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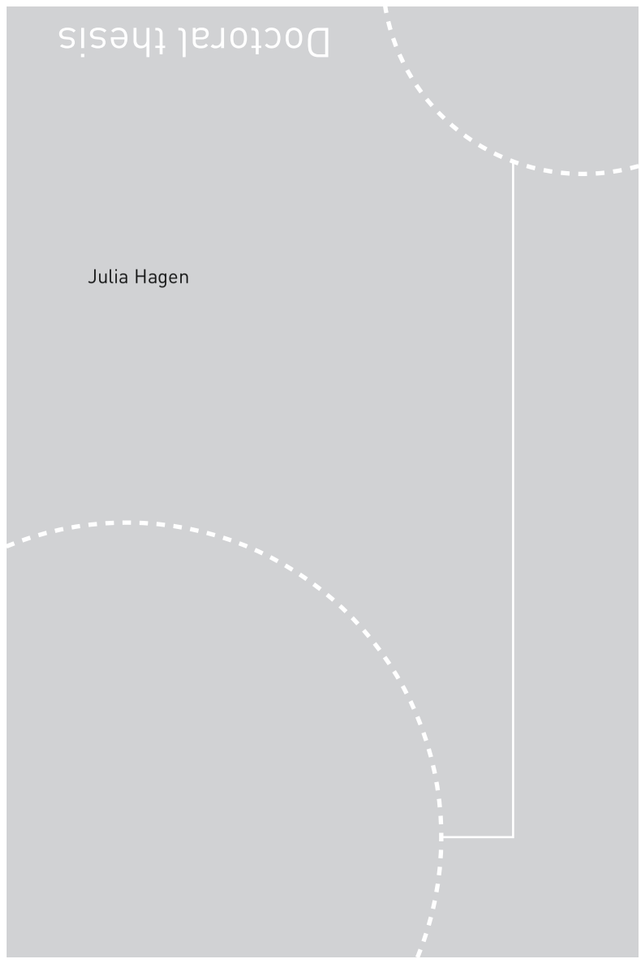
Care and control - Exploring experiences and perceptions of treatment and care of suicidal inpatients in psychiatric wards



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Thesis for the Degree of
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Trondheim, February 2018

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PREFACE

As a mental health nurse, I have cared for many people who have thought about and attempted suicide. Some of them have taken their own lives. These experiences have affected me profoundly, and have influenced my topic of investigation both as a master student and now as a doctoral candidate. In addition to increase my understanding of suicidality as a lived experience, I want to develop knowledge about treatment and care of potentially suicidal patients in psychiatric hospital wards. How do mental health workers experience caring for persons struggling with suicidality? What perspectives influence treatment and care? How do suicidal individuals themselves experience the mental health care provided? What is optimal care? How can we improve our efforts to prevent suicide? This thesis provides new insight into the field which may stimulate reflections and discussions on how suicide prevention in mental health care can be developed and moved forward.

My PhD project has been an academic journey where I have questioned established knowledge, participated in the public debate, and provided alternative thoughts about suicide prevention in mental health care. At times, it has been challenging to find my own voice. In my effort to contribute to a more caring mental health care, I have been particularly inspired by reading other clinicians and researchers arguing for person-oriented care and scholars asserting that an ethic of care should be the foundation of our living.

"Within a patriarchal framework, care is a feminist ethic. Within a democratic framework, care is a human ethic" (Gilligan, 2011, p.22).

ACKNOWLEDGEMENTS

This study and thesis could not have been completed without several significant people taking part in this work.

First of all, I wish to express my sincere gratitude to my supervisors Prof. Birthe Loa Knizek and Prof. Heidi Hjelmeland at the Norwegian University of Science and Technology (NTNU). Dear Birthe and Heidi, thank you for believing in me and giving me the opportunity to conduct this project. Thank you for your support and high standard guidance along the way, especially in times when I lost faith in my abilities to complete this work. Thank you for all I have learned during this time and for your kind companionship on our research travels in different parts of the world. I especially want to thank you for inviting me into your African - Norwegian Research Group on Mental Health (ANOGROM-H), and for introducing me to the other members; Eugene Kinyanda, James Mugisha, Charity Akotia, Joseph Osafo, Johnny Andoh-Arthur and Emmanuel Nii-Boye Quarshie. Thank you for the collaboration during the workshops arranged in South-Africa, Ghana and Uganda. I hope we will continue our research collaboration in the future.

Then, I would like to express my deep gratitude to the people who have participated in the study; people who have been (and still are) struggling with suicidality and mental health workers who provide care for patients and attempt to prevent suicide. Thank you so much for the personal experiences you have shared with me. A special thanks to those who courageously shared some very painful experiences. I also want to thank the management of the psychiatric clinics and the staff who assisted in the recruitment of participants.

Furthermore, I am grateful for the financial support I have received to conduct the study, including the scholarship at Sør-Trøndelag University College, Faculty of Nursing/Faculty of Health and Social Science, merging into NTNU from January 2016. I would like to thank my former colleagues at the master's programme of mental health care at Sør-Trøndelag University College/NTNU, particularly the PhD students Rickard J. Skjong, Johnny Andoh-Arthur, Nina Petersen Reed, and also Kristin Espeland, who just started her scholarship when I finished my position at NTNU. Thank you for showing interest in my work and for providing useful input in the process. I would also like to thank my new colleagues at the Regional Center on Violence, Traumatic Stress and Suicide Prevention (RVTS Midt), St.

Olavs Hospital, for the support you have given me in the final phase. I am especially grateful to Bente Espeland and Rita Småvik who gave me space and time to complete the thesis.

Finally, I want to thank my family and friends for the support and optimism you have had on my behalf, especially my mom Grethe Jenssen, and my second mom Anne-Britt Rønning and my dad Wilfred Hagen for having listened to me during difficult moments. Sadly, my beloved father passed away before I completed this work. I want to thank two of my closest friends, Astrid Dystvold and Lisa Digerud, for the good times we have shared during this period. I would also like to thank my former fellow students in the master's programme of health science; Solveig Fredriksen, Torill Vassli Sallaup and Berit Walla, for your encouragement along the way. I would like to give a special thanks to Lars-Sverre Lorentzen for your love and support, and to Thea and Morgan for welcoming me into your life. I would like to thank Jørgen Assar Mortensen for having discussed and commented on my work and for helping me with the final draft of this thesis, but foremost for being a great dad of our wonderful daughter Gina. Dear Gina, thank you for giving me so much love and joy in life.

Trondheim, October 2017
Julia Hagen

SUMMARY

This PhD thesis consists of four papers where I have explored treatment and care of suicidal patients in psychiatric wards from the perspectives of mental health workers and former suicidal inpatients. I interviewed eight therapists (four psychiatrists, four psychologists), eight mental health nurses and five former suicidal inpatients. The material was analyzed by means of different qualitative approaches; Thematic analysis, Systematic text condensation (STC), Interpretative Phenomenological Analysis (IPA), and by combining STC with a more theoretical approach. Paper 1 contributes to increased insight into ideological and organizational conditions influencing therapists' work, such as the therapists' emphasis on diagnostics and suicide risk assessments, their limited direct care for patients and fragmented mental health services. These aspects may challenge the health workers' efforts to connect with patients who are suicidal. Paper 2 contributes to increased knowledge of mental health nurses' specialized skills in identifying and responding to suicidal behavior among patients. The nurses' care involves a great deal of emotional work and is emotionally demanding, and the study points to the importance of ensuring that they receive sufficient resources and support to enable them to provide good care. Paper 3 contributes to increased insight into some of the differences between the experiences of therapists and mental health nurses, and how their experiences can be understood in light of ethics of care and ethics of justice. The study provides knowledge about theoretical-ethical perspectives and how the care of suicidal patients involves both relational and emotional aspects as well as instrumental and formal elements. Paper 4 contributes to knowledge of how former suicidal inpatients have experienced treatment and care in psychiatric wards. The participants emphasized a trusting connection with the professional, and appreciated being cared for by professionals who respected them and made them feel as valuable persons, who recognized and responded to their suffering and needs, and who supported them in their personal development and recovery process. Although the former inpatients reported more positive than negative experiences of the care provided, they pointed to several aspects that could be improved. Overall, the main findings of this study indicate that treatment and care of suicidal inpatients in psychiatric wards involve various aspects of *care* and *control*, including both a relational, emotional and person-centered care, and a more biomedical and instrumental approach. There are tensions and potential conflicts between the different ways of caring for the suicidal person. Sometimes, a biomedical and instrumental approach seems to have priority over the relational and person-centered approach, which appears related to the biomedical paradigm in

psychiatry and the emphasis on treatment of mental disorders and management of suicide risk. However, such a priority may challenge the professionals' efforts to connect with the patient, thus challenging a person-centered care. Professionals should focus on connecting with the patient, try to understand the complexity in the person's suicidality, and provide the kind of care that people with lived experience with suicidality seek. Dignified care of people experiencing a suicidal crisis should be given priority by health authorities, policy makers, researchers, management of mental health services, clinicians, and educators.

SAMMENDRAG (Norwegian summary)

Denne doktorgradsavhandlingen består av fire artikler hvor jeg har utforsket behandling og omsorg for selvmordstruede pasienter i psykiatriske døgnavdelinger fra helsepersonells og tidligere pasienters perspektiv. Jeg intervjuet åtte behandlere (fire psykiatere, fire psykologer), åtte psykiatriske sykepleiere, og fem tidligere innlagte selvmordstruede pasienter. Materialet ble analysert ved hjelp av ulike kvalitative metoder; Tematisk analyse, Systematisk tekstkondensering, Interpretative Phenomenological Analysis (IPA), og ved å kombinere Systematisk tekstkondensering med en mer teoretisk tilnærming. Artikkel 1 bidrar med økt innsikt om ideologiske og organisatoriske forhold som påvirker psykiateres og psykologers arbeid, slik som deres fokus på diagnostikk og selvmordsrisikovurderinger, deres begrensede direkte omsorg for pasientene, samt en fragmentert psykisk helsetjeneste. Disse aspektene kan utfordre deres innsats for å oppnå god kontakt/relasjon med pasienter som er suicidale. Artikkel 2 bidrar med økt kunnskap om psykiatriske sykepleieres spesialiserte ferdigheter i å identifisere og respondere på selvmordsatferd blant pasienter. Sykepleiernes omsorg innebærer en god del emosjonelt arbeid og er emosjonelt belastende, og studien peker på viktigheten av å sikre dem tilstrekkelig ressurser og støtte slik at de kan yte god omsorg. Artikkel 3 bidrar med økt innsikt i noen av forskjellene mellom behandlernes og sykepleiernes erfaringer, og hvordan deres erfaringer kan bli forstått i lys av omsorgsetikk og rettferdighetsetikk. Studien gir kunnskap om teoretiske-etiske perspektiver og hvordan omsorgen for selvmordstruede pasienter innebærer både relasjonelle og emosjonelle aspekter, samt instrumentelle og formelle elementer. Artikkel 4 bidrar med kunnskap om hvordan tidligere selvmordstruede pasienter har opplevd behandling og omsorg i psykiatriske døgnavdelinger. Deltakerne la vekt på en tillitsfull tilknytning/relasjon med helsearbeideren, og verdsatte å bli ivaretatt av profesjonelle som respekterte dem og fikk dem til å føle seg som verdifulle mennesker, og som oppfattet og responderte på deres vanskeligheter og behov, og som støttet dem i deres personlige utvikling og bedringsprosess. Selv om de tidligere pasientene rapporterte flere positive enn negative erfaringer knyttet til omsorgen de mottok, pekte de på flere aspekter som kunne forbedres. Samlet sett så indikerer hovedfunnene i denne studien på at behandling og omsorg for selvmordstruede pasienter i psykiatriske døgnavdelinger innebærer ulike aspekter av *omsorg og kontroll*, inkludert både en relasjonell, følelsesmessig og personsentrert omsorg, og en mer biomedisinsk og instrumentell tilnærming. Det er spenninger og potensielle konflikter mellom de ulike måtene å yte omsorg på. Noen ganger synes det som om den biomedisinske og instrumentelle tilnærmingen har

forrang fremfor den relasjonelle og personsentrerte tilnærmingen, og det kan være knyttet til det biomedisinske paradigmet i psykiatrien og fokuset på behandling av psykiske lidelser og håndtering av selvmordsrisiko. En slik prioritering kan imidlertid utfordre helsearbeidernes innsats for å oppnå en god kontakt/relasjon med pasienten og dermed utfordres en personsentrert omsorg. Fagfolk bør fokusere på å oppnå en god kontakt/relasjon med pasienten, forsøke å forstå kompleksiteten i personens suicidalitet, og yte den form for omsorg som folk med levde erfaringer med suicidalitet søker. En verdig omsorg for personer som opplever en selvmordskrise bør prioriteres av helsemyndigheter, forskere, ledelse ved psykiske helsetjenester, klinikere og utdanningspersonell.

LIST OF PAPERS

Paper 1:

Hagen J., Hjelmeland H., & Knizek B.L. (2017). Connecting with suicidal patients in psychiatric wards: Therapist challenges. *Death Studies,* 41(6): 360-367.

Paper 2:

Hagen J., Knizek B.L., & Hjelmeland H. (2016). Mental health nurses' experiences of caring for suicidal patients in psychiatric wards: An emotional endeavor. *Archives of Psychiatric Nursing,* 31(1): 31-37.

Paper 3:

Hagen J., Hjelmeland H., & Knizek B.L. (2017). Relational principles in the care of suicidal inpatients: Experiences of therapists and mental health nurses. *Issues in Mental Health Nursing,* 38(2): 99-106.

Paper 4:

Hagen J., Knizek B.L., & Hjelmeland H. (2017). The need for connection and dignified care: Former suicidal inpatients' experiences of care in psychiatric wards in Norway (submitted).

CONTENTS

New Horizons, New Sunrises

With permission from Elisabeth Bjørnsen Werp

1. INTRODUCTION

A suicide note written by a 40 year old woman who took her own life many years ago reads:

> "My dearest ones – You two have been the most wonderful things in my life – Try to forgive me for what I've done – Your father would be so much better for you. It will be harder for you for a while – but so much easier in the long run – I'm getting you all mixed up – Respect and love are almost the same – Remember that – and the most important thing is to respect yourself – The only way you can do that is by doing your share and learning to stand on your own two feet – Betty, try to remember the happy times – and be good to Nancy. Promise me you will look after your sister's welfare – I love you very much – but I can't face what the future will bring" (Shneidman, 1980, p.60).

The woman wrote several suicide notes and this one was to her two daughters (Shneidman, 1980). Behind every suicide there is a personal story, and a suicide note or other personal documents provides a glimpse into some of the pain and difficulties experienced by the individual at the time.

There are many individuals who suffer, annually, over 800 000 people take their own lives (WHO, 2017). In spite of increased efforts to prevent suicide the suicide rate does not seem to decrease (WHO, 2017). In Norway, about 550 people take their own lives every year (Norwegian Institute of Public Health, 2017), but it is suggested that the number may be up to 25% higher (Gjertsen & Johansson, 2011). The number of suicide attempts is estimated to about 10 times higher than the number of suicides (Norwegian Institute of Public Health, 2017), but we lack statistics on suicide attempts. A study conducted in the United States reported that the number of suicide attempts was about 32 times higher than the number of suicides in 2012 (Han et al., 2016). Thus, it is not unlikely that the number of suicide attempts is underestimated in Norway. Many people are affected when a person takes her/his own life, and it is suggested that in Western countries every suicide has 10-15 bereaved persons who struggle with the consequences of their loss (Dyregrov, 2011).

Suicidal acts and suicide among psychiatric patients is a challenge in the mental health services. A Norwegian study found that about 52% of the (first-time) admissions to

psychiatric hospital were related to suicidality (Øiesvold, Bakkejord, Hansen, Nivison & Sørgaard, 2012). Further, there is found an increased suicide risk during hospitalization (Hunt et al., 2013; Qin & Nordentoft, 2005) and in the first period after discharge (Bickley et al., 2013; Qin & Nordentoft, 2005). In 2015, nearly 27% of the suicides in Norway occurred among inpatients and outpatients, and some of the suicides occurred among people who had recently been discharged (Saastad, 2015). Providing optimal care for patients experiencing a suicidal crisis and preventing suicidal behavior is challenging for mental health professionals.

The present PhD study aims to shed light on aspects and challenges related to the psychiatric inpatient treatment and care of suicidal patients from the perspectives of both professionals and former inpatients. The knowledge gained in this study can help to develop mental health professionals' care of suicidal patients and thereby improve their efforts to prevent suicidal acts and suicide. In the first part of the thesis, some historical aspects of the suicide preventive work in Norway are described, including the increasing focus on suicide prevention in the mental health services. Then, I present some definitions of suicide and related concepts and discuss the use of certain terms (e.g. suicidal vs. non-suicidal behavior). Further, relevant theoretical perspectives related to clinical care of suicidal patients in psychiatric wards, and previous qualitative research about the experiences of mental health workers and (former) inpatients are described. This background leads to my own research aims and the four studies investigating experiences related to treatment and care of suicidal inpatients presented in the subsequent sections. The main findings are then discussed as a whole, including discussions on how the findings relate to each other and how they relate to the literature. Finally, some recommendations for clinical practice and future research are outlined.

1.1 Suicide prevention in Norway

In Norway, suicide prevention was especially put on the agenda from the 1990's when two national action plans were published; the Action plan against suicide 1994-1998 (extended to 1999) (Norwegian Board of Health Supervision, 1995, 2000a), and the follow-up project - Interventions against suicide 2000-2002 (Norwegian Board of Health Supervision, 2000b). The National Centre for Suicide Research and Prevention (NSSF) was established in 1996 to develop the knowledge in the field and to strengthen and coordinate the suicide prevention in Norway. In addition, four regional resource centers for suicide prevention were established during 1996 and 1997. Today, there are five Regional Centers on Violence, Traumatic Stress

and Suicide Prevention (RVTS). The centers have an important role in contributing to increased knowledge and competence among professionals in the specialist and community services.

In 2014, the *Action plan for the prevention of suicide and self-harm 2014-2017* was published (Norwegian Directorate of Health, 2014). The action plan has five main objectives: 1) good mental health and coping in the population, 2) reduced rates of suicide and self-harm in risk groups, 3) good follow-up and care of the bereaved, relatives and other concerned/affected, 4) knowledge-based services, and 5) knowledge-based strategies and interventions (Norwegian Directorate of Health, 2014). There are several examples of good interventions aimed at promoting mental health and preventing suicide in the population, and it remains to be seen if and how interventions are implemented locally in the different municipalities. Recently, the *Guiding material for the municipalities for the prevention of self-harm and suicide* was published (Norwegian Directorate of Health, 2017b). The material provides information about self-harm and suicidality and a step-by-step guide on how to help people who injure themselves and are suicidal (Norwegian Directorate of Health, 2017b).

1.1.1 Suicide prevention in mental health care

The *National guidelines for the prevention of suicide in mental health care* were published in 2008 and primarily concern suicide prevention in the specialized mental health services (Norwegian Directorate of Health and Social Affairs, 2008). These guidelines are particularly relevant for this study as they influence mental health professionals' efforts to prevent suicide in psychiatric wards, including how they approach and care for potentially suicidal patients. The guidelines consist of nine chapters: 1) S*creening and assessment of suicide risk* (e.g., asking all patients about suicidal thoughts/plans and previous suicide attempts, assessing the patients' mental state in relation to risk factors and suicidal thoughts/plans), 2) *Treatment*, 3) *Prevention of suicide in psychiatric inpatient units* (including continuous observation and observation at certain time intervals), 4) *Prevention of suicide after discharge* (e.g., ensuring follow-up), 5) *Chronic suicidality*, 6) *Care of relatives and the bereaved*, 7) *Reporting and follow-up after suicide and suicide attempt*, 8) *Legal basis for the health care*, and 9) *Knowledge summary*. In addition, there are suggestions for eight procedures: assessment of suicide risk, training in screening for suicide risk, training in assessment of suicide risk, observations of patients in relation to suicide risk, reporting suicide or serious suicide attempts, follow-up of bereaved after suicide, follow-up of patients who do not show for an

appointment, and physical security measures in psychiatric wards. The guidelines have contributed to increased awareness and knowledge about suicidality and of the importance of following up suicidal patients in the services. However, the document has a high emphasis on the formal responsibilities of psychiatrists and psychologists and clinical procedures related to assessment and management of suicide risk. This emphasis has contributed to create new frameworks for suicide management in Norway in which we need to study to understand the consequences of.

In 2013, a national patient safety program - *In safe hands 24-7* (Norwegian Directorate of Health, 2017a) was implemented in several acute psychiatric wards to prevent suicide. The program involved five interventions: Assessment of a specialist within one day, safety interventions (e.g., observation, safe environment), suicide risk assessment (upon admission, before leave, and before discharge), planning of leave, and discharge interventions (e.g., crisis/safety plan, follow-up agreement) (Norwegian Directorate of Health, 2017a). The interventions are in keeping with the national guidelines.

