with the participants in a positive way.

Participants

The design is explorative, which is suitable in a study with few participants.[32] Ten participants consisting of four women aged 21 – 45 and six men aged 25 – 52 years, were selected and asked to participate by a psychology specialist in connection with a follow-up after suicide attempts. The participants had different profiles and social situations. Several of them had had recent break-ups with partners. One participant lived in a stable partnership relationship. Four of the participants had from one to three children. Most lived alone in their own home; one of these had supervision. Five were on sick leave from permanent employment, one of them still working. Three participants were on disability insurance, and two were in the educational system. Several of the participants had had previous contact with psychiatric health care. For two of the younger participants, the suicide attempt led them to the first meeting with the support services. Suicide was attempted by consuming various doses and types of medicines; four had combined overdosing with alcohol. Forced hospitalization prevented one participant with a well thought out suicide plan from carrying it out. The person in question and four other participants were followed-up in the emergency psychiatric ward, while the other five were followed up by a crisis resolution team in a regional psychiatric centre. In addition to serious suicidal tendencies or an actual suicide attempt, the ability to verbalize experiences was an inclusion criterion for participation. The interview was to be carried out at the earliest 2 weeks after the emergency

situation, and the participant was to have an offer from a treatment person at least 2 weeks after the completion of the interview. An exclusion criterion was psychosis.

Data Collection

An in-depth interview inspired by Kvale and Brinkmann[33] was carried out. Those authors described the aim of an in-depth interview as to capture descriptions of the interview persons' life world that is to be interpreted. The interviews lasted from 90 to 110 minutes. The questions had an open character that invited the participant to feel free to tell whatever he wanted but within the scope of the questions[30]. We used an interview guide comprising eight questions aimed at capturing information to elucidate a number of research questions. This is in accordance with Gadamer [30], who states that to understand what is problematic, the researcher always has to ask. The following questions were relevant to this section of the study: What do you think of the manner in which you were met in various situations? What do you think about the treatment you were offered during and after the suicide crisis? Is there something you feel the caregivers should change in the way they meet and treat patients with suicidal problems – and if so, what? What do you see as important help moving forward for coping with daily life if the thoughts of suicide return? What do you think of your own contribution to improving in the desired direction? All the interviews began with an open-ended question on the actual situation that brought them in contact with the health care services. Some took more time to get to the actual attempted suicide, while others went to the issue immediately. The research interview became a recounting of parts of their life by oscillating between the current situation and of experiences from the immediate or a more distant past. The information was shaped into a dialogue in order to elaborate on, and to understand, the participants' understanding of self. In the dialogue, the interviewer checked the

interpretations of the participants' answer, that is, what Kvale and Brinkmann[33] described as one of many quality criteria for an interview.

The interviews were carried out by the first author, who met with the participants beforehand to make sure that the verbal and written information they had received was understood. After this dialogue, which functioned as a 'getting-to-know-you' meeting for both parties, the agreement to participate was signed. Two of the participants preferred that the interview take place in their own homes; four wanted the interview to take place at the researcher's office. For the other four that were under hospitalization at the time of the interview, the ward's meeting room was a practical space for conducting the interview. The interviews were tape-recorded and transcribed verbatim by the first author.

Analysis and interpretation

The findings that are presented in this article were arrived at by a thematic analysis of the research question. By Gadamer's hermeneutics,[30] the themes in this study have been developed by moving from the whole to the part, and back to the whole, trying to seek deeper meanings. Provisional themes were noted in a log immediately after the interview, and later in log form after transcription of each interview. The transcription is considered as a way to become familiar with the data; which is mentioned by Braun & Clarke[34] as the first phase in a thematic analysis. The second phase was a review of the individual interviews, an open reading in search of the participants' understanding of their own experiences in connection with the suicide attempt. Themes and keywords were noted in the margin. The third phase in the analysis comprised a systematic search for statements that could elucidate the research question. The statements were

put into a new document and the number of the pages was noted to facilitate data checking. Parallel to this phase, important points of view in the statements were extracted and recorded in another column, such as “To be given time to find the words”, “To feel that someone is listening”, and so on. These sub-themes were then reviewed in a fourth phase, in which provisional themes such as “Conversations that helped” were recorded in a third column. Following checking the data base, this one and two other themes seemed to capture essential viewpoints. A fifth phase involved what Braun & Clarke call ‘defining themes’, where the theme “Experiencing hope through encounters” seems to encompass the viewpoints in the descriptions of dialogue and meetings that were helpful. The findings are discussed in the light of the theories of Eriksson and Lindström, and relevant research on the theme.