1.2 Definition and understanding of suicide and related concepts

There is no consensus on how suicide, suicide attempt, or suicidal behavior/suicidality is defined (Silverman, 2016). In Norway, one common definition of **suicide** reads as follows: *"suicide is a conscious and deliberate act that the individual is doing to him/herself and where the injury has led to death"* (Retterstøl, Ekeberg, & Mehlum, 2002, p.12). The authors point to this definition's weakness of not including confusional states or certain psychosis (Retterstøl et al., 2002). Apparently, such mental states involve some uncertainty with regard to the conscious desire or the intention to die. The definition has its emphasis on the self-destructive act. The World Health Organization has the following definition*: "Suicide is the act of deliberately killing oneself"* (WHO, 2014, p.17). Although this definition points to suicide being a result of a deliberate act, it does not say anything about the intentions behind the act, or if the suicide was a result of a conscious desire to die. The definition has its emphasis on the outcome of the self-destructive act. I prefer the definition proposed by Shneidman (1985) over 30 years ago: *"Currently in the Western world, suicide is a conscious act of self-induced annihilation, best understood as a multidimensional malaise in a needful individual who defines an issue for which the suicide is perceived as the best solution"* (p.203). Although this definition is more complex than the two former definitions, its strength

is just that; it points to the complexity of each suicide, and that suicide occurs within a cultural context and must be understood in light of the individual's needs. In addition, suicide is described as the individual's perceived best solution at the time, which reflects a non-judgmental attitude towards the person and his/her self-destructive act.

Suicide attempt is defined as "*a conscious and deliberate act which the individual has done to hurt oneself, and that the individual could not be sure to survive, but where the injury has not led to death. One, albeit vague, intention to die has been present"* (Retterstøl et al., 2002, p. 13). The definition captures the ambivalence that is often present in the suicidal individual. WHO (2014) has a bit broader definition: "*suicide attempt is used to mean any non-fatal suicidal behavior and refers to intentional self-inflicted poisoning, injury or self-harm which may or may not have a fatal intent or outcome*" (p. 17). Thus, WHO has included non-fatal self-harm without suicidal intent in the definition, noting that suicide intent is complex and that it can be difficult to distinguish between self-harm with or without suicidal intent (WHO, 2014). **Suicidal behavior** involves both thoughts and plans about suicide and suicide attempt/suicidal acts and suicide (Beskow, Beskow & Ehnvall, 2005). **Suicidality** is defined in the same way as suicidal behavior, as it involves suicidal thoughts, suicidal acts and suicide (Beskow et al., 2005). Silverman (2016) argued that the term suicidality should be removed from the nomenclature because it is imprecise and thus not deemed clinically useful. However, Beskow and colleagues (2005) proposed that the term suicidal behavior should be replaced by the term suicidality, which they considered to be a more flexible concept. I agree with the latter and I have during this project increasingly used the concept suicidality rather than suicidal behavior. It seems more suitable as suicidal behavior indicates that suicidality involves an action, whereas it is well known that most often, thinking of suicide is the most common aspect of suicidality. Also, as noted by Beskow et al. (2005), the term suicidality connotes the suffering experienced by the person, the term is thus closer to the subjective experience; *"it is easier to talk about one's suicidality than about one's suicidal behavior"* (p.52). The term suicidality is understood as a unique, individual and changeable (not static) mental state and process.

The **suicidal process** can be understood as the process from the first thought about suicide to the final suicidal act and suicide, a process that can develop during a shorter or longer period of time (Retterstøl et al., 2002). The individual is perceived to be in a **suicidal crisis** when he/she has thoughts and plans of suicide and is near attempting suicide, it may be understood

as "*a deadly serious (temporary and treatable) psychache*" (Shneidman, 1993, p.55). Others (e.g., mental health professionals) may see warning signs of suicide and perceive the suicide risk to be high (Sun, Long, Boore, & Tsao, 2005, 2006b).

In the literature, **suicidal self-injury** (SSI) is usually distinguished from **non-suicidal self-injury (**NSSI) (Cutcliffe & Santos, 2012; Silverman, 2016). However, Kapur, Cooper, O'Connor and Hawton (2013) argued there is a strong association between non-suicidal and suicidal self-harm, and there is found an increased risk of suicide among persons engaging in self-harm (Cooper et al., 2005; Hawton et al., 2012). It is found that some people engage in both non-suicidal self-harm and attempted suicide, which suggests that there is an overlap between these two behaviors (Tørmoen, Rossow, Larsson & Mehlum, 2013). In addition, mental health nurses have reported that although they differentiated between self-harm and attempted suicide as a behavior, this was not reflected in their practice (O'Donovan & Gijbels, 2006). As the intent to die may not be clear (e.g. ambivalence) or concealed, and underlying motivations may be unclear, multiple and changing, it may be difficult to distinguish between non-suicidal self-harm and 'real' suicide attempts (Kapur et al., 2013; WHO, 2014). Consequently, although it is relevant to distinguish suicidal from non-suicidal self-injury, it may not be useful to rely on such 'either-or' categorizations in clinical practice. Suicide intention is a complex and multidimensional concept, and reducing it to a dichotomic (yes/no) category may be pragmatic, yet a dangerous generalization with potentially misleading and negative implications for clinical practice (Silverman, 2016, p. 20).

It is also common to describe suicidality as either acute or "chronic". **Chronic suicidality** is a term used in the *National guidelines for the prevention of suicide in mental health care* (Norwegian Directorate of Health and Social Affairs, 2008), and it is frequently used in other literature and in clinical practice. However, chronic suicidal/chronic suicidality is a stigmatizing and disempowering term that suggests little hope for change or improvement in the situation. Rather, it should be described as persistent or recurrent suicidality. Furthermore, distinguishing between acute and chronic suicidality may be problematic, because one may believe that someone with persistent suicidality is "less" suicidal, although they may experience periods with more acute suicidality as well. Thus, if someone is labelled "chronic" suicidal, one may ignore or underestimate the person's risk of suicide (Frahm Jensen & Weber, 2015).

In this study and in the four papers, the term "**suicidal patient/person/individual**" is used with an awareness of the diversity and complexity of each person's suicidality and related problems. Thus, with "suicidal patient" I do not suggest that the person is suicidal all the time, nor that suicidality is a fixed state with the same characteristics for every person who experiences it.

2. THEORETICAL PERSPECTIVES

This section provides a description of theoretical perspectives relevant for the study of treatment and care of suicidal inpatients in mental health services. This topic is extensive, and during the project I have immersed myself in literature across various professional fields; medicine, nursing, sociology, psychology, ethics, and philosophy. A selection is made based on the focus and main findings in this study. First, different ways of understanding and approaching suicidality are outlined, followed by a description of the importance of a trusting connection between the professional and the patient. Then, the theory of emotional labor is presented, which was significant for the understanding of the mental health nurses' experiences in paper 2. Last, ethics of care and ethics of justice are described, perspectives that were used in the interpretation of the therapists' and mental health nurses' experiences in paper 3.

2.1 Different ways of understanding and approaching suicidality

There are different ways of understanding suicide and suicidality that are relevant for treatment and care of suicidal patients in psychiatric wards in Norway. Suicidality is complex, and the reasons behind suicide may relate to (more or less conscious) psychological, existential, interpersonal, sociocultural, biological and other aspects that have influenced each other (Leenaars, 2004). Based on the present study, the understanding of suicidality and approach to suicidal patients in psychiatric wards appears to be strongly influenced by biomedical and psychological perspectives, particularly the former.

2.1.1 Biomedical perspectives

The biomedical model reflects an emphasis on detection and treatment of mental disorders, where professionals aim to reduce suicidality and prevent suicide by diagnosing and treating (typically with psychotropic medication) a presumed underlying disorder. Thus, suicidality is medicalized (Owens & Lambert, 2012; Pridmore, 2011) and pathologized (Marsh, 2010, 2016). Based on psychological autopsy studies, it is a common assumption that about 90% of suicides are related to mental disorders (Cavanagh, Carson, Sharpe, & Lawrie, 2003). However, several researchers have argued against such a strong association (Hjelmeland, Dieserud, Dyregrov, Knizek, and Leenaars, 2012), or against the automatic association between suicide and mental disorders (Cutcliffe & Stevenson, 2008a). Yet, mental disorders such as depression and schizophrenia, among others, are significant risk factors of suicide

(Lönnqvist, 2000; Palmer, Pankratz & Bostwick, 2005; Qin, 2011). To focus on risk factors of suicide is common in the biomedical perspective, and other risk factors than mental disorders are described in the *National guidelines for the prevention of suicide in mental health care*, for instance substance abuse, previous suicide attempt, loss of relationship, suicide in the family and lack of social network (Norwegian Directorate of Health and Social Affairs, 2008). Knowledge of risk factors for suicide and providing treatment and care of any mental health problem is important. However, most people continue living with their mental health problems and other difficulties and do not take their own lives (Hjelmeland & Knizek, 2017). Suicidality, thus, involves something *more* and something *else* than mental disorders and other risk factors (Hjelmeland & Knizek, 2013, 2016; Shneidman, 1993).

2.1.2 Psychological perspectives

There are several psychological theories of suicide and I have chosen to focus on the perspectives of Shneidman, who was a nestor in the field of suicide, followed by a brief description of the perspectives of Orbach and Baumeister. Shneidman (1985, 1993, 1996, 1999) argued that suicidality was related to unbearable psychological pain, "psychache":

> «Psychological pain is not the same as somatic or physical pain. It's how you feel as a person; how you feel in your mind or heart. It refers to how much you hurt as a human being. It is mental suffering; inner torment. It is called psychache. Psychache refers to hurt or misery. It is the pain of shame, or guilt, or grief, or humiliation, or hopelessness, or loneliness, or sadness, or anguish. It is how you feel inside. It is an ache in the mind» (Shneidman, 1999, p. 291).

This description appears closer to the suicidal person's subjective suffering than the biomedical perspective and the diagnostic descriptions of various symptoms. Although depression may involve such pain, Shneidman (1993) noted that suicide is not a psychiatric disorder and a suicidal crisis is best treated on its own terms. Even though Shneidman (1985) stressed that every suicide is unique, he outlined ten commonalities of suicide: unendurable psychological pain, frustrated psychological needs, seeking a solution, cessation of conscious, hopelessness and helplessness, ambivalence, cognitive constriction, communication of intention, egression/escape, and consistencies with lifelong coping patterns. Furthermore, Shneidman (1993) asserted that the risk of suicide was high when the individual experienced maximum psychological pain, maximum negative press and maximum perturbation

(agitation). Consequently, the professional attempting to help the suicidal person should try to relieve the person's experiences of pain and pressure and decrease the person's perturbation (Shneidman, 1993). Listening to the pain, inspiring hope, indicating alternatives, widening the perspectives, involving others, and supporting previous constructive coping strategies are important (Shneidman, 1985, 1993). Following Shneidman, Orbach (2001) agreed that suicide is an end result of unbearable mental pain, and he pointed out that suicide is an outcome of several internal and external self-destructive factors and processes, among other, biochemical factors, personality aspects, pain-producing patterns and stressful life events. A therapeutic approach to the suicidal individual involves empathizing with the suicidal wish, and exploring and working through the pain-producing patterns (Orbach, 2001). Baumeister (1990) described suicide as 'escape from self', meaning that the individual wants to escape from an aversive self-awareness produced by setbacks or disappointments where the individual blames him/herself for not living up to own expectations. Therapeutic interventions involve preventing the person from blaming shortfalls on the self and supporting more constructive ways of dealing with negative thoughts and emotions (Baumeister, 1990). These psychological perspectives of the suicidal person's mental suffering are significant and need to be understood in relation to the context the person is part of, including relational and social issues.

Although biomedical and psychological perspectives represent different views on suicidality, there are clinicians and researchers who try to reconcile these two ideologies. Within the field of suicide, the "Aeschi working group" (Aeschi is the name of a town in Switzerland where they first assembled in 2000) has collaborated to change what they perceived as too unempathic and unhelpful approaches to suicidal patients in the health services (Michel et al., 2016). Their view is that clinicians must focus on the patient's perspectives, establish a trusting relationship with the person and achieve a shared understanding of the patient's suicidality, which stands in contrast to the traditional medical model where the clinician is considered the expert whose main task is to identify and treat mental disorders (Michel et al., 2016). Their work has involved several meetings and publications where they have argued for a more person-centered, collaborative and a narrative approach to suicidal patients (Jobes, 2006; Michel et al., 2002, Michel & Valalch, 2011; Michel, Valach & Gysin-Maillart, 2017). Two of the working group members edited a book entitled "Building a therapeutic alliance with the suicidal patient" (Michel & Jobes, 2011), which is a valuable asset to the clinical field.

2.2 The importance of a trusting professional-patient connection

It is well known that a good or "therapeutic" relationship/alliance between the professional and the patient is important for treatment and care to be effective or experienced as meaningful (Norcross, 2010; Safran & Muran, 2000). Many years ago, Bordin (1979) asserted that the working alliance was the prerequisite for change: *"…the working alliance between the person who seeks change and the one who offers to be a change agent is one of the keys, if not the key, to the change process"* (p. 252). Such an alliance includes three features; agreement on goals, tasks and a relational bond (Bordin, 1979). Negotiations and agreements on goals and tasks might pose some challenges. Balint (1957/1963) described the physicians' "apostolic function", which implies that therapists attempt to "convert" patients to believe in and accept their viewpoints. In this respect, the relationship is used as a means to achieve collaboration and treatment compliance, for instance with regard to diagnosis and pharmaceutical treatment.

Rogers represented a more person-centered approach. He wrote about "client-centered therapy", later transforming it into "person-centered approach", understood as a view, a philosophy, a way of being and an approach in which growth of a person, a group or a community is part of the goal (Rogers, 1980, p. xvii). Rogers (1961, 1980) emphasized genuineness, acceptance, care and empathic understanding. In therapy, he recognized the importance of a subject-subject relationship; *"I enter the relationship not as a scientist, not as a physician who can accurately diagnose and cure, but as a person, entering into a personal relationship. Insofar as I see him only as an object, the client will tend to become only an object"* (Rogers, 1961, p. 201). Thus, in order to promote growth and helping a person to get behind the mask and "become himself" (Rogers, 1961) it is important that the therapist/care provider engages himself in the relationship and uses his personal qualities as a fellow human being. A professional distance and a focus on diagnostics and cure may be an obstacle to a therapeutic relationship (Rogers, 1961).

Rogers' philosophy is found among clinicians and researchers who emphasize the patient's perspectives and the importance of establishing a trusting connection with the person (Cutcliffe & Barker, 2002; Cutcliffe & Stevenson, 2007; Jobes, 2006; Leenaars, 2004; Michel & Valach, 2011; Rogers & Soyka, 2004). Caring for suicidal patients is an interpersonal endeavor where the professional has to engage in a close relationship with the person and

inspire hope (Cutcliffe and Stevenson, 2007; Cutcliffe & Barker, 2002). Through such a relationship the suicidal patient can feel recognized as a valuable human being (Samuelsson, Wiklander, Åsberg, & Saveman, 2000; Talseth, Jacobsson & Norberg, 2001; Talseth, Lindseth, Jacobsson, & Norberg, 1999; Vatne & Nåden, 2014), and be helped in the process of reconnecting to others and life (Cutcliffe & Stevenson, 2007; Cutcliffe, Stevenson, Jackson, & Smith, 2006). Thus, a trusting relationship where the patient feels understood and appreciated has the potential to be lifesaving (Jobes & Ballard, 2011). However, the relationship is prone to particular challenges when the patient's life is at stake, and issues of control, vulnerability and fear can make it difficult to establish and maintain a good relationship (Jobes & Ballard, 2011). Furthermore, a psychiatric hospitalization involves challenges related to the inpatient setting, such as the time limited nature of the professional-patient relationship and environmental stressors (Lineberry, 2011). The patient may experience increased anxiety and distress, the motivation to receive help may vary, and it can be difficult to establish trust in the relationship, particularly if the hospitalization is involuntary (Lineberry, 2011).

During the process of analyzing interview data from the psychiatrists and psychologists and writing up the findings, I chose to use the term *connection* rather than *therapeutic alliance* or *relationship*. "Alliance" denotes a productivity of a therapy work rather than the experience of the interaction between professional and patient (Weisshaar, 2007). "Therapeutic relationship" signals that professionals engage with the patients over time, which is not necessarily the case in this setting where patients may be hospitalized for a short time. "Connection", on the other hand, captures the quality of the professional-patient interaction, and is by Weisshaar (2007) understood as "*a healthy, caring and meaningful bond between therapist and client*" (p.84). To connect with a patient is understood as a way of achieving a good, meaningful or emotional contact with the individual, which is in accordance to several of the participants' statements in the present study. Furthermore, connection is described as "*the core of human growth and development*" and implies that professionals emphasize relational aspects and acknowledge the importance of connecting with patients (Jordan & Walker, 2004, p.2).

2.3 Care as emotional labor

The concept "emotional labor" was developed by Hochschild (1983/2003) who defined it as a labor that "*requires one to induce or suppress feelings in order to sustain the outward countenance that produces the proper state of mind in others - in this case, the sense of being cared for in a convivial and safe place*"(p.7). Although Hochschild (1983/2003) initially studied the commercialization of flight attendants' emotions, the author noted that emotional labor involves other jobs where professionals have face-to-face or voice contact with people. She asserted that professionals try to affect the emotional state in another person in a desirable way and to act in an appropriate and socially accepted manner (Hochschild, 1983/2003). The author suggested that the emotional work is influenced by "feeling rules" and "display rules", that is, expectations of what we should feel and corresponding outer display. Feeling rules and display rules are attached to social roles (Hochschild, 1983/2003), which indicates that there are certain expectations and norms of how mental health workers should feel and act towards patients. For instance, professionals are expected to feel empathy and show concern for the patients to make the patients feel cared for. Further, by drawing on the work of other theorists, among other Goffman, Hochschild (1983/2003) described two techniques that are part of professional's emotional labor; "*deep acting*", i.e., attempting to experience the feeling that one wishes or is expected to display, and "*surface acting*", i.e., working on appearance but concealing/suppressing feelings. The mental health worker's emotional labor is important to provide good care. However, emotional work may be demanding, and it is particularly surface acting (emotive dissonance) that seems to be most emotionally straining (Hochschild 1983/2003). The emotional labor theory has been applied by several authors in different contexts, including nursing (e.g., Smith, 1992/2012) and mental health nursing (e.g., Mann & Cowburn, 2005), but not (to my knowledge) with regard to the care of suicidal patients in psychiatric wards. The theory contributes to increase the understanding of mental health nurses' emotional demands and responses in the care of patients experiencing suicidality. Furthermore, it makes the emotional aspects in professional caring work more visible.

2.4 Ethical perspectives: Ethics of care and ethics of justice

In psychiatry or mental health care there is no one optimal ethical-theoretical framework (Bloch & Green, 2006). The four principles of biomedical ethics developed by Beauchamp and Childress in 1979 – respect for autonomy, nonmaleficence, beneficence, and justice – have guided other medical fields (Beauchamp, 1994), but its incompleteness has been pointed

out by several authors (Fulford & Hope, 1994; Radden, 2002). Fulford and Hope (1994) proposed that psychiatric ethics should be based on both these principles and a situational ethics relying on an understanding of the patient's lived experience. The latter is similar to the focus on the particularity of each person and situation in ethics of care (Gilligan, 1982/1993; Held, 2006). Several authors have suggested complementary models, for instance, integrating biomedical ethics with ethics of care (Bloch, 2007; Bloch & Green, 2006; Hewitt & Edwards, 2006), or integrating ethics of care and ethics of justice (Botes, 2000; Pettersen, 2008; Tronto, 1993/2009). In the present study, I found it most relevant to focus on how the experiences and perceptions of the participating mental health workers could be understood in light of ethics of care and ethics of justice, two ethical perspectives that deal with personal qualities and relational aspects as well as principles and rules (Gilligan 1982/1993). Ethics of care is characterized by caring and is relational, need-centered, holistic and contextual, whereas ethics of justice is characterized by fairness and equality, and rational-objective judgments based on universal principles and rules (Botes, 2000). A significant difference between these two ethical perspectives is that ethics of care has a relational ontology where people are regarded interdependent, whereas ethics of justice is more individualistic and oriented towards rights (Held, 2006; Nortvedt, Hem & Skirbekk, 2011). Whereas ethics of justice seeks equality and freedom, ethics of care has its emphasis on caring relations, trust, and attentiveness – thus fostering social bonds and collaboration (Held, 2006). Further, ethics of care is more than an ethical value; it is a practice (Held, 2006; Tronto, 1993/2009).

Held (2006) suggested that care is probably the most fundamental value; "*there can be care without justice: There has historically been little justice in the family, but care and life have gone on without it. There can be no justice without care, however, for without care no child would survive and there would be no persons to respect*" (p.17). Thus, ethics of care may be regarded as the overarching ethical framework within which ethics of justice can be integrated (Held, 2006). Furthermore, a focus on care and ethics of care on a personal as well as on a political and societal level would have profound implications on how society is structured and how people engage and care for each other (Held, 2006). People would be more thoughtful and attentive to the needs of others and thereby better democratic citizens (Tronto, 1993/2009). Regarding ethics of care as the fundamental ethical perspective would also have implications for how health services are organized and how people with mental health problems are cared for. This would not mean that other ethical perspectives, such as justice, are disregarded. Moral maturity and mature care involve balancing the interests of self and

others (avoiding the extremes of self-sacrifice and selfishness), thus, integrating ethics of care with ethics of justice (Gilligan, 1982/1993; Pettersen, 2008). Tronto (1993/2009) argued that theories of justice were necessary to avoid nondemocratic forms of care, such as paternalism/maternalism and parochialism. In clinical practice, integrating ethics of care and ethics of justice in terms of meeting the particular patient's needs and at the same time ensuring fair care for all patients may be challenging (Hall, Brinchmann, & Aagaard, 2012). Consequently, choice of appropriate caring response and to whom depends on the mature care-provider's reading of the particular circumstances in that context (Pettersen, 2008). Such sensitivity relates to the professional's emotional work (Hochschild, 1983/2003), the care-provider's emotional competence (Akerjordet & Severinsson, 2004), and the ability to intuitively read a patient/situation and respond appropriately (Benner, Tanner, & Chesla, 2009).