Ethics

The study was recommended through the Regional Committee for Medical Research and the Norwegian Social Studies Data Services. One of the factors included in research ethics is the assurance that a written statement of consent be provided, but also clearly understood. In this study, this was done through comprehensive discussions with the participants prior to their signing the statement of consent. Formal recommendations do not exempt the researcher from the responsibility for making choices along the way based on the individual participants’ needs and the situation itself. In practical research, ethical obligations supersede the research interests.[35] Ethical behaviour involves accepting what the participants say in confidence, with trust, and without diminishing the value of the other person.

Findings

Three themes appear to capture the participants' experiences with respect to the care- and treatment situations that they considered significant, defined as: 1) Experiencing hope through encounters, 2) Experiencing hope through the atmosphere of wisdom, and 3) Experiencing a ray of hope from taking back responsibility. The themes, associated to encounters with people and care cultures in connection with the suicide attempt, are interpreted as hope-inspiring care.

Experiencing hope through encounters

One item that emerged in the data was the participants' need to be understood in their suffering. The perception of being understood alleviates the suffering from feeling loneliness. Participants described the encounters with health care personnel who listened and attempted to capture meaning, both through participants` words and body language. The perception of being understood seemed to increase their hope of being connected with others, and that another person could help them to go on living. Several of the participants had communicated their need for professional help without been taken seriously, such as a young woman who communicated suicidal ideation to both a specialist in psychology and her primary physician. After attempting suicide, she came to an emergency ward. *They gave me hope*, she said. She described conversations in the emergency ward and at the emergency psychiatric unit that helped her to realise that that she could affect her own life situation, rather than remaining hopeless. *Then there is still hope,* another participant said, but *hope dwindles when I do not see results*. The result that seemed to inspire her hope was the experience of gaining confidence and of beginning to talk, *and then it became helpful to me. It really did,* she said.

The perception of being understood gave the hope of being in a process to go on living. Such experiences seemed to be strengthened by contrasting experiences like not being really listened to and understood. This contrast is shown in the following citation:

She does listen, but even after a few minutes, she has just about forgotten what I said, and asks about things that indicate that she could not possibly have understood what I had just said previously. So in a way I feel that I was not being heard at the time. And then she says we must talk about this the next time.

For this participant, it took time to begin to talk about thoughts and feelings she never had talked about before. To experience that someone gave the time it took to find words, listening to her suffering through both words and body language, inspired the hope of establishing contact with others, and thereby decrease the deep loneliness:

They sat down, and they noted that it was not because I did not want to say anything, but it was because I could not manage to do so. And they did not threaten me then … When you in a way are then totally clammed up, then it does not really help to hear they believe the worst and want to have you forcibly admitted and all of that, when what I really wanted to say was that I was misunderstood…that you have been totally stuck for words … This was what the other one did not do. She did look at the body language but in a way then interpreted it wrongly. So … it just became chaos.

Several participants described the importance of body language. One young man went so far as to say that he felt the emergency ward hospitalization was very offensive and humiliating. He felt that his physical energy left him, but on the other hand, he feared the pressure and humiliation he felt might result from acting on the anger that was inside him. He described an episode when he felt that the psychiatrist pressured him concerning a leave of absence matter. He did not feel a relationship with this psychiatrist, but as he said:

That nurse got to know me well after some time - managed to see when I became irritable … She sees from my body language that as it goes on now, I was beginning to be very angry. And the result then was that she took control of the conversation and said that we can talk about this; she saw right away that now I was beginning to get very furious about this. And she then took the doctor aside, and later they came back and said that you will get the leave.

The fact that one person saw him as a whole human being, in his suffering and despair, anxiety and worry about recovery from mental illness helped him to find a way to endure the stay in the emergency ward, to be ready to cope with life outside the ward.

For some participants, encounters with other patients also gave them a feeling of being understood and be in connection with others. *To hear others tell that they also struggle to get up in the morning, that helps, really,* says a woman. *Fortunately, I am not alone in this*, says a man who struggles with depression:

There are many on the ward who struggle with a feeling of emptiness, of not having human contact. And then there are those with too much contact, those with anxiety, they have huge connections with their feelings. While those of us who have depression are somewhat totally opposite on the scale. When observing the different feelings, one does not feel so special oneself any more.

A participant who was admitted to an open ward felt that the personnel reduced the opportunity for sharing experiences by controlling the interaction between the patients. He had conversations with patients who felt the same, i.e. that the lights were, in a way, turned off. This man felt a strong sense of shame about the suicide issue and found it difficult to talk to others about this subject. But: *in-between, then you get into it, and then the talking evolves*, he says.

Such conversations were described as significant experiences. These experiences are interpreted as hope-inspiring by giving a feeling of not being alone, feeling understood without saying so much, feeling that one is a normal human being, and feeling hope that one will recover by listening to others` stories.

Experiencing hope through the atmosphere of wisdom

Experiences with different caring cultures were brought up when the participants described treatment environments they had been a part of. They noted moods, values, and attitudes, despite – or perhaps just because of – the vulnerable situation they were in which seemed to affect their hope for life and the choice to go further. After surviving the suicide attempt, difficulties in life were not changed. They felt despair, loneliness and shame, and quilt in bringing suffering to their families. As they were doubtful about their place in relationships and in life, it was alleviating to

notice attitudes that gave a feeling of being a valuable human being who had potential in life. A young man described how the manner in which he was met by the nurses gave him *a somewhat good and warm feeling. They really cared, I could feel it right away. I think that was very good. I know that was very good.* He described what he noted as a common mood in the care from those he came into contact with in the emergency room. During the 24-hour period, he thought about his choice of life or death, which was a first step towards looking forward in life.

One of the male participants, who looked very depressed, said that he was not happy to have survived after four suicide attempts. He remembered that he had noted an atmosphere in the emergency psychiatric unit that surprised him and meant a lot. This atmosphere gave him a sense of being of value while in a phase filled with anxiety and deep depression, which he experienced and described as "a fundamental attitude" in the caring culture: *... It is very nice, you feel it, even if they do not talk about it, it is still somehow present in the spirit and in actions ... the way in which I was received made me calm.* This fundamental attitude in the atmosphere appeared to overshadow the limited freedom he had:

There was in any case no form of control or restrictions in the way they talked to you, even though there were of course many restrictions. I did not have a way out, I did not have this or that, in the beginning I did not even have a lighter, yet you did not take notice….

Another participant, who also stayed at an emergency psychiatric unit after a suicide attempt, described a mood that filled her with good feelings when she entered the room for a creative activity session:

You notice that there is so much soul in that room ... The place is full of wisdom and knowledge. You feel it right away when you enter the room, so it is almost as though you have entered into a holy place, you become a bit, like, inspired by just sitting there…. Because I have never been any good at either making things or drawing, or anything, but I made jewellery, belts…

This participant felt that the atmosphere stimulated her self-worth and creativity in a way she had not thought of before. She began to look forward. For example, she went to group therapy to build up relationships and began thinking about how she might use her potentials in a job or other activities. She seemed to be on the way towards building up meaning in life with a personal drive consisting of her own needs, wishes and hopes.

Experiencing a ray of hope from taking back responsibility

The participants described interaction that helped them find alternative coping strategies that strengthened their ability to exercise control over their suicidal impulses and thereafter their will to live. To have an appointment with someone after the suicide attempt gave structure to the daily routine, which alleviated suffering and seemed to strengthen their ability to go on living.

Five of the ten participants had been followed up by dialogue sessions in the crisis resolution team. The dialogues were important reference points immediately after the suicide attempt, says a young man: *But they were more worried about whether I would end my life in the period after, the weeks after, than… I was more engaged at the time in solving my problems, and getting a grip on my problems.* He went to see a private psychologist to begin right away on what he

understood to be the issue: identity problems related to his childhood. Modes of conversation that stimulated reflection over one's own situation and patterns of behaviour, in an open dialogue, were described by a number of participants as being a help in pointing out options and being able to "get a grip":

Just speaking with a psychologist is no help at all if he only listens; you need perhaps to receive feedback on how you are perceived and often, one needs some guidance…. I must take responsibility for things in my own life then, but you really don't know anything if no one tells it to you. However, you must really somehow have trust in those who are sitting here in order to be able to open up, for that is not accomplished in one day, for sure.