Theoretical-ethical perspectives, such as ethics of care and ethics of justice, contribute to increased understanding of mental health care, and help to clarify various dilemmas professionals may face in their care for persons experiencing suicidality.

3. PREVIOUS RESEARCH

In this section, findings from previous qualitative studies exploring experiences related to treatment and care of patients in psychiatric wards are described. The most relevant studies are selected. For this reason, studies only focusing on specific interventions, such as suicide risk assessments or close observation, or studies that explore experiences related to treatment and care in out-patient clinics or community mental health services are not included.

3.1 Findings from previous research exploring professionals' and suicidal patients' experiences of treatment and care in psychiatric wards

This description is based on the findings from 24 qualitative studies exploring experiences of psychiatric inpatient treatment and care of suicidal patients from the perspectives of *physicians/psychiatrists* (Høifødt & Talseth, 2006; Talseth et al., 2000), *staff from a range of professions* (Awenat et al., 2017), *nurses/mental health nurses* (Carlén & Bengtsson, 2007; Gilje & Talseth, 2014; Gilje & Talseth, 2007; Gilje, Talseth & Norberg, 2005; Larsson, Nilsson, Runeson & Gustafsson, 2007; Lees, Procter & Fassett, 2014; McLaughlin, 1999; Talseth & Gilje, 2011; Talseth et al., 1997; Tzeng, Yang, Tzeng, Ma & Chen, 2010; Sun et al., 2005, 2006a), and *(former) suicidal inpatients* (Berg, Rørtveit, and Aase, 2017; Cutcliffe et al., 2006; Lees et al., 2014; McLaughlin, 1999; Samuelsson et al., 2000; Sun et al., 2005, 2006a, 2006b; Talseth, Gilje & Norberg, 2003; Talseth et al., 2001; Talseth et al., 1999; Vatne & Nåden, 2014, 2016). Four of the studies explore the experiences of both nurses and patients (Lees et al., 2014; McLaughlin, 1999; Sun et al., 2005, 2006a). All studies are primary research except six studies which are based on qualitative meta-analysis (Gilje & Talseth, 2014), critical interpretative synthesis (Talseth & Gilje, 2011), systematic review (Berg et al., 2017), secondary analysis of qualitative interview data (Gilje et al., 2005; Talseth et al., 2003), and re-interpretation of published text (Gilje & Talseth, 2007).

All of the reviewed studies illustrate that caring for patients in a suicidal crisis is challenging, and although most studies focus on how to provide good care of suicidal patients in psychiatric inpatient settings, there are experiences and descriptions of insufficient care as well. Based on the studies' findings, the focus is on two main themes; experiences or perceptions related to good care, and experiences and perceptions related to insufficient care.

3.1.1 Experiences or perceptions related to good care

From the perspectives of mental health workers, good care of suicidal patients involves engaging with the patients, establishing good relationships with them, recognizing their suffering and needs, and acknowledging them as valuable persons (Carlén & Bengtsson, 2007; Lees et al., 2014; Sun et al., 2005; Talseth et al., 1997; Talseth et al., 2000; Tzeng et al., 2010). In Talseth and colleagues' (1997) study, good care is related to an attitude of *closeness* to patients, which means that the nurses are emotionally involved and present for the patients, meet them as unique persons, and respond to their needs. The findings are in keeping with more recent research, where good care is related to being emotionally prepared to open up and understand patients' pain and suicidality, and being sensitive to their needs (Tzeng et al., 2010). The nurses' ability to open up and understand patients' suicidality and provide good care is determined by their "inner door" - understood as a "*boundary between self and others and the inner regulator of defence and communication*" (Tzeng et al., 2010, p.1402). By opening their inner doors, the nurses can contribute to unlock the inner door patients use to exclude others (Tzeng et al., 2010). In physicians' stories, an attitude of closeness is reflected in the theme "Power To", which means that the physicians focus on the patients' lived experience and understand their suffering, while acknowledging their own mortality, vulnerability and fallibility (Talseth et al., 2000). Newly educated physicians experienced that mutual understanding and trust are important parts of a good relationship with patients, which help them in the process of making assessments (including a diagnostic formulation) and treatment plans (Høifødt & Talseth, 2006). Carlén and Bengtsson (2007) found that going beyond the labelling of patients (e.g., by psychiatric diagnosis or behavior) is important to understand the complexity of each patients suffering.

Sun and colleagues (2005) developed a suicide nursing theory consisting of four categories: *holistic assessment of suicide* (e.g., vigilant observations, interviewing skills), *providing protection* (e.g., monitoring and supervision, protecting patients' safety), *providing basic care* (e.g., mental and emotional care, physical care), and *providing advanced care* (the compassionate art of nursing-including empathy, being non-judgmental, acceptance of patient as person first, sincerity, kindness and respect for dignity-, the nurses' role, communication skills and instilling hope). The theory encompasses many aspects of care in which the subcategory "*compassionate art of nursing*" was found to be the overarching principle (Sun et al., 2005). Following this study, Sun et al. (2006) focused on contextual conditions (ward environment) and intervening conditions (nurses' responses). The study points to the

importance of team work, protective ward environment, and adopting non-judgmental attitudes towards patients with suicidal problems (Sun et al., 2006). In the study of Lees et al. (2014), nurses emphasize therapeutic engagement with the patients, which involves establishing rapport, active listening, empathy, genuineness, boundaries, unconditional positive regard, time and responsiveness. Such engagement has a reciprocal impact on nurses and patients, and contributes to positive intrapersonal changes (Lees et al., 2014). In other research, nurses have pointed to communication as the most important skill in nursing (McLaughlin, 1999). Larsson et al. (2007) found that nurses emphasize person-supported care, which involves being accessible, accepting, understanding, understandable, attentive, respectful, and committed.

Some studies provide deeper understanding of the relational, emotional and existential aspects involved in the care of suicidal patients (Gilje & Talseth, 2007; Gilje et al., 2005; Tzeng et al., 2010). Providing care of suicidal patients involves "struggling with self and sufferer", which among others, means adopting a (self) reflective stance with regard to the relationship with the patient and of what suicidal suffering involves (Gilje et al., 2005). Further, to care for suicidal patients - or to become ready to mediate consolation with suicidal patients – involves being "at home" with self (Gilje & Talseth, 2007). Being "at home" with self means having increased understanding of one's own self and existential struggles in life, which helps to make the care provider more open and ready to engage with suicidal patients in a meaningful way that uncover or recover their "at homeness" (Gilje & Talseth, 2007). These findings relate to the study of Tzeng and colleagues (2010), where nurses' readiness to engage with the patients on an emotional level implied reflecting on their own as well as the patients' mental state and opening their inner door, which in turn, could help the patients to open their inner door. The studies point to dynamic and reciprocal interaction processes between care providers and suicidal patients (Gilje & Talseth, 2007; Tzeng et al., 2010).

Gilje and Talseth (2014) synthesized previous research of how nurses experience suicidal patients (including several studies described here). Maneuvering through moral-ethical, relational, and emotional responses to the patients were one of their main findings. Further, the authors found that the nurses' competencies are complex and especially concern therapeutic relating to suicidal patients, but also knowledge of risk factors, risk assessments, close observation, safety, therapeutic milieu, and collaboration with patients and others involved (Gilje & Talseth, 2014). Another significant finding was that nurses held both

humanistic and mechanistic views of suicide and suicidal patients, that is, viewing the patients as human beings or sufferers, or as labels such as psychiatric diagnoses. These views will influence the care provided (Gilje & Talseth, 2014). Hence, it is important that nurses engage in self-reflection and receive sufficient support (Gilje & Talseth, 2014; Talseth & Gilje, 2011). Through critical reflections on self and suicidality nurses gain insight into their own attitudes and emotional reactions and responses, and how this might influence their care of suicidal patients (Talseth & Gilje, 2011).

People being hospitalized in a psychiatric ward because of suicidality have reported that good care involves being confirmed by the staff (Samuelsson et al., 2000; Talseth et al., 1999, Talseth et al., 2001). Being confirmed means encountering nurses and physicians who see them as unique persons, respect them and listen to them without prejudice, who open up to their feelings and accept them, and who involve them in their own treatment course (Talseth et al., 1999; Talseth et al., 2001). Good care also implies that the nurses attend to their basic bodily needs (e.g., food, sleep, fresh air), and communicate hope (Talseth et al., 1999). To encounter caring staff that understands them and give them the opportunity to talk when needed is important (Samuelsson et al., 2000). Communicating about their difficulties is considered as the most important part of care (McLaughlin, 1999). Confirmation conveys the message that the care provider acknowledges the patient's existence and experiences, and acknowledges their relationship (Talseth et al., 1999, Talseth et al, 2001). Through confirmation the suicidal patient may feel more connected to life, to the world and other people (Talseth et al., 1999), which is in keeping with the study of Cutcliffe et al. (2006) and their core variable of what constitutes good care of suicidal patients; "*re-connecting the person with humanity*". Re-connecting the person with humanity is described as a 3-stage process where suicidal patients is gradually moved from a "death" oriented position to a "life" oriented position through close engagement with nurses (Cutcliffe et al., 2006). Through supportive relationships with nurses, suicidal patients re-establish trust in the humanity, and gain increased insight into - and power over - their own suicidality, which help them to feel reconnected and hopeful (Cutcliffe et al., 2006).

Other research exploring (former) suicidal patients' experiences has reported the importance of therapeutic engagement (Lees et al., 2014), or as Sun and colleagues (2006b, p. 687) described it; *"safe and compassionate care giving via the channel of the therapeutic relationship".* Such care involves feeling safe in the ward and within the relationship with the

nurses, and being cared for by compassionate nurses who instill hope in them (Sun et al., 2006b). Further, "compassionate art of nursing" implies that patients are cared for by empathic and non-judgmental nurses who treat them as unique persons (Sun et al., 2005). Berg and colleagues' review of qualitative studies (2017) increase the understanding of what safety means to suicidal inpatients. Safety means "*feeling safe*", which involves establishing close connections with professionals, being protected by supportive staff and re-establishing a sense of control over their lives (Berg et al., 2017). Connections with professionals are of particular importance, and involve "meeting someone who cares", "receiving a confirmation of feelings", and "being acknowledged as a human being" (Berg et al., 2017).

Vatne and Nåden (2014) reported that suicidal patients long to be met with trust and as equal individuals, and they long to talk about their suicidality and to be understood and confirmed in their suffering. Encountering caring staff and being understood appeared to increase patients' hope of being connected with others, and that others could help them (Vatne & Nåden, 2016). The study of Talseth et al. (2003) shows that suicidal patients may long to be connected to professionals and long for consolation, yet they might feel vulnerable and disconnected, and can struggle to open up, to connect with another person, and to become ready for consolation. Becoming ready to open up is promoted by caring professionals who are open, available and present, and who listen, thus allowing the patient to release some of the suffering (e.g., by weeping and expressing feelings of despair) (Talseth et al., 2003). The sharing of suffering in an interpersonal communion relieves some of the pain and the patient can experience a shift in perspective, i.e., being in contact with positive and meaningful aspects of life (Talseth et al., 2003).

3.1.2 Experiences or perceptions related to insufficient care

Even though mental health workers have pointed to significant features of good care, this does not mean they always practice such care. Although nurses identify communication as the most important skill in nursing, many of them feel they lack training in communication and have too little time to talk with the patients (McLaughlin, 1999). Sun and colleagues (2006a) also found experiences of insufficient education and training, and time constraints, which in turn, led to insufficient care of suicidal patients. In addition, some nurses held judgmental attitudes towards patients (Sun et al., 2006a). Other research has shown that nurses emphasize therapeutic engagement with suicidal patients, yet they do not always prioritize such engagement and found themselves within a system reliant on medical and custodial

interventions (Lees et al., 2014). This is in keeping with other research where nurses have described experiences of insufficient engagement with patients, i.e., not being attentive to patients (Larsson et al., 2007). In addition, nurses have reflected on insufficient care after a patient suicide/suicide attempt, thinking they had not listened enough to the patient or had failed to connect with the person and understand the seriousness of their suicidality (Larsson et al., 2007). Awenat et al. (2017) demonstrated that some staff members are reluctant to talk with patients about their suicidality because they fear it can make the patient worse, and they fear negative consequences (e.g., being blamed) in case a patient takes his/her own life. Some staff members feel it is not their responsibility to talk about suicide with patients, thus, placing the responsibility to initiate such conversations on the therapist or the patient (Awenat et al., 2017). Experiences of young physicians showed that they worry about not having enough time to establish a good relationship with suicidal patients, and they fear making mistakes that can have a negative influence on their reputation (Høifødt & Talseth, 2006).

Many of the findings presented above are largely in keeping with the study of Talseth et al. (1997), where insufficient care is related to an attitude of *distance* to the patients, which mean that nurses are not emotionally involved in the patients' suffering. The nurses lack a trusting contact or relationship with the patients, avoid talking with them about their despair and feel incompetent and unable to help the patients (Talseth et al., 1997). The nurses do not go deep into the patients' thoughts and feelings, but rather 'work through' the patients' suicidality and problems in a more superficial way, for example by focusing on treating an underlying disease (Talseth et al., 1997). In the study of physicians' experiences, an attitude of distance is reflected in the theme 'Power Over', which means that the physicians do not achieve close contact with patients and do not open up and take part in the patients' suffering (Talseth et al., 2000). Rather, the physicians focus on patients' disease and need for medication (Talseth et al., 2000). To focus on clinical symptoms and psychiatric diagnosis can be a way for mental health workers to emotionally distance themselves from the patients and thus protect themselves from the emotional discomfort evoked by the patients' despair and hopelessness (Carlén & Bengtsson, 2007; Talseth et al., 1997, Talseth et al., 2000). However, "*diagnostic labels can be dehumanizing and stigmatizing*" (Gilje & Talseth, 2014, p. 18), and may contribute to conceal the patients' suffering (Carlén & Bengtsson, 2007). Theories and models are insufficient in order to really care for suicidal patients and understand their suffering (Talseth & Gilje, 2011; Talseth et al., 1997; Talseth et al., 2000). If care providers distance themselves emotionally, i.e., close their inner door (Tzeng et al., 2010), then the patients are

not given sufficient space or opportunity to acknowledge and go deep into their own thoughts and feelings (Talseth et al., 1997, Talseth et al., 2000).

Former suicidal inpatients have reported that insufficient care involves not being confirmed by the staff (Samuelsson et al., 2000; Talseth et al., 1999, Talseth et al., 2001), which is related to experiences of being overlooked, invalidated, treated with prejudice and not involved in their own treatment (Talseth et al., 1999, Talseth et al., 2001). Encountering staff that focus on diagnoses and medication contributes to experiences of not being recognized for who they are (Talseth et al., 1999). Other patients have related negative experiences to not knowing who their primary nurse is, encountering insensitive staff, feeling unsafe and not being sufficiently protected, and experiencing negative side effects of their medication (Sun et al., 2006a). Some patients suggested that nurses can improve their communication skills and spend more time listening to them and help them with their problems (McLaughlin, 1999). Lack of therapeutic engagement contributes to patients feeling isolated and overlooked, and not being heard or understood (Lees et al., 2014). Experiences of uncaring staff members may lead to patients refraining from making contact even if they need to talk to someone (Samuelsson et al., 2000). Vatne and Nåden's studies (2014, 2016) show that suicidal patients have experienced encounters with health personnel that lack trust, openness, understanding and confirmation. At worst, lack of caring encounters with staff can reinforce patients' suffering and reduce their hope for a better life (Vatne & Nåden, 2014, 2016). Unmet needs for connection, protection and control can make the patients feel unsafe and increase their suicidal thoughts (Berg et al., 2017). Disconfirmation communicates the message that the care provider does neither acknowledge the patient's existence and experiences, nor their relationship (Talseth et al., 1999, Talseth et al, 2001). Lack of confirmation can lead to increased hopelessness and suicidality among patients (Samuelsson et al., 2000; Talseth et al., 1999).

3.2 Knowledge gaps

As shown above, there are some qualitative studies on mental health professionals' (nurses in particular) and suicidal patients' experiences of psychiatric inpatient care in different contexts. However, many of these studies were conducted 10-20 years ago, including the research conducted by Talseth and colleagues in Norway. Considering the development in the mental health services during the last decade, with the implementation of the *National*

guidelines for the prevention of suicide in mental health care (Norwegian Directorate of Health and Social Affairs, 2008), and the increased focus on risk factors and suicide risk assessments, it was necessary to conduct new qualitative studies to shed light on how current treatment and care of suicidal inpatients in Norway are experienced by both professionals and former inpatients. Based on previous research, there were some knowledge gaps and aspects that needed to be further explored. For instance, we needed more knowledge about aspects that may challenge or constrain good connections between mental health workers and suicidal patients in psychiatric wards. Further, it was important to explore how mental health nurses experience their skills with regard to recognizing and responding to suicidality/suicidal acts among inpatients, and how they deal with the emotional demands in their work. In addition, we needed more knowledge about differences between the experiences of therapists and mental health nurses, and how their experiences can be understood in light of theoretical-ethical perspectives, in this case, ethics of care and ethics of justice. Furthermore, we needed more knowledge about how former suicidal inpatients had experienced treatment and care in psychiatric wards several years after the implementation of the national guidelines. In particular, it was important to explore what can be improved in the care provided.

4. RESEARCH AIMS

The overall aim of this study was to explore and describe treatment and care of suicidal patients in psychiatric hospital wards from the perspectives of mental health workers and former inpatients who had been admitted because of suicidality. The focus was on the professional-patient meeting/connection and on the care provided.

The specific aims of each paper were:

Paper 1: To shed light on current clinical practice by gleaning information from therapists' experiences. Research question: What aspects may contribute toward shaping and possibly constraining therapists' connections with suicidal individuals?

Paper 2: To extend the knowledge of how mental health nurses deal with the variety of demands in the care of potentially suicidal patients in psychiatric wards. Research questions: How do they experience their skills with regard to recognizing and responding to suicidal behavior/self-harm among patients? How do they react to suicide and suicidal acts, and deal with the emotional challenges in the care of patients at risk of suicide?

Paper 3: To explore and compare therapists' and mental health nurses' experiences of caring for suicidal inpatients, including how their experiences could be understood in light of ethical perspectives. Research questions: How can mental health professionals' experiences of treatment and care of suicidal patients be understood from the perspectives of ethics of care and ethics of justice? Are there differences in the experiences of therapists and mental health with regard to this?

Paper 4: To explore how persons admitted to psychiatric hospital because of suicidality have experienced treatment and care in the services several years after the implementation of the *National guidelines for the prevention of suicide in mental health care*. Research questions: How have (former) suicidal inpatients experienced treatment and care in psychiatric wards since the implementation of the *National guidelines for the prevention of suicide in mental health care*? What can be improved in the care of suicidal inpatients?

5. METHOD

5.1 Research design

The study applies a qualitative design where data were collected through semi-structured individual interviews. The material was analyzed by means of different approaches, such as thematic analysis (Braun & Clarke, 2006) in paper 1, Systematic Text Condensation (STC) (Malterud, 2011, 2012) in paper 2, combining STC and principles from a more theoretical-based approach (Jackson & Massei, 2012) in paper 3, and Interpretative Phenomenological Analysis (IPA) (Smith, Flowers & Larkin, 2009) in paper 4. More information about this and other methodological issues are described.

5.2 Philosophical, ontological and epistemological foundations of the study

The philosophical, ontological and epistemological underpinnings of this study are phenomenology, hermeneutics and social constructionism; the empirical material is based on subjective experiences related to the study's topic, and the findings are based on interactions (interviews) with the participants and interpretations of the participants' narratives. In addition, the study is based on the assumption that knowledge is subjective and relational, it is constructed in interaction with others and it is influenced by the context which I am part.

Phenomenology is the philosophy and methodology related to the study of subjective experiences and how people make sense of their lifeworld (Finlay, 2011; Giorgi, 1985; Smith et al, 2009; Smith & Osborn, 2003). Husserl and Heidegger were two major phenomenological philosophers (Heidegger, 1927/1962; Husserl, 1913/2014). Husserl (1913/2014) described phenomenology as the science of essences. He was concerned with "going back to the things themselves" and suggested that we needed to "bracket", or put aside, the taken-for-granted world to focus on the phenomenon under study (Giorgi, 1985; Smith et al., 2009). Following Husserl, the phenomenological attitude of reduction (including epoché/bracketing) involves that the researcher has a non-judgmental, open and reflective stance towards the phenomenon under study while putting aside both his/her past assumptions and knowledge, and existential claims about what is being experienced (Finlay, 2011; Giorgi, 2008). Finlay (2008) described the phenomenological attitude as a reductive-reflexive dance. Heidegger, who was a student of Husserl, developed the philosophy into a more existential and hermeneutical direction; being more concerned with human existence and how we relate

to and engage with the world and other people (Heidegger, 1927/1962; Smith et al., 2009). Heidegger emphasized that interpretation was a significant part of the understanding of lived experiences, and suggested that "bracketing" can only be partly achieved since some of the preconceptions are only revealed once the interpretation is underway (Smith et al., 2009).

Hermeneutics is the philosophy and methodology of interpretation of meaningful phenomena (Gilje & Grimen, 1993). Gadamer, who was a student of Heidegger (Smith et al., 2009), discussed and continued the work of his teacher related to interpretation and the role of preconceptions (or fore-conceptions) (Gadamer, 1975/2013). He pointed to the process in which interpretation is influenced by one's preconceptions, which in turn are revised as a consequence of the new understanding, which then influences further interpretation and so forth (Gadamer, 1975/2013). In other words: *"when we read a text, our reading and understanding are forms of engaging in a dialogue between something that is old (a fore-understanding) and something which is new"* (Smith et al., 2009, p.26). Our preconceptions are always present, but it is important to be aware of them and remain open to the meaning of the other person or text (Gadamer, 1975/2013, p.282), thus staying open to what is unique and different in the phenomenon under study (Smith et al., 2009). In keeping with these assumptions, it has been important to stay close to the participants' narratives, being open for their unique experiences and trying to prevent my preconceptions blocking new insight. At the same time, the interpretation and understanding of the interview data are inevitably influenced by my preunderstanding. It has, for instance, influenced what questions I have posed to the material and how I have made sense of the participants' experiences. A researcher's preunderstandings consist of many components, among other, personal experiences and beliefs, language and concepts, and these are continuously changing in the face of new experiences (Gilje & Grimen, 1993). It is a strength that the interpretation of interview data was conducted in collaboration with the coauthors, although they are influenced by their own preunderstanding.

The hermeneutical circle is significant in hermeneutics and is concerned with the relationship between the parts and the whole in the circular interpretative process; to understand a word or parts of a text (e.g. interview transcript) you have to look at the whole text, to understand the whole text you have to look at parts of it and so forth (Gadamer, 1975/2013; Smith et al. 2009). Furthermore, the hermeneutic circle refers to the connection between what we are interpreting, our preunderstandings and the context in which we interpret (Gilje & Grimen,

1993). These interpretative principles have been relevant for the analysis of the material (paper 1-4), regardless of which analytic approach I have employed. Furthermore, some qualitative research methods, for instance Interpretative Phenomenological Analysis (IPA), involves a double hermeneutic in two different ways: a) the researcher make sense of the participant who make sense of x, and b) the researcher combines a hermeneutic of empathy (adopt an insider perspective) with a hermeneutic of questioning (a more distanced and analytic stand) (Smith et al., 2009).

Berger and Luckman (1967) asserted many years ago that reality is socially constructed and that the development of knowledge is influenced by the social context. Central principles in **social constructionism** are that knowledge is relational, contextual and changeable (Gergen, 1985). Understanding is the result of an active collaboration among people engaging in interpretative and meaning-making processes (Gergen, 1985; Gergen, 2001). Thus, the knowledge gained in this study are the result of my interactions with the participants and my collaboration with the co-authors. In addition, my interpretations and understandings are a result of my background, my relations and meetings with various people in life and the cultural context in of which I am part. Social constructionism invites us to question taken-for-granted knowledge and commonly accepted categories, opening up for reconstructions, new understandings and alternative interpretative possibilities (Gergen 1985; Gergen, 2001). This attitude to knowledge has been important for this research, although, at times, challenging. It feels safe to stay within well-known and traditional knowledge, and raising critical questions within a field (for instance with regard to the biomedical-psychiatric paradigm) can provoke resistance. However, from a constructionist position, there is no "one truth" and knowledge is continuously evolving (Gergen, 1985); "*all that seems 'clearly the case' could be otherwise*" (Gergen, 2001, p.31). Questioning current assumptions and practices within mental health care and including alternative understandings has been a significant part of this PhD study. This thesis and the findings in the four papers are part of the continuous knowledge development within the field.

It may appear conflicting to combine phenomenology and social constructionism, as the former (particularly Husserl's descriptive phenomenology) implies searching for *essences* of the phenomenon under study (Finlay, 2011), whereas from the latter standpoint, there is no one true essence or one truth (Gergen, 1985). Further, phenomenology appears focused on the individual experience, whereas social constructionism has an emphasis on how meaning and

knowledge is constructed in relationships. However, in keeping with phenomenology, searching for essences involves capturing nuances of experience and subjective meanings of experiences which are not regarded as objective truth (Finlay, 2011; Giorgi, 1985). Further, approaches such as Giorgi's descriptive phenomenological method focus most on uncovering essential characteristics of a specific phenomenon, and even though this is achieved through the study of individual experiences, the emphasis is not on the individual as such (Giorgi, 2008; Finlay, 2011). In addition, hermeneutic phenomenology has a focus on how our understanding of lived experiences is related to interpretation influenced by our engagement in the world (Smith et al., 2009). It is important to note that this study is not purely phenomenological, but the research and the qualitative methods used are inspired by phenomenological philosophy (and particularly hermeneutical phenomenology), which is compatible with a social constructionist standpoint.

5.3 Participants and recruitment procedure

In qualitative interview studies, one typically uses a purposive sample of participants who can reflect and talk about the phenomenon under study (Tjora, 2017). There are different strategies to select the sample, and the chosen strategy is influenced by aspects such as time frame and access to potential participants (Malterud, 2017; Patton, 1990). Saturation is often used as a criterion to limit the sample size (Malterud, 2017, Charmaz, 2003). However, the relevance of such a concept may be questioned, as there might always be a possibility of finding something new or something else, either by approaching the material differently or by interviewing several people. Furthermore, the concept of saturation opposes the social constructionist view of that knowledge is partial and temporary (Malterud, 2012). According to Malterud (2017), it is rather the strength of the information in the sample that should determine how many participants we need. Following is a description of the participants and recruitment procedure in each study/paper.

In paper 1, we had a purposive sample of four psychiatrists (two women, two men) and four psychologists (one woman, three men) aged 28-59 years working in two different hospitals and six different psychiatric wards in Central Norway. Their professional experience ranged from 2 - 30 years. Six of the therapists had more than 10 years of experience. Seven of the participants had professional experience from (locked) acute wards, five still worked with acutely admitted persons and three were working at a general psychiatric ward or a unit for

psychosis. I contacted the units' management by e-mail and they assisted in recruiting participants. The main criterion for being included in the study was experience of treating suicidal patients, including patients admitted for the first time because of suicidality and patients receiving treatment because of recurrent suicidality. I contacted the potential participants by e-mail and agreed on the time and place for the interview when they had accepted to participate. Thus, the strategy for recruiting the participants (purposefully) was influenced by homogenous sampling (in terms of their work as therapists in psychiatric wards and their experience of treating suicidal patients), and convenience sampling (accessibility) (Patton, 1990).

In paper 2, we had a purposive sample of eight mental health nurses (seven women, one man) aged 43-60 years working in two different hospitals and five different psychiatric wards in Central Norway. Their professional experience in psychiatric hospital ranged from 5-25 years. Seven participants had 15 years of experience or more. Five of the mental health nurses worked in locked acute wards, one in an acute/crisis unit, one in a specialized ward and one worked in a rehabilitation ward. The gender ratio largely reflects the situation in many psychiatric hospital wards, where the majority of mental health nurses are women. In addition, I had contact with the units' management by e-mail and they assisted in recruiting participants by asking mental health nurses with experience of caring for suicidal patients to participate. Thus, clinical experience and willingness to participate in the study was emphasized regardless of gender. I contacted the potential participants per e-mail and agreed on the time and place for the interview once they had accepted to participate. The strategy for selecting the participants (purposefully) was influenced by homogenous sampling (based on their professional background and clinical experience), and convenience sampling (accessibility) (Patton, 1990).

In paper 3, the participants were the mental health workers included in the first and second paper. This means that a purposive sample of eight therapists (four psychiatrists, four psychologists, three women and five men), and eight mental health nurses (seven women and one man), aged 28-60 years participated. The participants were working in two different hospitals and ten different psychiatric wards in Central Norway. Their clinical experience ranged from 2-30 years. Thirteen of the included mental health workers had more than 10 years of experience. Eleven of them were working in an acute ward or a crisis unit, and five

were working in other wards (general psychiatric ward, rehabilitation ward, unit for psychosis, or another specialized ward). Recruitment procedure is described above.

In paper 4, we had a purposive sample of five persons (four women and one man aged 33-54 years) who had been admitted to two different psychiatric hospitals in Central Norway because of suicidality. Two had been admitted to a psychiatric unit for the first time, and they were hospitalized in a locked acute ward before being transferred to a district psychiatric center. Their hospitalization lasted for about three months. Three participants had been admitted several times during the past fifteen years. Their last hospitalization in a (locked) acute ward followed by transfer to a district psychiatric center lasted for about 2-3 weeks. Three participants were admitted because of a suicide attempt (hanging or self-poisoning), and two were admitted because they were close to attempting suicide. At the time of the interviews, it had been from one week to nine months since their last hospitalization.

The staff in different inpatient and outpatient psychiatric units assisted in recruiting participants that had been hospitalized because of suicidality during the last 12 months. I had contact with the units' management and the leaders of the different psychiatric wards and outpatient clinics, both by e-mail and by attending staff meetings where I had the possibility to inform the staff members directly about the project. In some units I attended several meetings to remind the staff about the study because of the slow progress in the recruitment process. The research ethics committee approving the study determined the following recruitment procedure: Therapists in outpatient psychiatric clinics informed about the study and asked patients whether I could contact them by phone to ask if they wanted to participate. It had to be minimum 24 hours since they had been informed until I could contact them. Two of the participants were contacted and recruited this way. Certain staff members in acute inpatient units informed about the study and handed out an information letter to potential participants, who then had to contact me - the researcher - after discharge. Three participants made contact by phone and agreed to participate. The strategy for purposefully selecting participants was influenced by homogenous and criterion sampling (based on their experience of being psychiatric hospitalized because of a suicidal crisis within the last 12 months) and convenience sampling (based on accessibility) (Patton, 1990).

Initially, we aimed at a bit larger patient sample (N=8-10). It was, however, challenging to recruit former suicidal inpatients, partly because of the recruitment procedures determined by

the research ethics committee. We found the committee's request of former inpatients having to contact a, for them, unknown researcher unsuitable. To take initiative to participate in a project and make contact with an unknown researcher may be challenging for a lot of people, not least for persons who have been hospitalized because of suicidality. They could have perceived it safer to learn more about the study from the researcher, and then, they could have been requested to participate after the discharge if they had allowed the researcher to take contact with them by phone. Then, they would have had some time to think about the study, and they would have had the opportunity to deny participation or even not respond to the researcher's phone call. In addition, staff members that were assisting in recruiting participants gave different reasons (either directly to me or through their leader) why they had difficulties in recruiting former suicidal inpatients. The staff members in the inpatient wards said they forgot to give information to several potential participants before they were discharged, and some patients had said they did not want to participate. Therapists in outpatient clinics reported that they forgot to ask potential participants, they found it difficult to ask patients because of other challenges that occurred during their consultations, and sometimes they did not think it was suitable to ask them. According to the leader of the research and development department at one unit, there weren't many potential participants at their outpatient clinic. Furthermore, in some cases, therapists had felt it was inappropriate to ask the patient about research participation because of the therapeutic process they were in, and some therapists reported that they had asked some patients that did not want to participate. The management of one outpatient clinic did not want to assist in recruiting former suicidal inpatients, because they thought the patient would find it difficult to deny such a request from their therapist. In addition, I had been in contact with two user organizations (Mental Health and National association for prevention of self-harm and suicide), and information about the study was distributed to members, but nobody signed up to participate. Again, with such a sensitive topic I think it would have been more appropriate to allow therapists to recruit possible participants on behalf of the researcher. Then, the possible participants could have had some time to decide whether or not they would meet the researcher.

Even though we had aimed for a few more participants in the former inpatient group, we considered the content of the interview data to be rich and the material was suitable to be analyzed by means of IPA in order to illuminate our research questions in paper 4. A small

sample is common in studies with in-depth analysis of how individuals experience illness or psychological distress (Smith, 2011; Smith et al., 2009).

5.4 Data collection

I collected data by conducting one individual semi-structured interview with each of the 21 participants. Qualitative research interviews are suitable for providing knowledge about people's subjective experiences and perceptions (Malterud, 2017). Through conversation, the researcher learns about people's lived world – among other their feelings, opinions, hopes and fears – from their own perspectives (Kvale & Brinkmann, 2009). Knowledge is produced based on the interaction with the participant, it is thus co-constructed (Kvale & Brinkmann, 2009). The knowledge production is related to the quality of the interview, in which the interviewer has the main responsibility; interviewing is a craft depending on the knowledge, skills and personal judgment of the interviewer (Kvale, 2001; Kvale & Brinkmann, 2009). Following is a description of the data collection in the present study; when and where I conducted the interviews, the use of interview guides, reflections about the interview conversations (see also ethical considerations in section 4.6.2) and the field notes, as well as the transcribing process.

I interviewed the mental health workers in 2013, and the former suicidal inpatients in the period 2013-2015. The participants could suggest and decide the time and place for the interview. The interviews of the mental health workers took place in their respective working places, except for one whom I interviewed in a meeting room not located at the hospital. I interviewed three of the former inpatients in a meeting room/office at my work place, one of them in a meeting room at a psychiatric outpatient clinic, and one in the person's home. The interviews of the mental health workers lasted for about 60 minutes, whereas the interviews of the former inpatients lasted on average for about 80 minutes. One of the interviews lasted nearly two hours, whereas one interview lasted 31 minutes.

I had two interview guides, one for the interviews of the mental health workers and one for the former inpatients (see appendix). In keeping with Kvale (2001) all interviews had an introduction/"briefing" part, where I talked about the project, emphasizing that participation was voluntary and that he/she could end the interview and withdraw from the study without giving any reason. I also pointed out that the participant decided what to share or not about

the topic, and that he/she could choose not to answer my questions. I noted that when they described their experiences, I would appreciate that they tried to do so in a concrete and detailed way, as if I was a person without any knowledge about the topic. I assured them that the information would be treated confidentially. I obtained consent to use the audio recorder and asked some demographic questions (this information was noted but not recorded). In addition, I asked the participants if they had any questions before we started the interview.

The main part of the interviews consisted of several open questions concerning the participants' perceptions and experiences related to the study's topic. Although I had an interview guide (see appendix), it was important to stay open for the participants' responses and follow their leads to a certain extent. The questions in the interview guides were only used when necessary, for instance if we had not talked about some of the issues/themes. Malterud (2017) noted the importance of being open and focused at the same time. In keeping with Kvale and Brinkmann (2009), I probed for further description (e.g., can you elaborate? How did you experience that?), and used confirmatory/interpreting questions (e.g., so you think that…? If I understand you correctly, you experienced that...?) in an attempt to clarify the participants' experiences and perceptions. At the end of each interview I had a "debriefing" part (Kvale, 2001), attempting to sum up the most important aspects with regard to the topic and asking if the participant had anything else to add, perhaps there were some questions about the topic I had not asked which they thought was important. I also asked how they had experienced to be interviewed. Everyone confirmed that it had been okay to participate. Some of the former inpatients noted that it had been a bit challenging to recall and describe previous experiences in detail (see section 5.6.2 for more information about the former inpatients' experiences).

In my experience, the interviews went well. The mental health workers shared both good and challenging experiences related to their treatment and care of suicidal patients, of whom some had attempted suicide or taken their own lives. However, one therapist was reluctant to describe a recent experience of a patient suicide. I sensed that the person was emotionally affected and did not want to elaborate on the incident. Thus, I had to respect her boundaries and I did not go further into the matter. It was a bit challenging to get the mental health workers (particularly the therapists) to share their experiences in a concrete and detailed way, which could be related to their professional role and professional distance to the topic. It was obvious that the former inpatients' were more personally involved and more closely related to

the study topic. They shared life experiences related to their suffering and suicidality, and also about their positive and negative experiences of the treatment and care provided in psychiatric wards. One of the participants, however, was less talkative than the others. I needed debriefing and advice after one of the interviews, as I felt anxious after one of the former inpatients had shared her experiences of suicidality. It reminded me of the fear and uncertainty I sometimes felt regarding suicidal inpatients I previously had cared for. After some reflection, I believe that my anxiety was connected to the participant's pain and fear as her suicidality was not resolved and she was uncertain about the future. This experience resembles what Finlay (2008) has called *reflexive embodied empathy* evolving from the interviewer-participant interaction and the intersubjective experience. Further, transferences of emotions may occur during research interviews (as it does in therapeutic settings), which may provide the researcher with a deeper understanding of the participant's experiences (Jervis, 2009). However, the researcher might need help to distinguish his/her own feelings from the participant's (Jervis, 2009). The debriefing after the interview was helpful in this regard.

After each interview I wrote field notes; my impression of the interview situation, the content of the conversation, reflections on how I had conducted the interview, and thoughts on how I could improve my interviewing skills or otherwise obtain even richer descriptions in the next interviews. Both interview guides were slightly revised twice following these reflections. I included information (in the introduction part) and a question to help the participants express more specific and detailed descriptions of their experiences.

I had assistance in transcribing the interviews. Then, I listened through the audio recordings while correcting each transcript carefully. Although some authors encourage qualitative researchers to transcribe their own interviews (e.g., Malterud, 2017), I think that my careful attention to the audio recordings and transcriptions was sufficient to make me familiar with the data. Further interpretation of the data involved spending a lot of time with the material; reading and re-reading the transcripts, dwelling on the content and reflecting on various meanings. When interview excerpts from the transcripts were translated into English for publishing purposes, we tried to stay as close as possible to the participants' wording. Sometimes, a "slightly modified verbatim mode" was used to prevent strange wording or misunderstandings (Malterud, 2017, p.78).

5.5 Data analysis

Choosing the most suitable research method depends on the research question (Malterud, 2017). During this project, I learned that to choose the most suitable qualitative analytic method one must also consider the participants' relation to the study topic and the content of the data. This issue is elaborated in the following description of the chosen analytic approach in each paper.

In paper 1, we chose to analyze the interview data by means of thematic analysis (Braun & Clarke, 2006; Braun & Clarke, 2014). Initially, Interpretative Phenomenological Analysis (IPA) was the chosen approach. However, during the analysis of the therapist interviews, we came to question IPA's suitability for this particular data material. The approach did not match the data because the therapist interviews reflected a professional distance to the topic and it did not seem appropriate to conduct a deeper phenomenological and psychological analysis. It became obvious that the therapists' positions and perspectives were very different to those of the former inpatients. The interviews of former inpatients contain more specific and existential descriptions and reflected their personal involvement and closeness to the topic. Thus, it was appropriate to choose a method such as IPA to gain a deeper understanding of their experiences, including an interpretation of psychological aspects. Thereby, IPA was considered suitable to interpret the interviews of former inpatients, but not the interviews of therapists. IPA appears most suitable to interpret data rich on personal and existential descriptions, which is typically found in interviews about lived experiences of illness or psychological distress (Smith, 2011). IPA appears less suitable to interpret data rich on professional and more technical-distanced descriptions. I do not think IPA is an unsuitable method of analysis for interviews of mental health professionals in general. However, such an analytic approach should not be used if the data lacks the depth necessary to provide an insightful, detailed and nuanced interpretation. If IPA is used regardless, it can contribute to a superficial and poor analysis, providing a misleading picture of what it entails to conduct a thorough phenomenological analysis.

Thematic analysis was considered the most suitable approach, and it provides a systematic framework for identifying, analyzing and reporting patterns (themes) of meaning across the qualitative data in relation to the research question (Braun & Clarke, 2006; Braun & Clarke, 2014). I conducted all steps of the analysis and collaborated with my coauthors in the

following way: (a) We read and re-read the transcripts during the whole process. I organized and structured the content into coded meaning units, including the use of computer-assisted qualitative data analysis software (Hyper Research version 3.5.2). (b) The material generated many codes and themes related to therapist-suicidal patient meetings (including meaningful contact/alliances, challenging encounters/alliances, patient characteristics/diagnoses, suicide risk assessments, safety procedures, treatment interventions, patient suicide/suicide attempts, professional role, and responsibility), which I then visualized in a thematic map using Mindjet MindManager software. (c) We then focused on certain aspects of the material according to the study's research question. (d) I categorized relevant coded meaning units into candidate themes (e.g., focus on psychiatric diagnoses, emphasis on standardized assessments, organizational aspects), and discussed the content from the transcripts and the themes with my co-authors. Together we developed the candidate themes into final main themes (moving back and forth between the descriptions of the themes and the transcripts to ensure that the findings were grounded in the data), illuminating the participants' experiences concerning aspects influencing and possibly constraining their connections with suicidal patients. (e) We developed the analysis to a latent level (Braun & Clarke, 2006), as we sought to identify aspects of the context (e.g. underlying assumptions and ideology) shaping the therapists' accounts.

In this first study, I used computer-assisted qualitative data analysis software, such as Hyper Research, as tools during early stages of analysis. In keeping with Tjora (2017) Hyper Research can be useful to get familiar with the material and to keep close to the participants' statements when the initial codes are made. However, using the program was a bit time consuming and it was difficult to get good prints of the organized material. Thus, I chose not to use Hyper Research or other software tools in the other studies. Rather, it was useful to make separate documents with relevant meaning units, initial codes, themes and visualizations without the aid of a software program.

In paper 2, systematic text condensation (Malterud, 2011, 2012) was a suitable approach to analyze the interview data of mental health nurses' experiences. Systematic text condensation (STC) is an approach inspired by Giorgi's phenomenological method (Giorgi, 1985). If one imagines a continuum with more or less phenomenological approaches, STC can probably be placed in between thematic analysis and IPA. STC has similarities with both approaches but it seems less (psychological and) phenomenological than IPA and more phenomenological than

thematic analysis. STC matched the data well, since the interview of the mental health nurses were more personal and emotional than the therapist interviews, yet it did not contain as much depth and psychological and existential issues as the patient interviews.