In such dialogues, the reflections and feedback helped this participant to see own patterns in thoughts and actions, but also own possibilities. Beginning to "get a grip" seemed to increase the will to go further in life, for example to re-establish contact with his daughter that he loved.

One of the participants related how, through a course in coping with depression, she became familiar with tools that she felt had "turned the situation around". The method and questions from the course leader helped her, among other things, to see who the important support persons were in her personal network. She felt that, through the course, her confidence with respect to thinking rationally and to making her own choices was boosted.

Many of the participants told about a crisis plan, or a written or verbal agreement they have had. These seemed to be generally viewed as positive and for some, life-saving. A younger man told about how depression occurs, how sleep does not come, food intake becomes minimal, and the

threatening voices inside his head become louder. He tells about his agreement with the therapist: *if such an episode came back, then I should report it rather than doing what I usually do, which is to isolate myself. So, I did not plan to say anything….* But when the therapist asked a direct question, then he did not have the strength to deny the suicidal plan, and he then could be forcibly admitted. For him, this was a terrible situation, one that re-activated the suffering. The participant had been under continuous supervision and then switched to supervision at intervals, every 15 minutes… *without even letting me know*, he says. *I tried to sleep, but then I had this girl running into my room every 15 minutes, it made me quite irritated.* On the other hand, he said, *"agreements were a good method for me. The primary contact person understood that. It was a way by which to control me.* The first leave of absence from the emergency ward, which lasted a few hours, was described as follows:

The suicidal thoughts that I told my therapist about, they were there, all the time. I considered them, but at the same time, I had entered into an agreement with my primary contact that I was not to do anything to myself. They understood this, that keeping promises was a bit my way at the time… As far as I am concerned it is important that one can trust me, that I keep promises and so on …

This participant felt humiliated and said that he did not like the personnel, except one of the primary contacts who gave him the feeling of being an equal human being. Struggling with suicidal thoughts when absent from the emergency unit, this relationship seemed to become important for him in his choice to go back to the emergency unit, as he earlier had agreed to do. Another man talked about a crisis plan that he thought he had, which included the number of an

unattended telephone: *they were not there; it was at a wrong time. So I then tried to call the accident and emergency unit, and they could not help me* .... The solution was to call a ward where he had been admitted previously; *she talked to me for one and a half hours, "but you are not calling the correct number now",* she said. Being met by this caring person alleviated the despair and anxiety and seemed to strengthen him in his struggle for life.

Discussion

The theme, *Experiencing hope through encounters,* is seen as reinforcing the strength of the relationship and providing options for the suicidal patient in the encounters. The interventions that seemed to inspire hope through the participants' perspectives in this study involve dialogues and engagement in the persons' suffering – what Cutcliffe and Barker[6] call 'engagement as the means to inspire hope'. Hope is assessed as a valued attribute[27] and as a necessary means of coping with suffering.[36] As Lindström[28] points out, hope emerges because the individual's innermost longing is enabled. Hope comprises an important part of mental health care and nursing,[37] also shown in the context of suicidality.[6, 19-20, 22, 38] To recreate hope presupposes perhaps meeting someone who helps to open up for dialogues about needs[20], tolerates hopelessness and is capable of suffering alongside the person.[36] In this study, compassionate encounters with professionals that serve to reinforce hopelessness are described as missing. Not feeling that one is properly met, with respect to difficult themes, e.g. shame, can be experienced as a rejection[8] by a person who for some time has kept silent about suicidal thoughts. Through the encounter, someone who gives the time it takes to be able to open up can inspire hope in the patient through a growing feeling of being worthy.[16] This hope is essential since the suicidal persons' attitude holds that no one or nothing can help.[5] A study by Koehn & Cutliffe[38] supports