The approach is described as a four-step procedure which we conducted in the following way: (1) Reading the transcripts to get an overall impression and identify preliminary themes; (2) Extracting meaning units from the transcripts and sorting them into codes and code groups; (3) Condensing the meaning within each code group; (4) Summarizing the content into meaningful descriptions (Malterud, 2011, 2012). We read the transcripts, and I conducted all steps of the analysis and discussed the interpretations with my coauthors during the process. Final descriptions were developed and refined over time, and transcripts were read repeatedly during this hermeneutical process (moving back and forth between data and the literature) to ensure that the constructed descriptions were grounded in the empirical data (Malterud, 2011, 2012).

In paper 3, we combined two approaches in the analysis of the mental health workers' experiences. I used inductive principles from systematic text condensation (Malterud, 2011, 2012) in the initial analysis (step 1 and 2 - see below) and then I used theoretical perspectives, that is, plugged one text (data) into another (theory) (step 3) inspired by the method described by Jackson & Mazzei (2012). Finally, these two approaches were combined to ensure that findings were grounded in the empirical data (step 4 and 5). I conducted all steps of the analysis, but my coauthors read the transcripts and were involved in the process of interpreting data. I conducted the analysis in the following (simplified) steps: (1) Reading the transcripts and extracting relevant meaning units. (2) Sorting meaning units into several codes (e.g., observing, reporting, documenting, assessments of suicide risk, diagnosis, emotional contact, dialog etc.) and preliminary themes (e.g., professional responsibility, patient autonomy, protecting the patients, protecting themselves, keeping the patient alive, collaborative relationship, emotional care etc.). (3) Then, we interpreted the content and initial codes and themes in light of perspectives in an ethics of care and an ethics of justice (Botes, 2000; Gilligan, 1982/1993; Held, 2006; Pettersen, 2008; Tronto, 1993/2009). (4) Based on the hermeneutical process of moving back and forth between data (codes, meaning units and the whole material including field notes) and relevant literature, we developed two descriptions characterizing the participants' experiences and perceptions related to treatment and care of potentially suicidal patients in psychiatric wards; 'connection and care' and 'duty and

control'. We linked these two approaches to perspectives in ethics of care and ethics of justice. (5) We compared the interview data of therapists and mental health nurses to explore differences with regard to these two approaches and ethical perspectives.

The blending of two analytic approaches may be challenging. Baker, Wuest and Noerager (1992) asserted it as not unproblematic to combine two methods, particularly if the approaches have different philosophical underpinnings. However, combining a phenomenological inspired method, such as STC, and a more theory driven approach is possible as long as the analytic steps are described clearly. The combination of approaches required that in the initial analysis, I had to try to "bracket" previous knowledge to be more open to the participants' unique experiences and not block new insight. Later in the analytic process, the preliminary themes and descriptions were read through the chosen theoretical concepts (ethics of care, ethics of justice) to further illuminate the participants' experiences.

In paper 4, we chose to analyze the interview data of the five former suicidal inpatients by means of Interpretative Phenomenological Analysis (IPA) (Smith et al., 2009; Smith & Osborn, 2003). The method is suitable for in-depth analysis of data from a small sample and is commonly used to analyze illness experiences, particularly experiences that are of existential importance to the participant (Smith, 2011). The method's theoretical underpinnings are phenomenology, hermeneutics and idiography, which denote the focus on a close interpretative engagement of particular instances of lived experiences and the meaning the person makes of those experiences (Smith et al., 2009). The interview data contain specific and detailed descriptions of the participants' lived experiences of being admitted to psychiatric hospital because of suicidality. Thus, IPA was appropriate to gain a deeper understanding of their experiences, including an interpretation of psychological aspects.

We conducted the analysis in the following steps: (I) We read and re-read the transcripts to get familiar with the participant's personal experiences of being suicidal and receiving mental health care. (II) I created a document with relevant meaning units, and (III) organized the content according to the timelines a) before hospitalization, b) during hospitalization-in treatment, and c) after discharge-life now. Then, I developed preliminary themes (e.g., existential struggle, relational problems, resources, experiences of support/lack of support, ongoing processes of pain and recovery), and (IV) searched for connections across emergent themes. (V) I moved to the next transcript and repeated the process described above. I

analyzed each narrative in depth before moving on to the next transcript, and then, looking for patterns, similarities and differences across the data to develop more general descriptions (Smith et al., 2009). I conducted all steps of the analysis and thoroughly discussed the interpretations with my coauthors until agreed upon final themes and descriptions. In keeping with Smith et al. (2009), we attempted to 'bracket' prior knowledge and assumptions, particularly in the initial analysis, in an effort to be more attentive of the participants' unique experiences and to prevent our own preunderstandings from blocking new insight. In this reflexive and hermeneutical process - moving between data, our understandings and descriptions, and the literature - we have attempted to stay close to the participants' experiences and perceptions.

5.6 Ethical considerations

Ethical considerations constitute a very important part of research. In this study, there were several general ethical considerations that were made in addition to more specific considerations related to the interview setting and my research position.

5.6.1 General ethical considerations

Ethical considerations were made throughout the research process, and the study was conducted in accordance to the Health Research Act (Lovdata, 2008). The Regional Committee for Medical and Health Research Ethics (REC) approved the study. The participants signed an informed consent to participate. I informed them that they at any time could withdraw from the study (until publication) without giving any reason. The data (tape recordings, transcripts, filed notes) and information about the participants are treated confidentially. The material is stored on a password protected computer and in a locked cabinet at work. In keeping with the Regional Committee for Medical and Health Research Ethics, and a guide on privacy and information security in research projects in the health and care sector (Norwegian directorate of Health, 2013), the material will be stored for at least 5 years after the completion of the project before it is deleted. People who assisted in transcribing the interviews has signed a declaration of secrecy. The interview transcripts and field notes are labelled with letters and numbers (signaling the participants' background and the order of the interviews), and this can be connected to a separate document with the participants' names that is only available for me on my password protected computer. Information about the participants and their interactions with suicidal patients/mental health

workers is presented in such a way that they are not identifiable. To protect the participants' anonymity, they are referred to as participant, professional, therapist, mental health worker, mental health nurse or "she/he" (paper 1, 2 and 3), and the former inpatients are referred to as participant or "she" (paper 4).

5.6.2 Ethical considerations with regard to the interviews

The researcher has to be particularly careful when potentially vulnerable people participate in studies about sensitive and personal topics. In interviews, it is particularly important that the participant's mental boundaries are not violated (The National Committee for Medical and Health Research Ethics, 2010). In keeping with ethical guidelines in research, the researcher has a particular responsibility to avoid participants being exposed to harm or severe stress (The National Committee for Research Ethics in the Social Sciences and the Humanities, 2006). Interviews about painful experiences can evoke discomfort, but it was not expected that participation in the study would cause severe stress or harm. Although I assumed little risk for discomfort or harm, special considerations were made for the former suicidal inpatients. I informed the participants that they had the opportunity to contact me after the interview if they had any questions about the study or their participation, or if the interview had evoked mental distress and they needed a follow-up consultation. Before any of the former inpatients were recruited I had arranged with a mental health nurse at a psychiatric liaison service at the general hospital that could offer a consultation on short notice. However, none of the participants took contact after the interview and none of them expressed any need for a follow-up consultation.

Several authors have underlined how important it is that the researcher conducts interviews in a morally responsible manner (Fog, 2004; Kvale, 2001), in which practical skills of situated judgment is important (Kvale & Brinkmann, 2009). The interviewer has to act in a skillful, sensitive and respectful way (Kvale & Brinkmann, 2009). It was important that I created a trusting atmosphere, was empathic and respected the participant's boundaries. The participants could talk openly about their experiences and it was important that they did not feel pressured to answer any of my questions. I aimed to give the participants a positive and meaningful experience even though it could be challenging for them (particularly the former inpatients) to share painful experiences. I was particularly sensitive to signals communicated by the former inpatients indicating stress and discomfort. I would have suggested to end the interview if the person had felt very uncomfortable. Although one former inpatient cried during parts of the

interview, no one appeared severely distressed, and it was thus not necessary to end any of the conversations.

At the end of each interview of the former inpatients, I asked how they had experienced to be interviewed. Four of them said that it had been okay, and one stated that it had been good to talk about it and was glad she had the opportunity to contribute to such a study. One participant admitted that it had been a bit tiring, but that it was worth it if she could contribute something to the study and perhaps improve the situation for herself and others. These experiences are in keeping with my previous interview study (Hagen, 2009) as well as of other researchers who have found that most participants think it is positive to participate in a research project about suicide (Ekern, 2006; Hjelmeland, Dieserud, Dyregrov, & Knizek, 2010). Participation in suicide research is not associated with increased suicidality (Mathias, Furr, Sheftall, Hill-Kapturczak, Crum, & Dougherty, 2012; Smith, Poindexter, & Cukrowicz, 2010). The National Committee for Medical and Health Research Ethics (2010) pointed to the positive experiences participants may have in a research interview, both in terms of being recognized and finding it meaningful to provide others with increased knowledge and understanding of their situation.

5.6.3 Reflections on my position: Being a mental health nurse and a researcher

Bourdieu (2004) emphasized a reflexive research practice. He argued that a reflexive analysis needs to address the researcher's *"...position in the social space, position in the field and position in the scholastic universe"* (Bourdieu, 2004, p. 94). Not only to make the research process more transparent and to present some of the presumptions that the scientific knowledge is based on, but also to consider aspects that may bias the research (Bourdieu, 2004). The present study is influenced by my background as a mental health nurse. From 1998 until 2012 I worked in several psychiatric wards, mainly acute psychiatric wards. I cared for many patients who struggled with suicidal thoughts and several of them attempted suicide. Some of the patients I met took their own lives. During my time in clinical practice and even more so during the PhD training, I have become increasingly critical to the biomedical paradigm and the use of coercion in mental health care. I have embraced a more humanistic approach to people experiencing mental health problems and suicidality. My clinical experiences have influenced the research process in several ways; the study's topic, the research questions, the method for collecting data, analytic approaches, and theoretical framework. Furthermore, my position and preunderstandings influenced my meetings with the

participants, for instance, with regard to how I communicated, what questions I posed in the interviews, and what clues I followed.

My background as a mental health nurse was a strength when I conducted the interviews. I have knowledge within the field and I have had many conversations with patients who have attempted suicide or had suicidal thoughts. Thus, my background could contribute to create trust so that the participants felt safe enough to share their personal experiences (Asselin, 2003; Malterud, 2017). My clinical experience was also an advantage with regard to the considerations of the former inpatients' possible need for a follow-up consultation. However, it was important with an awareness of acting as a researcher and not as a therapist/professional care provider. There are significant differences between an interview and a therapeutic conversation, particularly with regard to the purpose of the conversation (Fog, 2004; Kvale, 2001). The main purpose of the interview is knowledge development, whereas the purpose of therapy is change or improvement in the patient's mental health and situation (Kvale & Brinkmann, 2009). Although both kinds of conversations may lead to increased understanding and change (Kvale & Brinkmann, 2009), it is not the researcher's task to act as a therapist who initiates change in the participant, and that is not what the participant has agreed to (Fog, 2004; Kvale, 2001). However, researchers cannot detach themselves from their therapist or helping role and have to be aware of and provide support in situations where the participant experiences severe discomfort and needs help (Holloway & Wheeler, 2010).

Researching within one's own field may also pose some other challenges, for instance what Malterud (2017) has described as *field blindness*, which means that the researcher risks finding only what he or she already knows and ignores clues that could lead to new knowledge. According to Asselin (2003), interviewing participants from within one's own field may be challenging because they take it for granted that the interviewer understands what they talk about, and thus fails to elaborate on their statements. It was a bit challenging to get some of the mental health workers (particularly the therapists) to share their experiences in a concrete and detailed way, which could be related to that I had clinical experiences and thus they perhaps did not think it was necessary to elaborate on their experiences. In addition, some of the mental health workers said it was a bit difficult to remember and describe in detail meetings with suicidal patients. The therapists had limited contact with the patients, particularly the chief psychiatrists who had a great deal of administrative duties, thus

indicating a professional distance to the study topic. Further, one of them noted that in recent years, he has put things quickly behind him and that he recalls more situations from when he was younger and things made a stronger impression on him.

Malterud (2017) asserted that health workers who collect data about health and illness have professional field blindness, and thus interpret the field through their health worker lens. In that case, the participants in the mental health worker group and I have that in common, a professional field blindness that has shaped the interview conversation and that may have contributed to limit the exchange of other perspectives on the study's topic. Another researcher with a different background would perhaps have posed other kinds of questions and followed other leads, and thus produced a different data material. Reflecting upon one's own preunderstanding and field blindness and trying to be open to new perspectives is therefore important. Finlay (2008) described it as a dialectic dance between reduction and reflexivity, which means that the researcher relates to and reflects upon his/her own preunderstanding and at the same time is able to *see* the other and the phenomenon that is explored in a new way. This process is neither easy to do in practice nor to put into words (Finlay, 2008). I think I have managed to be open to new aspects of the phenomena under study. Several times during the data interpretation I felt excited, for instance when I understood the emotional aspects of the mental health nurses' work more in depth (and relating their care to the emotional labor theory), or when it became more clear to me that suicidal patients, in spite of their suffering and vulnerability, have a lot of strength and resources to change their life for the better. Furthermore, interpreting mental health workers' perceptions and experiences of treatment and care of suicidal patients in light of ethics of care and ethics of justice increased my understanding of the complexity of care.

6. FINDINGS

Summary of paper 1

Connecting with suicidal patients in psychiatric wards: Therapist challenges.

The aim of this study was to explore and describe aspects that may contribute towards shaping and possibly constraining therapists' connections with suicidal patients in psychiatric wards. I interviewed four psychiatrists and four psychologists and analyzed the data in collaboration with the coauthors by means of thematic analysis. We developed three main themes: Emphasis on categorizations of suffering and suicidality, Limited direct care of suicidal patients, and Fragmented mental health services. The findings suggest that high emphasis on diagnostics and standardized suicide risk assessments, limited direct (and one-to-one) care of the inpatients and fragmented services may challenge therapists' connections with suicidal patients. The study contributes to increased knowledge about ideological and organizational conditions influencing therapists' work, aspects that might challenge their efforts to connect with suicidal persons admitted to psychiatric hospital.

Summary of paper 2

Mental health nurses' experiences of caring for suicidal patients in psychiatric wards: An emotional endeavor.

The aim of this study was to investigate mental health nurses' experiences of recognizing and responding to suicidal behavior/self-harm and dealing with the emotional challenges in the care of potentially suicidal inpatients. I interviewed eight mental health nurses and analyzed the data in collaboration with the coauthors by means of systematic text condensation. We found that the participants' experiences involve alertness to patients' suicidal cues, relieving psychological pain and inspiring hope. In addition, experiences of suicide and suicidal acts evoke various emotions. The mental health nurses seem to regulate their emotions and emotional expressions, and balance emotional involvement and professional distance in an effort to take good care of the patients and themselves. The study contributes to increased knowledge of mental health nurses' specialized skills in identifying and responding to suicidal behavior. Our study suggests that mental health nurses are alert to and respond to all kinds of self-harm/suicidal acts to keep the patients safe. The nurses have thus an important role in the prevention of self-harm and suicide among inpatients. The nurses' work is however

emotionally demanding, and our study points to the importance of ensuring that they receive sufficient resources and support so they can continue to provide good care.

Summary of paper 3

Relational principles in the care of suicidal inpatients: Experiences of therapists and mental health nurses.

The aim of this study was to explore and compare the therapists' and the mental health nurses' experiences of caring for suicidal inpatients, and to interpret their experiences in light of two ethical perspectives; ethics of care and ethics of justice. The interview data of the professionals were analyzed in collaboration with the coauthors by means of systematic text condensation and then theoretically scrutinized. The findings indicate two approaches; connection and care, duty and control, both reflecting aspects of ethics of care and ethics of justice. The two approaches and the ethical perspectives appear largely intertwined. However, sometimes ethics of justice may be in conflict with ethics of care when the professionals' focus on biomedical aspects and clinical procedures contributes to less flexibility in encounters with patients and less focus on his/her particular needs. Accomplishing a good balance between formal obligations and attending to the patient's needs seems challenging, and our study suggests that a high emphasis on instrumental aspects might put the care of suicidal patients under pressure. The study contributes to increased insight into some of the (ethical) challenges mental health professionals face in the care of suicidal inpatients, and also points to some differences between the therapists' and nurses' roles and responsibilities. For instance, the therapists have more authority and legal responsibilities, and the nurses provide most of the direct care. The study increases the knowledge of ethical-theoretical perspectives and ethical dilemmas related to the care of suicidal inpatients.

Summary of paper 4

The need for connection and dignified care: Former suicidal inpatients' experiences of care in psychiatric wards in Norway.

The aim of this study was to illuminate how former suicidal inpatients have experienced treatment and care in psychiatric wards following the implementation of the National guidelines for the prevention of suicide in mental health care. The main focus was on aspects that can be improved in the care of suicidal inpatients. I interviewed five persons that had

been admitted to psychiatric hospital because of suicidality. The interview data were analyzed in collaboration with the coauthors by means of Interpretative Phenomenological Analysis (IPA). The findings consist of three themes: *"seeking a trusting connection", "seeking dignified care"*, and *"seeking support in their personal development"*. Although the participants reported mostly positive experiences of the care provided, there are examples of insufficient care. Sometimes, they experienced that their suffering and suicidality were not recognized or responded to in a dignified manner. Our study indicates that although there has been increased focus on suicidality in the services, among other through the national guidelines, some mental health workers need more competence and should focus more on how to provide dignified care of suicidal inpatients. From the perspectives of former suicidal service users, mental health workers should first and foremost recognize them as valuable persons, make efforts to connect with them, explore and understand their suicidality, and respond to their particular needs as well as promote their personal development. Based on the participants' experiences, mental health workers should use more of their personal qualities as empathic fellow beings when they respond to inpatients' suffering and suicidality. The study contributes with increased understanding of dignified care of suicidal inpatients, a topic that should be given a higher priority among policy makers, researchers, educators and practitioners.

7. DISCUSSION

The experiences and perceptions of the mental health workers and the former inpatients in this study, as well as parts of the literature, reflect two different ways of caring for the suicidal person; a relational, emotional and person-centered care, and a more biomedical and instrumental approach. These approaches involve both caring for the person, but also efforts to control the situation and any mental disorder and suicide risk. *Care* and *control* appear as significant aspects of the clinical care of suicidal inpatients, of which I will elaborate on next. Then, aspects related to the study's quality based on the principles relevance, validity and reflexivity are discussed. Finally, recommendations for clinical practice and future research are outlined.

7.1 Perspectives of clinical care for suicidal inpatients: Care and control

The therapists, the mental health nurses, and the former inpatients who participated in this study described a relational, emotional and person-centered care of suicidal patients. More specifically, the therapists thought it was important to establish stable, trusting and collaborative connections with the patients (Paper 1; Paper 3). The therapists appeared to make efforts to provide person-centered care and inspire hope, even though they had limited contact with the patients (sometimes just one or a few meetings) and had to spend much time on formal requirements and clinical procedures (Paper 1). The mental health nurses appeared emotionally involved in the care of suicidal inpatients, and they reported skills in recognizing and responding to suicidality among patients, relieving the patients' psychological pain and inspiring hope (Paper 2). Furthermore, patients' self-harm/suicide attempts and suicides evoked strong emotions in the nurses, and they seemed to engage in a lot of emotional work to provide good care of the patients and themselves (Paper 2). The former inpatients appreciated trusting connections with the mental health workers, which seemed to involve experiences of closeness, openness and fellowship with the care provider (Paper 4). Such a connection entailed feeling safe and comfortable with sharing personal problems including suicidality. Further, the former inpatients sought dignified care, which meant that the mental health workers treated them with respect, made them feel as valuable persons, took them seriously and recognized their suffering and suicidality (Paper 4). The former inpatients emphasized that the mental health workers used their personal qualities and acted as empathic fellow human beings (Paper 4).

The participants' experiences and appreciation of a relational, emotional and person-centered care are reflected in much of the literature. There are several authors arguing for a person-centered and collaborative approach (Jobes, 2006; Leenaars, 2004; Michel et al., 2002; Rogers, 1961, 1980), where the mental health worker engages in the patients' suffering and acknowledges them as valuable persons (Carlén & Bengtsson, 2007; Gordon, Cutcliffe & Stevenson, 2011; Lees et al., 2014; Samuelsson et al., 2000; Talseth et al., 1999; Talseth et al., 2001; Tzeng et al., 2010; Vatne & Nåden, 2014, 2016; Webb, 2010), and inspires hope through the interpersonal relationship (Cutcliffe & Barker, 2002; Cutcliffe & Stevenson, 2007; Cutcliffe et al., 2006). This approach's emphasis on the person's needs in his/her particular situation and on caring relations is in keeping with an ethics of care (Botes, 2000; Gilligan, 1982/1993; Held, 2006), which is part of the ethical framework that appears to influence mental health workers' care of suicidal patients (Paper 3). The care involves emotional labor (Hochschild, 1983/2003), particularly for those who provide most of the direct care of the suicidal patients, such as the mental health nurses (Paper 2). Part of the emotional work means balancing emotional involvement and professional distance (Paper 2), which is consistent with an ethics of care and the need to balance the needs of oneself (caregiver) and others (care-receiver) (Gilligan 1983/1993; Pettersen, 2008; Tronto, 1993/2009).

Person-centered care is largely in keeping with a recovery-oriented approach where the individual's lived experience, wishes, needs and resources are emphasized and the person is an active participant in his/her own recovery process (Anthony, 1993; Deegan 1996; Heller, 2014; Leamy et al., 2011). In this study, the interviews of the former suicidal inpatients illustrate that in spite of their problems and vulnerability they communicated strength and resources to change their lives for the better (Paper 4). The participants had learned much through their suffering and were still in a process of development and recovery, and they benefited from the support of mental health workers (Paper 4). However, even though mental health workers and patients emphasize a relational, emotional and person-centered care, there are certain aspects characteristic for current mental health services/psychiatry that may challenge such care.

In the present study, the participants' experiences and perceptions reflect that suicidality and suicidal patients sometimes are approached in a biomedical and instrumental manner (Paper 1; Paper 2; Paper 3; Paper 4), which seems related to the biomedical and technical paradigm

in psychiatry (Bracken et al., 2012), and the focus on risk factors of suicide and suicide risk assessments (Large, Galletly, Myles, Ryan, & Myles, 2017; Large & Ryan, 2014a), and on observation as a common safety intervention (Bowles, Dodds, Hackney, Sunderland & Thomas, 2002; Cutcliffe & Barker, 2002; Cutcliffe & Stevenson, 2008a; Vråle & Steen, 2005). Marsh (2010) has provided valuable insight into (and problematized) how suicide and suicidality have been framed within a medical and psychiatric paradigm since the early nineteenth century. The focus on instrumental aspects and standardization is in keeping with the rational-technical and universal thinking in an ethics of justice (Botes, 2000; Gilligan 1982/1993; Held, 2006), which is part of the ethical framework that seems to influence mental health workers' care of suicidal patients and their efforts to control suicide risk (Paper 3).

More specifically related to our study, the therapists emphasized to categorize the patients' suffering and suicidality to clarify diagnosis and subsequent treatment, as well as suicide risk and any safety interventions (Paper 1; Paper 3). The mental health nurses appeared to have similar views with regard to mental disorders and suicide risk, although they talked less about diagnoses and treatment (Paper 3). Suicidality could be controlled and prevented if it only was a consequence of treatable mental disorders. In fact, a common assumption is that there is a strong association between suicide and mental disorders, which is promoted by research asserting that at least 90% of all suicides are related to mental disorders (Cavanagh et al., 2003), or other research focusing on the increased risk of suicide in people with certain disorders (e.g., Chesney, 2014; Qin, 2011). The 90% statistic is largely based on psychological autopsy studies with a focus on mental disorders and where the diagnosis is assigned the person - the deceased - after the suicide, based on the responses of someone else (Hjelmeland et al., 2012). This diagnostic process is problematic, mainly because of the questions in the standardized diagnostic instruments and because questions related to subjective feelings, thoughts and experiences cannot be answered *reliably* by anyone else than the person himself (Hjelmeland et al., 2012). Thus, Hjelmeland and colleagues (2012) concluded that because of this and other methodological weaknesses, psychological autopsy studies cannot constitute a *valid* evidence base for such a strong association between mental disorders and suicide. The authors do not claim there is no association, but even though there is a relationship between mental disorders and suicide we do not know *how*, and the suicide may be related to other aspects than the disorder itself (Hjelmeland & Knizek, 2017). Furthermore, even though the suicide risk is increased in people with mental disorders, most people with a mental disorder do not take their own lives (Hjelmeland & Knizek, 2017). It is

thus insufficient to focus on detection and treatment of mental disorders in suicide prevention. Such a focus may even be unfortunate, as it may contribute to less attention on other important cultural, social, and political aspects contributing to suicide/suicidality (Pridmore, 2011), and people can mistakenly believe there is no suicide risk if there is no mental disorder present (Dyregrov, 2008).

In specialized mental health services, which constitute the context of this study, prioritizing diagnostics and treatment of mental disorders is required and common practice, as also found in this study (Paper 1; Paper 3). However, the present study shows that persons who have been suicidal have reported negative experiences with regard to meeting professionals focusing much on mental disorders and medical treatment (Paper 4), which is in keeping with what other former suicidal patients have communicated in previous research (Talseth et al., 1999; Talseth et al., 2001; Webb, 2010). Some participants expressed doubts about the diagnosis/diagnoses assigned to them, and one of them found it difficult to accept the diagnosis assigned to her at all (Paper 4). Further, four of them experienced limited or no effect of antidepressants and other medication in addition to negative side effects (Paper 4). These experiences indicate that even in this setting, a high emphasis on biomedical and instrumental approaches can be unfortunate for the care of the patient experiencing suicidality. Related topics are the validity and utility of psychiatric diagnoses in general, and the effectiveness of psychotropic medication, which are discussed by several authors who are critical towards current practices in mental health services (Gøtzsche, 2013; Kinderman, 2014; Kinderman, Read, Moncrieff, & Bentall, 2013; Whitaker, 2010). Furthermore, another characteristic of the study context is that the mental health services are fragmented, i.e., the division of several different inpatient and outpatient units, which may both challenge stable connections between professionals and suicidal patients and continuity of care (Paper 1). The fragmentation of the services reflects an instrumental approach where considerations of efficiency are emphasized on the expense of the patients' need for stable connections with mental health workers.

The present study (Paper 1; Paper 3) shows that mental health professionals' perceptions and experiences are influenced by The *National guidelines for the prevention of suicide in mental health care,* which have a high emphasis on assessment and management of risk factors (such as mental disorders), and suicide risk (Norwegian Directorate of Health and Social Affairs, 2008). In fact, the word *risk* (such as in suicide risk, risk factor and so forth) is written 147

times in the document, whereas words such as care and empathy are barely mentioned. The guidelines' focus on assessment and management of suicide risk may have contributed to an exaggerated faith in standardized suicide risk assessments (Hagen, Hjelmeland, & Knizek, 2014). The present study indicates that mental health workers attempt to control suicide risk by performing suicide risk assessments (Paper 1; Paper 3). However, there are certain problems related to such procedures. First, the predictive value of such assessments is low (Cassells, Paterson, Dowding, & Morrison, 2005; Large et al., 2017; Powell, Geddes, Hawton, Deeks, & Goldacre, 2000). In a Norwegian study, it was found that routine suicide risk assessments based on the recommendations in the national guidelines (Norwegian Directorate of Health and Social Affairs, 2008) had low predictive value, thus the utility of such assessments was questioned (Fosse, Ryberg, Carlsson, & Hammer, 2017). Further, to identify a number of suicide risk factors does not improve the predictive strength of the risk assessment (Large et al., 2017). The value of suicide risk categorization (high and low-risk groups) and risk assessments seem limited (Large et al., 2016), and we lack evidence that risk categorizations can reduce suicidal acts or suicide (Large, Ryan, & Nielssen, 2011; Wand, 2012). Some authors have suggested that suicide risk categorization should not guide clinical decision-making, and that policies and guidelines requiring such categorizations should be withdrawn (Large & Ryan, 2014a). In Norway, several clinicians/researchers have expressed dissatisfaction with the *National guidelines for the prevention of suicide in mental health care* and its focus on risk factors and suicide risk assessments, because such an emphasis can be unfortunate for clinical practice and the care of potentially suicidal patients (Aarre, Hammer, & Stangeland, 2017, Hagen et al., 2014; Straume, 2014). Thus, the guidelines should be revised (Aarre et al., 2017).

Another problem related to assessment and management of suicide risk that was found in the present study (Paper 1; Paper 3) is "secondary risk management", that is, managing risks - personal and legal - posed to oneself and the institution (Power, 2004). Secondary risk management can threaten the quality of different services because then, professionals are more preoccupied with themselves (how they can protect and defend themselves against negative outcomes) and the organization's reputation than with the service user's needs (Power, 2004). Undrill (2007) wrote about the *risks of risk assessment*, such as health workers' self-protective acts and anti-therapeutic interventions with the purpose of minimizing their own anxiety evoked by the risk assessment. Rogers and Soyka (2004) described the current crisis intervention model (which involves mechanistic and superficial

assessment of the patient's mental state and suicide risk) as a "one-size-fits-all" approach that can be de-humanizing and contribute to exacerbate suicide risk. The authors noted that the approach has created an illusion of competence that has led to others perspectives and approaches not being taken into account (Rogers & Soyka, 2004). Further, it appears that current suicide risk management has created an illusion of control, where it is assumed that mental health workers have more control of patients' suicidality and suicide risk than they can have.

Tensions between care and control

The findings in this study indicate that the different ways of caring for the suicidal patient are largely intertwined. However, there might be some tension and potential conflict between the relational, emotional, and person-centered approach on the one hand, and the biomedical and instrumental approach on the other, or between what I have referred to as *care* and *control*. For example, mental health workers think a good professional-patient relationship is important to enhance the suicidal patient's connection to life, but they also view it as a means to achieve treatment collaboration and compliance (Paper 3). Furthermore, some experiences and perceptions reported by mental health workers and former suicidal inpatients in this study (Paper 1; Paper 3; Paper 4) reflect what Balint (1957/1963) described as the clinician's "apostolic function", which implies that professionals attempt to "convert" patients to believe in and accept their standards and treatment interventions.

Another example is that mental health workers assess and document suicide risk with the intention of protecting the patients, but they perform such procedures also to protect themselves (secondary risk management), that is, trying to avoid negative consequences and demonstrating to others (society, health authorities, relatives) that they make efforts to control the situation and suicide risk (Paper 1; Paper 3). Further, the nurses' observation (e.g., every 15 minute or continuous) of patients appears both as a caring intervention to prevent the person from harming himself, and as an instrumental approach where regular "check-ups" (which are documented) serve as control (Paper 2; Paper 3). According to ethics of care, it is important to attend to the needs of oneself as well as the patient's needs (Gilligan 1983/1993; Pettersen, 2008). However, important questions are; when does the balance shift towards more concern with one's own or the institution's or the health authorities' interests rather than with the patient's? And when can we say care is overshadowed by professionals' need and efforts to control the situation?

Other authors indicate the tension and potential conflict between care and control; some have raised concern about a shift away from care towards control in mental health care (Hannigan & Cutcliffe, 2002), which is also reflected in national suicide prevention strategies (Cutcliffe & Stevenson, 2008b). Some have suggested to "shift professionals' beliefs from *cure* to *care* and actions from *control* to *connection"* (Gordon, Cutcliffe & Stevenson, 2011, p.37). Care is complex, however, and involves various expressions, including self-sacrifice and paternalism/maternalism (Held, 2006; Tronto, 1993/2009), and loving and empowering care may easily become something disempowering and controlling (Fox, 1995). The tension between care and control is probably especially challenging in a hospital setting where mental health workers try to protect the patients from self-harm and suicide. Even though formal observation of patients (continuous or at certain time intervals) is common in an effort to prevent patients from harming themselves, as also demonstrated in this study (Paper 3), several authors have argued against such an approach because it may be ineffective and counter-productive, and patients may not feel well taken care of (Bowles et al., 2002; Buchanan-Barker & Barker, 2005; Cutcliffe & Barker, 2002). Patients' experiences of observation appear strongly influenced by who the observers are and how they act, and negative experiences (reported by suicidal patients in particular) have been related to being together with nurses who did not know them or did not talk to them (Jones, Ward, Wellman, Hall & Lowe, 2000). Patfield (2000, p.372) asserted that professionals' efforts to make the environment "safer" (e.g. by monitoring and control) may contribute to worsen the well-being of the patients, thus frustrating the professionals' goal of helping them and paradoxically make suicide more likely. The possibility for "nosocomial suicides", that is, suicides related to negative experiences of the hospitalization itself (Large, Ryan, Walsh, Stein-Parbury, & Patfield, 2014) must be taken seriously and should be further investigated (Large, Chung, Davidson, Weiser, & Ryan, 2017).

Protection thus needs to be provided within an ethical framework of care (Sun et al., 2006), where the professionals prioritize to engage closely with the person, and respond to his/her psychological pain and specific needs in a way that promotes human connection and inspires hope (Bowles et al., 2002; Cutcliffe & Barker, 2002; Patfield, 2000; Shneidman, 1985, 1993). Suicidal inpatients' experiences of safety in psychiatric wards are related to *feeling safe*, which is highly dependent on their connections with care providers who meet their needs (Berg et al., 2017). The present study shows that it is important that mental health workers

establish a trusting connection with the patient to get insight into the person's lived experience of suicidality (Paper 4). If not, the person will probably not share her/his painful thoughts and emotions or make any contact with the professional when she/he is about to self-harm/attempt suicide (Paper 1; Paper 4), which is also pointed out in previous research (Samuelsson et al., 2000). An existential-constructivist alternative is less of "a way to do" assessment and intervention and more of "a way to be" in the process of connecting with the suicidal person, engaging in a growth-promoting relationship where the context and meaning of the suicidality is explored more in depth (Rogers & Soyka, 2004). This 'way of being' is phenomenological in spirit, thus, qualities and skills in qualitative research are transferable to clinical practice and vice versa (Finlay, 2011). Close engagement with patients struggling with suicidality involves being self-reflective (Gilje et al., 2005), being 'at home' with self (Gilje & Talseth, 2007), and opening one's own inner door (Tzeng et al., 2010). Such relational and emotional care can contribute to increase the patients' understanding of themselves and their suicidality, and help them to uncover or recover their 'at homeness' (Gilje & Talseth, 2007), and opening their inner door (Tzeng et al., 2010), so they can feel reconnected (with self and others) and hopeful (Cutcliffe et al., 2006). The former inpatients in this study seemed to seek such care (Paper 4).

One important issue, though, is that mental health workers appear to be required to prioritize a biomedical and instrumental approach over a relational, emotional, and person-centered approach. At least, such a priority is reflected in the *National guidelines for the prevention of suicide in mental health care* (Norwegian Directorate of Health and Social Affairs, 2008). In this setting, the mental health workers have to meet formal requirements, including clinical procedures and interventions (for instance related to diagnostics, suicide risk assessments and safety interventions such as observation) imposed on them (Paper 1; paper 3). The mental health workers participating in this study seem to largely support these procedures and interventions. However, sometimes, they question the usefulness of them or think that such procedures may contribute to less flexibility in their meetings with patients (Paper 1; Paper 3). Some of the mental health workers' and former inpatients' experiences suggest that an emphasis on biomedical and instrumental aspects can be unfortunate for the professional-patient connection as well as for the well-being of the patient (Paper 1; Paper 3; Paper 4). It may contribute to fundamental aspects, such as the professional-patient connection and person-centered care, are not first priority, although such aspects are vital in order to provide a

good and safe mental health care and in the prevention of suicide (Berg et al., 2017; Sun et al., 2006a, 2006b; Talseth et al., 1999; Talseth et al., 2001; Vatne & Nåden, 2014, 2016).

In summary, the main findings in the present study indicate that clinical care of suicidal inpatients involve aspects of care and control, including both a relational, emotional, and person-centered care, and a biomedical and instrumental approach. The findings suggest that the different approaches are largely intertwined. However, there are tensions and potential conflicts between the different ways of understanding and responding to suicidality. Sometimes, a biomedical and instrumental approach seems to have priority over the relational and person-centered approach. Such a priority appears related to the biomedical paradigm in psychiatry, and an emphasis on detecting and treating mental disorders and performing suicide risk assessments to manage suicide risk. However, such a priority may have negative consequences for the care of suicidal patients.

7.2 Relevance, validity, and reflexivity

Quality criteria can be useful for evaluating qualitative research and for learning how to conduct good qualitative research (Tracy, 2010). However, there are a range of criteria for assessing the quality of qualitative research, among others, trustworthiness (credibility, transferability, dependability, and confirmability) (Shenton, 2004), sensitivity to context, commitment and rigor, transparency, and coherence (Yardley, 2000), and analytic generalization and transferability (Polit & Beck, 2010). In addition, researchers representing different analytic approaches, such as Thematic Analysis (Braun & Clarke, 2006), Interpretative Phenomenological Analysis (Smith, 2011) and Qualitative content analysis (Graneheim & Lundman, 2004) describe their own criteria for what constitutes a good analysis and a good paper. There is no consensus on what criteria or procedures to apply for evaluating qualitative research (Denzin, 2009). During this project, several journals referred to the 22-item checklist (COREQ) (Tong, Sainsbury, & Craig, 2007) in the author guidelines, thus, indicating that this checklist has gained greater influence on current qualitative studies. Considering the diversity of qualitative research, Denzin (2009) argued for flexible guidelines adjusted to the specific genres. I have chosen to discuss aspects related to the quality of this study based on principles proposed by Malterud (2001, 2017); relevance, validity and reflexivity.

This study has relevance both to suicide prevention in general and to clinical practice in particular. One of the study's strengths is that the research is conducted close to clinical practice and those engaged in it, that is, both professionals and former inpatients. The triangulation of sampling has contributed to several perspectives regarding treatment and care of suicidal patients in psychiatric wards, which together provide an insight into current mental health care. However, triangulation of data collection methods (e.g. observation) could have strengthened the data material further, and thus strengthened the study's relevance and validity. The findings in this study are closely connected to the context in which they were developed. Nevertheless, the findings can apply to other similar clinical settings and other persons in similar situations as the participants. Thus, the findings may have a certain degree of transferability (Malterud, 2001, 2017). However, the assessment of transferability will largely depend on the viewpoints of readers and consumers of the research (Polit & Beck, 2010).

During the interviews, I posed confirmatory questions to the participants in an attempt to clarify their perceptions and experiences and avoid misunderstandings (Kvale & Brinkmann, 2009). I did not seek feedback from the participants with regard to the transcripts and findings (participant validation or member check) because of problems related to such strategies (Giorgi, 2008; Sandelowski, 1993). Among other, the researcher and the participants have different stories and different agendas, and they have different understandings of what constitute scientific findings or good accounts (Sandelowski, 1993). Furthermore, the participants may have forgotten some of the information they provided or they may want to change or remove parts of the data, which in turn, may influence the findings (Sandelowski, 1993). However, as Sandelowski (1993) noted, the participants' stories are constantly changing and represent the participants' experiences and views at a particular moment. Giorgi (2008) pointed to that using phenomenological methods is time consuming and challenging, and allowing the participants to change parts of the findings or the final account would make such analyses fragile. The analysis was conducted in collaboration with my co-authors to bring several perspectives to the interpretations and in an effort to prevent that my preunderstandings would block for new insight. The participants may not agree with all the choices I/we have made, yet, the findings are grounded in the data and serve the purpose of developing the knowledge within the field, which is in keeping with The National Committee for Medical and Health Research Ethics' (2010) guidance for research ethics and scientific evaluation of qualitative research in medicine and health sciences.

I have attempted to have a reflective attitude throughout the research process. In this thesis, reflexivity is discussed particularly with regard to my position as researcher and mental health worker, and how my background and preunderstandings might have influenced the research process (see ethical considerations, section 5.6.3). Denzin (2009) problematized that trust is highlighted as an issue particularly for qualitative and not quantitative researchers, in terms of that lack of trust is introduced in the research process due to influence the perspective of the qualitative researcher can have on the development of knowledge. However, as Denzin (2009) asserted, we are all blinded by our own perspectives, and we can never know the true nature of things. In keeping with a social constructionist view, knowledge is always partial and continuously evolving (Gergen, 1985; Denzin, 2009).

7.3 Recommendations for clinical practice

First, the focus in the care of suicidal patients should be reconsidered, which implies to give a higher priority to a relational, emotional, and person-centered care. Such a priority entails increased focus on mental health workers' communication skills and their ability to achieve trusting connections with suicidal patients. Such competence should not be underestimated or taken for granted by clinicians, management of mental health services or health authorities. Furthermore, mental health workers should focus more on the suicidal patients' experiences, needs, wishes, and resources, and support the patients in the process of finding meaning and learning from the suffering (including suicidality) (Cutcliffe, Hummelvoll, Granerud & Eriksson, 2015), which is in keeping with a recovery-oriented mental health care (Anthony, 1993). Mental health workers should receive sufficient education, training and support so they are able to connect with the patients and provide the kind of care that people with lived experience with suicidality seek.

An emphasis on a relational, emotional, and person-centered care should be reflected in policy and clinical guidelines so that professionals are encouraged to focus even more on the *person* in front of them and try to grasp the complexity of the patient's suicidality, rather than on being too occupied of categorizing the person's mental suffering and suicide risk. This means that mental health care - even in this context of psychiatric hospital settings - should be less biomedical and less risk management oriented. The *National guidelines for the prevention of suicide in mental health care* (Norwegian Directorate of Health and Social Affairs, 2008)

should be revised in order to contribute to change the focus in the care of people who are or who might become suicidal.

Second, the significant role of mental health nurses should be more recognized. Nurses who work day and nights shifts in the wards provide most of the direct care of inpatients, and with experience they can learn to be alert to and respond to the patients' suicidal cues (Paper 2), and are thus in a very significant position to recognize and respond to the patients' suicidality (Cutcliffe & Barker, 2002; Cutcliffe & Stevenson, 2007). This kind of competence should be more emphasized. However, the nurses' competence and role seem undervalued. At least, their role is barely mentioned in the *National guidelines for the prevention of suicide in mental health care* (Norwegian Directorate of Health and Social Affairs, 2008). There, it is the responsibility and competence of the therapists (psychiatrists and psychologists) that are emphasized. Furthermore, the emotional labor - with its different aspects, benefits and costs - which is a significant part of the nurses' work, should be more valued and made more visible. The emotional and relational care is very important, yet it is challenging and can be emotionally straining. Thus, the care providers should be ensured sufficient education, training and formal support (including regular clinical supervision) so they are able to provide the kind of care that patients experiencing suicidality need. By strengthening the position of mental health nurses and acknowledging their significant role in providing good and dignified care of suicidal inpatients, the suicide preventive work in the services can be improved.