the view that it is precisely in the relational sphere that those actions occur which inspire hope in the mind of the suicidal person. In a good relationship, the patient feels validated and understood even when the communication is wordless. In this study, a caring action is described based on the nurse's interpretation of a body language that expresses an increasing level of aggression. The fact that the person involved feeling himself validated in this situation is experienced as a help to retake control of themselves and to defend their own dignity. Dignity is seen as an overarching moral principle emanating from a care-based ethical perspective on nursing and patient care.[39] To alleviate suffering and strengthen dignity, the person in a suicidal crisis needs to be met with sensibility and trust.[13] The participants' experiences of openness, trust, and engagement are interpreted as hope-inspiring communication that strengthen the will to go on. To be met by an emotional engagement[6, 40] appears to be a central factor in building hope according to this study. This can serve to increase the patients' belief in the process, and his confidence in being worthy of another person's time. Lindström[28] describes a relationship with the individual patient as an encounter between knowledge and ignorance; person to person, an encounter in 'no man's land'. It is perhaps exactly in this 'no man's land' that hope can be inspired. Both parties must show trust in the other person, and must involve themselves personally.[28] Such encounters can liberate inherent strengths and have the effect of moving the process towards health.

Encounters with persons who recognize what they themselves experience as the "the light being switched off", are interpreted as encounters that have inspired hope. To establish links to other persons[16] in psychiatric wards can be an important reminder for the patient that it is possible to achieve fellowship and belongingness, which persons in suicidal suffering often lack.[3] The

importance of sharing experiences after a suicide attempt is validated by patients who, following such a suicide attempt, are interviewed in a focus group study.[7] Such interactions can serve to normalize suicidal thought[15] that can alleviate shame and strengthen the patients' feeling worthy and dignified. Findings in this study show that when patients encounter other patients being in suicidal crisis might strengthen their feelings of not being alone and instead, of being normal human beings.

The other theme, *Experiencing hope through the atmosphere of wisdom,* emanates from the experiences from caring cultures that the participants in the study had experienced in various treatment contexts. Such cultures are seen as components of the whole which have worked together to inspire hope in the participants during their suicide crisis. Lindstrøm[28] describes a caring culture as that which has its expression through language, rituals, traditions, and other factors. Being in depression the persons' dignity might be affected. Then, the "fundamental attitude" practiced by caregivers, as a participant in this study called it, can alleviate suffering and promote dignity. Practicing values such as openness, equality, and trust in emergency care units, seem to overshadow the negative feeling of, for example being controlled and pressured. For another participant, the culture in a similar unit was seen as purely controlling and highly offensive. The caring culture in a ward or in a team is created by individuals. Without authentic relations, culture will collapse and become ossified in form, Lindstrøm.[28] states. If persons undergoing crisis and with a strong sense of hopelessness are to be able to experience the "fundamental attitude" in the caring culture, then all personnel have to work with their own attitudes and the maintenance of their own feelings of hope. Moore[37] points to the meaning of health care personnel having strategies for building up and strengthening their feelings of hope.

Suicidal persons need to meet a caring culture whose individuals are bearers of hope. Research studies show that interpersonal relations and an environment characterized by empathy have therapeutic and restorative importance following suicide attempts,[7] which is something that this study also appears to confirm. The feeling of being seen as a human being with potential appears to be essential in building up the hope in life and the will to go on.

Suffering, according to Eriksson[26] is caused by the fact that persons are deprived of their dignity in an objective or subjective sense. The caring culture may build up according to a person's perception of self-worth, belonging, and its meaning for others, through attitudes, written and unwritten rules, and traditions. It is exactly such psychological requirements that are threatened in a suicidal crisis.[3] In a state of chaos, anxiety, loneliness, and hopelessness, communication in caring cultures can have an important hope-generating effect.

The study's third theme, *Experiencing a ray of hope from taking back responsibility,* is seen as care and interaction based on mutual trust, good faith in the inherent life force of human beings, and on the belief that the situation can always change. Actions aimed at restoring a person's control over suicidal impulses and the capability of confronting the challenges of life, are contingent upon activity from both parties. The action in psychiatric care called 'safety'[28] is carried out in various forms and with varying intensity in the present study. Cutcliffe and Barker[6] argue that the model of 'Engagement' should replace 'Observations' as a main principle. The present study seems to confirm that reflective dialogues with careful listening, emotional engagement and feed-back, is an intervention that inspires hope, and is connected with human beings will, according Lindström.[28] Through dialogue, the suicidal person can see him-/herself in

new ways in the situation. Hope could be an important tool for crisis intervention because it can, as Biong and Herrestad[41] pointed out, open up something that is locked. Openness, trust, and engagement help people open themselves up in a dialogue on difficult subjects. Then it can open up for hope, and thereby strengthen the will to “get a grip”, as a participant in this study called it, on his own life.