7.4 Recommendations for future research

We need more qualitative research, including field studies in psychiatric hospital wards, where interview data can be complemented with observational data. In addition to listening to professionals' and patients' narratives, we need to collect data on how they act and engage with each other in practice. Future studies should further investigate aspects that may promote or hinder good professional-patient connections, and whether certain procedures and interventions might contribute to suppress dignified care of suicidal inpatients. Further, we need to study experienced mental health nurses' (and other professionals') ability to recognize suicidal cues communicated by patients who are about to harm themselves. In this respect, we need more knowledge of characteristics of suicidal cues or warning signs, and how nurses and other professionals can develop competence in recognizing and responding to such cues. In addition, several studies should explore the emotional aspects and the emotional work

involved in the care of suicidal patients. Future research should further study dignified care of suicidal patients, particularly what such care means to people with lived experience of suicidality. Furthermore, former suicidal service users should be involved as collaborators or co-researchers to strengthen their position and perspectives in research as well as in clinical practice. A recovery framework (e.g., Heller, 2015; Leamy, Bird, Bouitillier, Williams, & Slade, 2011) with a focus on studying the suicidal person's personal recovery process and resources to develop or change a life situation for the better would be fruitful.

Knowledge development in suicide prevention needs to be more based on the perspectives of people who have experienced how it *feels* to be suicidal. Webb (2010, p.166), who wrote a PhD thesis based on his personal experiences of suicidality and recovery, stressed that we need to recognize and listen more to the first-person voice of the suicidal person: "*Suicide prevention needs to hear from those who know suicide 'from the inside'*".

8. CONCLUDING REMARKS

People who experience a suicidal crisis need to connect with empathic fellow human beings who recognize and respond to their suffering and needs. This study has provided increased knowledge about how mental health workers and former inpatients have perceived and experienced treatment and care of suicidal inpatients in psychiatric wards. The findings show experiences of good connections between professionals and suicidal patients and experiences of good care, but the findings also show examples of challenging encounters or connections between professionals and suicidal patients and experiences of insufficient or poor care. In the present thesis, as in the four papers written during the study, the main focus has been on challenging aspects of care and on how the care of suicidal patients can be improved.

Clinical care of suicidal inpatients appears to involve aspects of *care,* including relational, emotional, and person-centered care, as well as *control*, involving a biomedical and instrumental approach. Even though these two approaches seem largely intertwined in clinical practice, there are tensions and potential conflicts between the different ways of understanding and responding to suicidality. In fact, the care of persons struggling with suicidality appears to be under pressure as the mental health care system is increasingly shaped by standardization and clinical guidelines with a focus on detection and treatment of mental disorders and management of suicide risk. As the present study shows, this may constrain professionals' efforts to connect with the suicidal individual and hamper the kind of care suicidal persons seeks. Thus, we should reconsider the focus in the mental health care of suicidal patients by giving much higher priority to a relational, emotional, and person-centered care. Such a priority should be reflected in policy and practice. Further, the role of those who provide most of the direct care of suicidal patients, such as mental health nurses, need to be more recognized in the suicide preventive work in the services.

Caring for suicidal patients in psychiatric wards is challenging for mental health workers. There are no simple answers or simple solutions with regard to how to prevent persons from taking their own lives. Suicidality is a complex phenomenon. However, this complexity should not be feared and simplified, but embraced and further studied in order to provide the field of suicide prevention new and hopefully life promoting perspectives in the future.

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PAPERS 1-4 & INTERVIEW GUIDES

Paper I

Hagen, Julia; Hjelmeland, Heidi Marie; Knizek, Birthe Loa. Connecting with suicidal patients in psychiatric wards: Therapist challenges. Death Studies 2017 ;Volum 41.(6) s. 360-367.

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Paper II

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Mental Health Nurses' Experiences of Caring for Suicidal Patients in Psychiatric Wards: An Emotional Endeavor

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A B S T R A C T

The purpose of the study is to investigate mental health nurses' experiences of recognizing and responding to suicidal behavior/self-harm and dealing with the emotional challenges in the care of potentially suicidal inpatients. Interview data of eight mental health nurses were analyzed by systematic text condensation. The participants reported alertness to patients' suicidal cues, relieving psychological pain and inspiring hope. Various emotions are evoked by suicidal behavior. Mental health nurses seem to regulate their emotions and emotional expressions, and balance involvement and distance to provide good care of patients and themselves. Mental health nurses have an important role and should receive sufficient formal support.

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Caring for patients with suicidal behavior is one of the most challenging tasks for mental health nurses in psychiatric wards, and preventing suicidal acts may be difficult. Suicide prevention in mental health services involves suicide risk assessments that should not only be based on standard risk factors (Cassells, Paterson, Dowding, & Morrison, 2005; Paterson et al., 2008), but warning signs; 'what is my patient doing (observable signs) or saying (expressed symptoms) that elevates his or her risk to die by suicide …'(Rudd, 2008, p. 88). The latter requires more involvement with the patient, exploring aspects relevant to the individual's suicide risk at that particular moment. In Norway, it is the therapist (psychiatrist/psychologist) who has the main responsibility for performing and documenting assessments of inpatients' suicide risk (National guidelines for Prevention of Suicide in Mental Health Care, Norwegian Directorate of Health and Social Affairs, 2008). However, nurses provide most of the direct care of the patients and have the opportunity to identify warning signs of suicide and prevent suicidal behavior (Bolster, Holliday, Oneal, & Shaw, 2015; Cutcliffe & Barker, 2002). According to Sun, Long, Boore, and Tsao (2005); Sun, Long, Boore, and Tsao (2006), nurses assessed patients' suicide risk through vigilant observation, recognizing warning signs, using their interviewing skills and gathering information about cues to suicide. Assessing the patients continuously throughout the hospital stay seems important to capture the patient's changing state of mind (Aflague & Ferszt, 2010; Sun et al., 2005). However, some nurses are not properly educated and trained in suicide assessments (Bolster et al., 2015).

The recognition of patients' suicide risk should lead to meaningful interventions (Cutcliffe & Stevenson, 2007, 2008a). The literature has pointed to the importance of nurses engaging in a close relationship with the suicidal patient (Cutcliffe & Barker, 2002; Cutcliffe & Stevenson, 2008b; Gilje & Talseth, 2014), where the patient feels confirmed as a significant human being (Samuelsson, Wiklander, Åsberg, & Saveman, 2000; Talseth, Lindseth, Jacobsson, & Norberg, 1999; Vatne & Nåden, 2014) and is moved from a 'death-oriented' position to a 'life-oriented' position through the process of 're-connecting with humanity' (Cutcliffe & Stevenson, 2007; Cutcliffe, Stevenson, Jackson, & Smith, 2006). However, patients have reported that experiences of not being sufficiently cared for (e.g. lack of confirmation, not being seen) have led to increased suicidal behavior while hospitalized (Talseth et al., 1999; Samuelsson et al., 2000).

Caring for suicidal patients is emotionally demanding (Cutcliffe & Barker, 2002; Cutcliffe & Stevenson, 2008a, 2008b), and suicide/suicide attempt/self-harm evoke painful feelings in the professionals (Bohan & Doyle et al., 2008; Castelli-Dransart et al., 2014; Joyce & Wallbridge, 2003; Séguin, Bordeleau, Drouin, Castelli-Dransart, & Giasson, 2014; Takahashi et al., 2011; Valente & Saunders, 2002; Wilstrand, Lindgren, Gilje, & Olofsson, 2007; Wurst et al., 2010). It has been suggested that nurses may distance themselves in meetings with suicidal patients to protect themselves from emotional discomfort (Carlén & Bengtsson, 2007; Talseth, Lindseth, Jacobsson, & Norberg, 1997). To cope with the challenges involved in the care of potentially suicidal patients the literature has emphasized sufficient education, training, supervision and support (Bohan & Doyle, 2008; Cutcliffe & Barker, 2002; Cutcliffe & Stevenson, 2008a; Gilje & Talseth, 2014; Takahashi et al., 2011; Talseth & Gilje, 2011; Wilstrand et al., 2007).

The aim of this study is to extend the existing literature and develop further the knowledge of how mental health nurses deal with the variety of demands in the care of potentially suicidal patients in psychiatric

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wards: How do they experience their skills with regard to recognizing and responding to suicidal behavior/self-harm among patients? How do they react to suicide and suicidal acts, and deal with the emotional challenges in the care of patients at risk of suicide? We use the term 'suicidal patient' with an awareness of the diversity and complexity of each person's suicidality and related problems.

MATERIALS AND METHODS

Participants

A purposive sample of eight mental health nurses (seven women, one man) aged 43–60 years working in two different hospitals and five different psychiatric wards in Norway participated in the study. The lack of gender difference largely reflects the situation in many psychiatric wards where the majority of mental health nurses are female. In addition, the units' management assisted in recruiting mental health nurses with experience of caring for suicidal patients in psychiatric wards, thus, clinical experience and willingness to participate was emphasized regardless of gender. Thereby, the strategy for selecting the study subjects (purposefully) was influenced by homogenous sampling (in terms of professional background and clinical experience) and convenience sampling (Patton, 1990). Their professional experience in psychiatric hospital ranged from 5–25 years. Seven nurses had 15 years of experience or more. Five of the nurses worked in an acute ward, one in an acute/crisis unit, one in a specialized ward and one worked in a rehabilitation ward.

Interview Procedure

The first author conducted the interviews. Seven of the nurses were interviewed at their respective working places (available office/meeting room in or outside the ward, one interview was conducted in a vacant patient room), and one of the participants was interviewed in a meeting room not located at the hospital. The interviews lasted from 48 minutes to 1 hour and 22 minutes. A semi-structured interview guide was used as a tool to obtain detailed descriptions of the nurses' caring experiences, including both good interactions with suicidal patients and challenging experiences involving suicidal acts and suicide among patients. Main questions were: How do you experience working in a psychiatric ward? How do you experience meetings with suicidal patients? Can you describe a situation where you did/did not achieve a good relationship with a suicidal patient? Have you experienced that a patient have attempted suicide or taken his/her life? Can you describe your experiences with regard to that? All interviews were recorded and transcribed verbatim.

Data Analysis

The data were analyzed by means of systematic text condensation (Malterud, 2011, 2012). The approach is inspired by Giorgi's phenomenological analysis (Giorgi, 1985, cited in Malterud, 2011), and is described as a four-step procedure: (1) reading the transcripts to get an overall impression and identifying preliminary themes (e.g. emotional burdens, colleague support); (2) extracting meaning units from the transcripts and sorting them into codes (e.g. being calm and steady), and code groups (e.g. managing emotion); (3) condensing the meaning within each code group; (4) summarizing the content into meaningful descriptions (Malterud, 2011, 2012). Two simplified examples of the analytic approach are illustrated in Table 1. All authors read the transcripts, and the first author conducted all steps of the analysis and discussed the interpretations with the second and third author during the process. The first author's background as mental health nurse with knowledge and experience within the field has influenced the process of collecting and interpreting data. The final descriptions were developed and refined over time, and transcripts were read repeatedly during this hermeneutical process (moving back and forth between data and the literature) to ensure that the constructed descriptions were grounded in the empirical data (Malterud, 2011, 2012).

Ethical Considerations

The Regional Committee for Medical and Health Research Ethics approved the study. The mental health nurses signed an informed consent to participate. They were informed that they at any time could withdraw from the study (until publication) without giving any reason. Data were treated confidentially and information about the nurses and their interactions with suicidal patients is presented in such a way that they are not identifiable. All nurses and described patients are referred to as "she" to protect their anonymity.

FINDINGS

We found that the mental health nurses' experiences involve being alert to suicidal cues, relieving the patients' psychological pain and inspiring hope. Further, experiences of suicide and suicidal acts evoke various emotions. The nurses seem to regulate their emotions and emotional expressions and balance their emotional involvement and professional distance in the relationships with the patients in order to provide good care of the patients as well as themselves. These findings are elaborated below.

Alertness to Suicidal Cues

Seven of the mental health nurses' accounts indicate that they are sensitive and alert to the patients' emotional state and pick up suicidal cues or warning signs, which they act upon to prevent self-harm/suicidal acts. Three of the nurses use the phrase *"gut feeling"* to describe their feelings or sensations of the patient's mental state and the situation. It appears that they very much rely on intuitive knowledge, although they acknowledge that they sometimes may be wrong. Several participants believe that they have saved patients by acting at the right time.

> *We have saved many people, we managed to, so in the moment we should be there, we were there. We managed to save them. (…)… gut-feeling is very important then. And then, so it has happened that,*

Table 1
Examples of the Analytic Approach.

Excerpt of meaning unit	Codes	Code group *condensed unit	Description
Experience over many years, signals emitted that are a bit difficult to explain. But – but many patients we know (…) Signals that the other sends out that – that tells me a little bit about plans.. of self-harm that could lead to something more, that is.	Experience, signals emitted, capture signals of self-harm	Responding to suicidality * The informant seems sensitive, and picks up signs of self-harm/suicidal acts	Alertness to suicidal cues
…if there are too many admissions in here, then I am little afraid that we quickly may become both mom, sister, aunt, friend, etc. *And what is then left of the motivation to go out in the world and find it, I think. So to be warm and empathetic on the one hand, but do not become everything for the patient on the other hand, that is an art as I see it.*	Many admissions, danger of becoming mom, sister, friend warm and empathetic, but do not become everything, an art	Managing emotion *It seems important to be close, but prevent being too emotional close to the patients	Balancing emotional involvement and professional distance

you have supervision of a patient every 15 minutes, but that does not mean that 15 minutes is 15 minutes, you can die within 15 minutes, right? (…) But you check on the patient once, and then your gut-feeling tells you that, oh, no, you [the patient] are lying calm and smiling. But, then the gut-feeling tells you to come back in one minute and surprise her.(…) And then, then you're right, that has happened, that I have experienced. You come, you go out and close the door and then look back, oh, what is she doing (…) is about to strangle herself or hang herself ".

The nurse seemed to respond to subtle non-verbal signs communicated by the patient. Several statements from the participants show that, in addition to the assessments and decisions made by the therapist/psychiatrist, they make their own judgment regarding suicide risk and implementation of safety measures based on their intuitive sense of the patient's mental state. Although the nurses talk about differences between caring for patients who self-harm and patients who attempt suicide, or patients who are 'acute' or 'chronic'[1] suicidal, they seem to think that the outcome (suicide) can be the same regardless if they do not act to rescue them in time.

"It is like balancing just barely. She [the patient] *knows exactly the mg of paracetamol, for example, (…) And knows exactly when to make themselves known, or make sure to be found. It can be strangulation just enough to allow passage of some oxygen and a little circulation. (…) If we then do not find the person in time, the person will then die, so in that respect he is suicidal, right. So that is - that is another group of patients really, it is. But the outcome can be the same".*

The statement suggests that it might not always be useful to distinguish between suicide attempts and self-harm, (or 'acute' vs. 'chronic' suicidal), and to claim that only the former action is suicidal and the latter is not. The nurses' alertness to suicidal cues seems to relate to all patients engaging in suicidal acts.

One important challenge is that staff members lacking competence and/or clinical experience (e.g. temporary staff working in the summer and occasionally in the afternoons/weekends), seem to lack the skill to pick up suicidal cues or other signs indicating exacerbation in patients' mental state. *"…if the patient does not take his own life, we have – we do have more self-harm when we have a lot of temporary staff in the ward in the summer. We do. We also have more like acting out, we notice that too. (…) they do not pick up the signals before the turmoil starts, right".* It appears to be difficult to provide good care if several of the staff members on duty lack competence, which may lead to failure in the follow-up of suicidal patients and/or increased self-destructive behavior.

Relieving Psychological Pain and Inspiring Hope

Several of the mental health nurses' descriptions of interactions with suicidal patients were about relieving their psychological pain and inspiring hope. This process seems to involve gaining a joint understanding of the patient's life situation and suicidality, and then, helping the patient to be more oriented toward life and the future. Broadening the patient's perspectives and making the patient more receptive to positive input seem to be part of this process.

"…to try to open some hatches to let in some light, so to speak, I am very engaged in then, when it comes to conversations. Because, if everything is revolving around the sad, terrible, and…then I think we are like taping black bags on the windows, making it even more black. I am a little concerned about trying to open some hatches and then getting in some more light".

This metaphorical description illustrates the importance of drawing attention to life and possibilities for change and improvement in the situation, and not only focusing on the suicidality and related problems, although exploring the person's psychological pain and the background of the suicidality seems to be part of the process. However, although all participants are specialized in mental health nursing, one of them stated that she does not feel educated or confident enough to talk with patients about suicide, and another informant stated that there should be much more focus on caring for suicidal persons in the education.

Emotions Evoked by Suicide and Suicidal Acts

All nurses expressed sadness related to patient suicides, and one of them said that suicide was the worst part of the job. Several of the participants' statements express guilt after suicide/suicidal acts. *"And the bad thing is when they actually do it [suicide]. You feel a bit like guilty, and guilty conscience and … That you actually didn't see the person enough, or did enough or…".* The suicide becomes a sign of failure, and the informant feels she should have been more attentive. Another informant felt she had failed in her attempt to establish a good relationship with a patient who tried to kill herself while they were together. In addition, after a patient suicide one of the nurses had wondered whether some of the patient's activities that day (e.g. doing the laundry) could be a sign of her suicide, as if she could have prevented the suicide if she had only been more alert. It appears like a patient's suicide or suicide attempt may lead to self-judging among the nurses, who may not feel good or competent enough. This reflects a strong sense of responsibility for the patient's safety.

However, being put in a helpless position seemed to reduce the sense of responsibility. One of the nurses was contacted by a patient (on leave) who was about to attempt suicide. There was nothing the nurse could do, and she felt helpless, yet angry to be put in this position. *"So I felt a little discomfort, and then I felt that I was a little angry – I became very annoyed and angry, because she was putting me in the situation where I felt that discomfort».* The nurse's growing discomfort and anger in the statement may reflect the intensity in her experience as she recalls and describes the situation. It seems as though the nurse feels that the patient put her life in her hands, but the nurse will not accept the responsibility, yet she is left with uncertainty, anxiety and fear. Three other participants also shared experiences of feeling anger and frustration, particularly when a patient repeatedly engaged in suicidal acts.

One of the nurses revealed that although she felt sadness after a patient had taken her own life, she also felt relief. *"But when she takes her life then… It is sad, but at the same time also sort of a – it is bad to say it, but…a little relief, because you may have been so tired and so angry at times too, right".* She seemed slightly ashamed, yet exhausted of experiencing emotional turmoil over time. The participant had shared experiences about collaborative problems in the staff group. Thus, the strain seemed not only evoked by the patient's emotional pain, but by the challenging working conditions. The suicide put an end to some of her burdens, and the feeling of sadness was accompanied with relief.

Regulation of Emotions and Emotional Expressions

The mental health nurses seem to try to control their emotions and be confident and calm, or at least to appear as such, in acute and difficult situations (e.g. facing distressed and suicidal patients, verbal/physical aggression). A calm and controlled appearance sometimes involved suppressing or concealing negative feelings such as fear, anger and sadness. Several participants used words such as *"being steady",* and talked about how they had to withstand threats of suicide/self-harm, and endure the pain communicated by suicidal patients in order to provide good care.

[1] 'Chronic' suicidal is a term we do not usually use because we think it is stigmatizing and disempowering. However, it is the term used by the participants and it is frequently used in clinical practice.

"Yes, it is about being the calm and confident one. (…) We represent, or in my opinion should represent, when someone in a deep crisis is admitted, and then someone in the surroundings has to stay calm and steady. And appear like confident then. (…) You must be aware of it so that the patient's crisis does not color [affect] you so much that you are at a loss, but that you're able to be there and endure hearing that someone says 'yes, I want to die. I don't want to live'".

It seems as though it may be difficult to actually *feel* and *be* calm and confident. Further, it seems important not being too much affected by the patient's state of mind to prevent being overwhelmed or paralyzed by the patients' strong emotions. Another nurse thought that if she did not show any emotions and spoke with a calm and neutral voice, it could be easier for the patient to share personal experiences on sensitive issues.

Even though a calm appearance seems to be important, some of the participants' descriptions reveal that this is not always easy and may have some costs. One of the nurses, while striving to be calm and professional to a patient, felt anger toward the person who for a long period repeatedly tried to strangle herself. *"…you manage to be professional to the patient, but you struggle a lot, you know, you have to – as a professional on the outside, and then you're being torn inside".* The nurse experienced a mismatch between her feelings and her appearance, which seemed to be emotionally straining. Sharing thoughts and feelings with colleagues (e.g. in the staff room as challenges occur) is important and seems to be a way of regulating themselves emotionally, and thereby making it easier to act in a caring and professional manner.

Although it seems common to suppress/conceal negative feelings, two participants describe situations where they expressed irritation or anger to a patient who had engaged in suicidal acts. One of the nurses thought she perhaps was unprofessional in the situation, whereas the other nurse (who knew the patient well) seemed to express her anger because she wanted to contribute to change in the patient's self-destructive behavior.