Beskow[40] describes a cognitive approach characterized by an emotional engagement, open dialogue and co-operation to problem-solving rather than merely talking about the problem, that some of the patients in this study experienced. In a model for risk assessment and treatment at the time of the suicide, the core element is a co-operation with a basis in the patient’s perspective point of view. A Crisis Response Plan is included in this, which means to provide support for coping.[42] The starting point is that the patient obtains knowledge regarding his/her own risk factors. In a study carried out in Denmark, a great degree of satisfaction was observed with this model. 74% of the selected sample of 42 patients judged that they no longer were at risk of suicide, and 83% had experienced a close collaboration and a good relationship with the therapist.[43] Precisely this openness and collaboration towards making the situation more secure is seen as assistive factors in meetings as described by the participants in this study. The feeling that someone is listening carefully, taking their point of view in their suffering and helping them to `get a grip` through engaging themselves, appears to be a critical factor in the security measures that the participants describe as hope-inspiring help.

Actions aimed at strengthening the security of the patients can be experienced as a form of control, just as one of the participants judged agreements to which he had consented. At the same time, he judged agreements as being "a good method" for him in his situation. Understanding

suicidal behaviour as a coping strategy,[17] such intervention seems to help the patient to cope with thoughts and plans about suicide, and thus be able to experience safety and thereby control in life. There is a scarcity of research on patients' experiences with agreements and contracts. A study by Davis, Williams, & Hays[44] shows that patients feel that written contracts which they themselves have signed are a support in coping with their personal life-threatening forces. The contract's `pitfalls` and possibilities are frequently described and discussed based on the professional's experiences. In situations without available time to establish trust in the relationship, contracts are judged to be more a hindrance than a help.[45] Without emotional engagement and time for dialogue on solutions that can be set up under the patient's own personal security, authority and control can be a result. The manner in which the conversation is conducted will possibly have considerable importance. The participants state how openness in conversations, feedback, consultation, and guidance regarding alternative actions provide them with the tools to understand connections and to cope with self-destructive impulses. Such interaction can inspire hope in finding "a path to restore his or her original status as agent", as Fredriksson and Eriksson[46] state, and thus be free to take back responsibility in life, which patients in suicidal crisis for some time has been relieved for by others.

Methodological considerations

The findings are based on data material obtained during ten interviews, which makes thorough understanding possible. During a time when many cultures interact, the participants from non-Western cultures apparently would have provided a more nuanced picture of what would help and give hope in a suicidal crisis.

The findings from the study are judged to be valid and reliable based on the background of theoretical perspective and methodology. Experts selected participants whom they judged were able to contribute with important experiences. Data were assessed as rich, based on content and depth, because they were produced in an atmosphere of trust and a considerable degree of openness and in a situation where time was assigned to the interview situation itself. The participants received transcripts of their own interview and in this way were able to check their own statements.

Conclusion

The study validates the potential of the encounters for inspiring hope and alleviating suffering in suicidal patients. Within care and treatment situations there still exist the risk of reinforcing suffering. The patients need to be interpreted and understood through both verbal and body communication. Being met by health care personnel who sympathize with the patient and become engaged in an emotional way appears to be critical in inspiring hope. When values and attitudes permeate the caring culture in which the patient is engaged, then the caregivers' collective behaviour could inspire hope which can be critical for the patient's choice of life or death. Patients in suicide crisis need various forms of support and help in order to 'get a grip' on their own personal situation. Coming up with actions that can provide hope in restoring safety seems to be helpful. Action that help patients in taking back responsibility must occur through an open dialogue in which the engagement is aimed towards what can help the individual person in his or her situation. It is through dialogue and cooperation that patients' ability to cope safely with suffering is created, and thereby the hope and will to struggle for life.

Hope seems to be essential in work involved with guiding suicidal patients back to life. This calls for an increased research focus on conditions such as patients' feelings of hope, the helpers' own relationship with hope, and how hope can be inspired so that the patients' life force become strengthened.

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Conflict of interest

The authors declare that there is no conflict of interest.

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