Balancing Emotional Involvement and Professional Distance

To balance emotional involvement and professional distance seems to involve being empathic and caring, yet maintaining a distance to the patient. Several participants related their care to motherhood; one felt that it could help her to achieve a connection with suicidal patients who were at the same age as her children, whereas another nurse mentioned it with regard to avoiding a too close connection with the patient. *"… I am little afraid that we quickly may become both mom, sister, aunt, friend,* etc.*".* The nurse seems to add other intimate family/friend relationships to emphasize the importance of not establishing a too strong emotional bond to the patient, and thus attempting to avoid becoming a substitute for significant others and increase the patient's dependency.

Another nurse was challenged by what she perceived as too intimate care provided by some of her colleagues to a traumatized and (occasionally) suicidal patient. *"But we are not mother – if they miss a mother in their lives, there are many who do – a father too perhaps, but missing a mother, no one can replace that".* The participant seems to assume that some patients may seek a mother figure in the nurse, and that some nurses respond to this need. And although the nurse appears to think it is important not to be emotionally involved like a mother, she refers to some of the patients as children in need of clear boundaries.

Self-delineation seems to be important in order to balance emotional involvement and professional distance, which appears to involve reflecting upon challenging interactions (e.g. with colleagues or alone in the car on the way home), processing the experiences and attempting to separate their own feelings from the patients'. *"One has to have oneself – one must be…clarified oneself, one must know what – what feelings are mine and what feelings are the patient's now, in this. And what am I going to carry now for the patient, and what is it that the patient should get back to carry himself".* Separating their feelings from the patients' feelings seems to help the nurses to clarify for themselves what their responsibilities are.

A more practical way of self-delineation is reducing the emotional involvement by sharing the burden with other staff members and/or taking a break. *"…if one has been in that kind of pressure with several patients* [engaging in suicidal acts/self-harm] *over several weeks, and that-that one somehow feels that now I need a break, if it could be possible that I work with another kind of issue now, then I prefer that for a few days to kind of collect myself a little again".* The statement reflects the emotional intensity and strain in caring for patients who engage in suicidal acts and the need to occasionally distance oneself and recover.

Several participants state that they receive debriefing or supportive conversations from their managers after challenging situations such as a patient suicide. Only one nurse mentioned that clinical supervision (in groups) is offered and that she recently has considered attending.

DISCUSSION

The findings indicate that mental health nurses experience having specialized skills in detecting and responding to suicidality among psychiatric inpatients. In addition, caring for potentially suicidal patients involves managing emotions, emotional expressions and balancing emotional involvement and professional distance, which may be a way of providing good care of patients and oneself.

Mental health nurses' ability to pick up suicidal cues seems to be an emotional and experience-based competence that may prevent self-harm and suicidal acts among patients. Our finding is similar to what was found in Tofthagen et al.' study (2014), where mental health nurses were able to observe signs of self-harm and sometimes experienced a sense of intuition regarding a patient's impending self-harm. Furthermore, our findings are in keeping with Sun et al. (2005, 2006) who found that nurses observed overt and covert suicidal cues (verbal and behavioral) displayed by the patients. Observing non-verbal communication is important (McLaughlin, 1999; Vråle & Steen, 2005), and nurses continue to assess suicide risk through observations and conversations with the patients (Larsson, Nilsson, Runeson, & Gustafsson, 2007), and implement safety measures if necessary (Vråle & Steen, 2005). According to Benner, Tanner, and Chesla (2009), 'expert nurses' are able to read a patient/situation and respond instantaneously, claiming that there are intuitive links between noticing significant aspects and ways of responding to them. It has been suggested that intuition is involved in experienced mental health nurses' suicide assessments (Aflague & Ferszt, 2010), and that the intuition is linked to formal and tacit knowledge (Welsh & Lyons, 2001). Whereas Akerjordet and Severinsson (2004) stated that intuition is a part of mental health nurses' emotional intelligence, Klein (2003) described it as a skill built up through repeated experiences in which one learns to recognize a set of cues. This may relate to semiotics (the study of signs), and semiotic competence, in which one learns to interpret communicative signs (Andersen, 2009). Further research should investigate the characteristics of (more or less subtle) suicidal cues communicated by patients and how a competence in recognizing such cues may be developed. Emotional and experience-based competence may be undervalued in current emphasis on evidence-based practice, and more focus on such knowledge in education and training of nurses could promote their skills in caring for suicidal patients.

Some of the participants point to the lack of competence among temporary and/or inexperienced staff, leading to higher demands on experienced nurses and poorer care, which may contribute to increased (self) destructive behavior among the patients. Thus, adequate staffing and sufficient training of all staff members is important. In addition, potentially suicidal patients should be cared for by the most experienced professionals, as these persons need specific and sophisticated forms of care (Cutcliffe & Barker, 2002).

Suicide and suicide attempt/self-harm among patients evoke various strong feelings in the participants, such as sadness, guilt, anger,

frustration, fear, helplessness, and feelings of having failed. These painful emotions are common following a patient's suicidal behavior (Bohan & Doyle, 2008; Joyce & Wallbridge, 2003; Valente & Saunders, 2002; Wilstrand et al., 2007). In addition, one nurse's sadness was accompanied with relief after a patient suicide, which is less reported (Castelli-Dransart, 2014; Wurst et al., 2010). However, people bereaved by suicide have described relief as part of the reaction when the suicide is the end of a long period of suffering and difficulties (Sveen & Walby, 2008). Several participants reported that caring for potentially suicidal patients was emotionally straining, particularly when the patient repeatedly self-harmed, and that they sometimes needed to share the burden or take a break. This is consistent with previous findings where caring for patients who harm themselves repeatedly have been challenging and frustrating (O'Donovan & Gijbels, 2006; Tofthagen, Talseth, & Fagerström, 2014; Wilstrand et al., 2007). Nurses might be burdened with feelings (Wilstrand et al., 2007), or feel traumatized after a suicide/suicide attempt (Bohan & Doyle, 2008). Some of the emotional burden may be related to the projection of painful emotions from the patient, which might evoke negative feelings in the mental health nurse that can, at worst, trigger self-harm in a patient (Tofthagen et al., 2014). Richards (2000) maintained that suicidal patients might find it difficult to share their distressing feelings, and thus project (unconsciously) those feelings onto the professional and then possibly evoke countertransference reactions. Recognizing transference–countertransference processes and managing one's own emotions in a professional way is important to avoid acting out negative countertransference reactions (Cureton & Clemens, 2015; Richards, 2000).

Mental health nurses' care of potentially suicidal patients seems to involve a great deal of 'emotional labor', a concept developed by the sociologist Arlie Hochschild (1983/2003). Hochschild (1983/2003) argued that jobs with face-to-face or voice contact with the public imply 'emotional labor' with the purpose to affect the emotional state in others in a desirable way and to act in an appropriate and socially accepted manner. The author suggested that the emotional work is influenced by 'feeling rules' (expectations of what we should feel), and 'display rules' (corresponding outer display). Furthermore, the emotional labor may be performed through either 'deep acting' (attempting to experience the feeling that one wishes or is expected to display), or 'surface acting' (working on appearance but concealing/suppressing feelings) (Hochschild, 1983/2003). In our study, both techniques seem to be involved when the mental health nurses attempt to feel and appear calm, confident and caring (deep acting), or to just appear as such (surface acting), when they encounter distressed and suicidal patients. Being calm, attempting to not being overwhelmed by the patient's strong emotions and suppressing/concealing one's own feelings (of for instance fear, sadness, anger) may protect the professionals from being too involved and weakening their clinical judgment (Mann, 2005).

However, the participants in our study also seem to spontaneously experience and express care of the patients, and although Ashforth and Humphrey (1993), p.94) stated that the genuine experience and expression of expected emotion meant that there was no need to 'act' (thus arguing for a third way of accomplishing emotional labor), some emotional effort is required to ensure that expressed emotions match patient or social expectation (display rules) (Mann, 2005). Two of the participants shared examples of expressing genuinely felt negative emotions (e.g. anger) in encounters with patients engaging in suicidal acts, suggesting that it is not always easy or desirable to comply with the common display rules in professional care. This raises the questions of what it means to be professional and of which display rules apply to mental health care, particularly with regard to the expression of felt negative emotions.

Although the purpose of emotional labor is positive outcomes for both professional and patient it may have a negative impact on the health and well-being of the caregiver (Mann, 2005), including higher levels of stress (Mann & Cowburn, 2005). In our study, there are examples of experiences in which a mismatch between feelings and appearance (surface acting) seems to be emotionally straining. It has been suggested that experiencing emotional dissonance over time may contribute to emotional exhaustion and depersonalization (Brotheridge & Grandey, 2002; Hochschild, 1983/2003); signs of burnout (Maslach & Jackson, 1981). Our study suggests that some mental health nurses make a lot of efforts in managing emotions to maintain a professional appearance in the care of patients who engage in suicidal acts repeatedly and over time, as these patients seem to evoke more anger, fear and frustration. This is consistent with Wilstrand et al.' (2007) findings, where nurses reported that caring for patients who self-harm sometimes involved being so overwhelmed by fear and frustration that they struggled with their professional demands. This aspect of mental health nurses' emotional labor should be further explored in future research.

Our findings indicate that it is important, yet difficult, to balance emotional involvement and professional distance in the relationships with the patients. Based on the participants' accounts, mental health nurses' care may resemble a mother's care of her child or other intimate family/friend relationships, although it appears important not being too motherly (or too close) to avoid compromising the patient's autonomy and the nurses' professional integrity. Acting as a mother figure is described by other nurses as well, for instance in research describing nurses experiences of preventing patient violence (Virrki, 2008), or caring for patients with eating disorders (Malson & Ryan, 2008). Hochschild (1983/2003) suggested that women's maternal role may attach to several professional roles, in which women may be and act motherly at work. This seems particularly relevant for nursing, a female-dominated profession that involves taking care of people. However, Hochschild (1983/2003) argued that women are in danger of overdeveloping altruistic characteristics and lose track of its boundaries, which relates to one of the nurses' experiences in our study. Her experience of some colleagues' providing a too intimate care might also reflect transference–countertransference mechanisms between the colleagues and the patient. Becoming overinvolved and assuming too much responsibility for the patient are common countertransference responses (Ens, 1999; O'Kelly, 1998). Our findings add to previous research addressing challenges with regard to closeness and distance (Talseth et al., 1997; Tofthagen et al., 2014; Tzeng, Yang, Tzeng, Ma, & Chen, 2010) and balancing professional boundaries (Gilje, Talseth, & Norberg, 2005; Wilstrand et al., 2007) in the relationship between the nurse and the potentially suicidal patient.

The present study shows that the nurses appreciate the informal support from their colleagues. Caring for suicidal patients is demanding (Cutcliffe & Barker, 2002; Cutcliffe & Stevenson, 2008b), and nurses need informal and formal support (Gilje & Talseth, 2014) of emotional and educational character (Talseth & Gilje, 2011). Castelli-Dransart et al., 2014 found that respondents that had received sufficient support reported low emotional response and traumatic impact after a patient suicide. However, our study indicates a need for more formal support, which is also reported by other nurses caring for potentially suicidal patients (Bohan & Doyle, 2008; Takahashi et al., 2011; Wilstrand et al., 2007). Clinical supervision may lead to increased self-reflection and competence (Akerjordet & Severinsson, 2004), and enhanced emotional awareness related to transference and countertransference reactions (Cureton & Clemens, 2015; Rayner, Allen, & Johnson, 2005). Furthermore, supervision might enable the nurses to continue caring for suicidal patients (Cutcliffe & Barker, 2002; Cutcliffe & Stevenson, 2008a), and contribute to lower levels of burnout (Edwards et al., 2006; Sherring & Knight, 2009). Considering the adverse effects burnout may have on professionals' mental health (Pompili et al., 2006) and on quality of care (Maslach & Jackson, 1981; Sherring & Knight, 2009), our study suggests that there should be more focus on formal support systems for mental health nurses.

CONCLUSIONS

Although this is a small-scale qualitative study, it provides insights into mental health nurses' experiences of their clinical skills and

management of emotions in the care of suicidal inpatients. The findings indicate that experienced mental health nurses may have an important role in preventing suicidal acts/self-harm among patients. By providing close care and getting to know the patients they have opportunities to recognize and respond to their expressions of mental distress (verbal and non-verbal) that are possible warning signs of suicide or self-harm. However, caring for potentially suicidal patients involves a great deal of emotional work and may be emotionally straining, in which the theory of emotional labor (Hochschild, 1983/2003) has extended our understanding. Our study points to the importance of providing the mental health nurses with sufficient resources and support to enable them to provide good care.

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Paper III

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Paper IV

The need for connection and dignified care: Former suicidal inpatients' experiences of care in psychiatric wards in Norway

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The need for connection and dignified care: Former suicidal inpatients' experiences of care in psychiatric wards in Norway

Abstract

The aim of this study is to explore how former suicidal inpatients experienced treatment and care in psychiatric wards in Norway following the implementation of the *National guidelines for the prevention of suicide in mental health care*. The focus of the analysis was on aspects of care with potential for improvement. We interviewed five former inpatients and analyzed the data by means of Interpretative Phenomenological Analysis. Experiencing trusting relationships with the staff and receiving dignified care was important for the participants. This involved encountering mental health workers who treated them with respect, made them feel valued, and who recognized their suffering and needs. They experienced personal development, which was promoted by the support of mental health workers. Although the participants reported mostly positive experiences, there were examples of insufficient care. Sometimes, they felt that their suffering and suicidality were not recognized or responded to in a dignified manner. Our study indicates that although there has been increased focus on suicidality in the mental health services, some mental health workers still lack competence and should focus more fully on how to provide dignified care for suicidal inpatients.

Key words: Care, dignity, psychiatry, qualitative research, suicide

Introduction

Many of those who are admitted to psychiatric hospitals struggle with suicidality. For instance, a Norwegian study found that about 52 % of first-time admissions to psychiatric hospitals were related to suicidality (Øiesvold, Bakkejord, Hansen, Nivison & Sørgaard, 2012). Mental health workers face the task of helping these patients through their suicidal crisis and preventing suicide attempts and suicide. However, preventing suicidal acts is challenging, and in 2015, about 27 % of the suicides in Norway occurred among patients or recently discharged patients of specialized health services (Saastad, 2016).

The *National guidelines for the prevention of suicide in mental health care* were published in 2008 with the purpose of making mental health workers more competent and confident in dealing with suicidality among patients (Norwegian Directorate of Health and Social Affairs, 2008). Although the guidelines have raised mental health workers' awareness about suicidality, the main emphasis is on the assessment and management of suicide risk and not on how to provide good care to suicidal patients. Previous research has shown that patients appreciate being cared for by staff who value them as individuals and respond to their needs (Talseth, Lindseth, Jacobsson & Norberg, 1999; Talseth, Jacobsson, & Norberg, 2001) and who inspire hope and move them from a "death-oriented" position to a "life-oriented" position (Cutcliffe & Stevenson, 2007; Cutcliffe, Stevenson, Jackson & Smith, 2006). Some patients have reported that experiences of not feeling valued have contributed to increased suicidal behavior while they were hospitalized (Samuelsson, Wiklander, Åsberg & Saveman, 2000; Talseth et al., 1999). Good care implies more than identifying and managing mental disorders and suicide risk, which has been established by several clinicians and researchers in the field (Cutcliffe & Santos, 2012; Michel, Valach & Gysin-Maillart, 2017; Rogers & Soyka, 2004). Considering the increasing focus on suicidality in mental health services over the last

decade, there is a need to investigate the experiences of people who have been admitted to psychiatric hospitals because of suicidality.

The purpose of this study is to investigate how persons admitted to psychiatric hospitals because of suicidality are experiencing treatment and care in mental health wards since the implementation of the *National guidelines for the prevention of suicide in mental health care* several years ago (Norwegian Directorate of Health and Social Affairs, 2008). More knowledge from the service-user perspective may contribute to increasing mental health workers' understanding of how their care is experienced by suicidal patients and thus improve suicide prevention work in the psychiatric wards. Our research questions are: How have (former) suicidal inpatients experienced treatment and care in psychiatric wards since the implementation of the *National guidelines for the prevention of suicide in mental health care*? What can be improved in the care of suicidal inpatients?

Method

This is a qualitative study. We collected data through individual and semi-structured interviews and analyzed the material by the means of Interpretative Phenomenological Analysis (IPA) (Smith, Flowers & Larkin, 2009; Smith & Osborn, 2003).

Participants

The participants were five persons (four women, one man; aged 33-54) previously hospitalized in psychiatric wards because of suicidality. Two had been admitted to a psychiatric hospital for the first time and were hospitalized for about three months. Three had been admitted several times over the past fifteen years. Their most recent hospitalizations lasted for about 2-3 weeks. All were admitted to an acute ward before being transferred to a district psychiatric center. At the time of the interviews, it had been from one week to nine

months since the participants' last hospitalization. Three were admitted because of a suicide attempt (self-poisoning or hanging), and two were admitted because they were close to attempting suicide.

Recruitment procedure

Some nurses in selected acute psychiatric wards and therapists in selected psychiatric outpatient units in Mid-Norway assisted in recruiting the participants. The first author provided the staff with an information letter about the study describing the inclusion criteria: former patients over 18 years old who had been admitted to an adult psychiatric ward because of suicide attempt or severe suicidal thoughts during the last 12 months. People who had one or more admissions and people who had been hospitalized repeatedly because of recurrent suicidality could also participate in the study. The research ethics committee approving the study determined the recruitment procedure. Therapists working in out-patient services informed potential participants about the study and asked patients whether the first author could contact them by phone to ask if they wanted to participate. Two patients consented to be contacted by the first author and agreed to participate. Additionally, selected staff members working in acute inpatient units identified potential participants, informed them about the study, and gave them an information letter. Those willing to participate had to contact the first author after they had been discharged. Three of the participants made contact by phone and agreed to participate. The strategy for purposefully selecting participants was influenced by homogenous and criterion sampling (based on their psychiatric hospitalization because of a suicidal crisis within the last 12 months) and convenience sampling (based on accessibility) (Patton, 1990).

Interview procedure

The first author conducted the in-depth, semi-structured interviews of the participants, who could suggest or decide on the time and place for the interview. She interviewed three participants in an office/meeting room at her workplace, one participant in a meeting room at a psychiatric outpatient service, and one participant in the person's home. Four interviews lasted from 85-114 minutes, whereas one interview lasted 31 minutes. All conversations were recorded and transcribed verbatim. The first author used an interview schedule as a tool to help guide the conversation (if necessary) to obtain relevant information about the participants' experiences of being suicidal and hospitalized in a psychiatric ward. The main questions in the guide were: Can you please tell me about your situation and how you felt when you were admitted to hospital? How did you experience being hospitalized after attempting/contemplating suicide? How did you experience your encounters with the professionals (mental health nurses and therapists)? What does a good connection/relationship with a professional mean to you? Can you please describe a situation where you did/did not experience a good contact/relationship with a professional? What does good care mean to you? What do you think was most important to you during the hospitalization? In keeping with Smith et al. (2009), the interviewer probed for further description (e.g., Can you please tell me more about it? How did you feel?) to go deeper into the participants' experiences and to obtain more specific and detailed descriptions. The interviewer used confirmatory/interpreting questions (e.g., So you felt/thought. . . ?) in an attempt to clarify the participants' experiences and views (Kvale & Brinkmann, 2009). At the end of the interview, she asked the participants how they had experienced the interview.

Analysis

We analyzed the interview data by the means of Interpretative Phenomenological Analysis (IPA) (Smith, Flowers & Larkin, 2009; Smith & Osborn, 2003). The approach is

suitable for in-depth analysis of data from a small sample and is commonly used to interpret experiences of illness or psychological distress, particularly experiences that are of existential importance to the participant (Smith, 2011). IPA's theoretical underpinnings are phenomenology, hermeneutics and idiography, which calls for a focus on a close interpretative engagement of particular instances of lived experience and the meaning the participant makes of those experiences (Smith et al., 2009). The approach involved the following steps: (I) All authors read and re-read the transcript to become familiar with the participant's personal experiences of being suicidal and receiving mental health care. (II) The first author created a document with relevant meaning units and (III) organized the content according to the timelines a) before hospitalization, b) during hospitalization, and c) after discharge/life now. Then, she developed preliminary themes (e.g., existential struggle, relational problems, resources, experiences of support/lack of support, ongoing processes of pain and recovery) and (IV) searched for connections across emergent themes. (V) The first author moved to the next transcript and repeated the process described above. She analyzed each narrative in detail before moving on to the next transcript and then, looking for patterns, similarities and differences across the data to develop more general descriptions (Smith et al., 2009).

The first author conducted all steps of the analysis, including the initial organization of the content and coding of the material and thoroughly discussed the interpretations with the second and third author until all authors agreed upon final themes and descriptions. In keeping with Smith et al. (2009), we attempted to 'bracket' prior knowledge and assumptions, particularly in the initial analysis, in an effort to be more attentive to the participants' unique experiences and to prevent one's own prior knowledge from blocking new insight. In this reflexive and hermeneutical process - moving between data, our understandings, and descriptions and the literature - we have attempted to stay close to the participants' narratives.

Ethical considerations

The Regional Committee for Medical and Health Research Ethics approved the study. The participants signed an informed consent form. They were informed that they could withdraw from the study at any time prior to publication without giving a reason. The participants had the opportunity to contact the researcher after the interview if they had any questions about the study or their participation or if the interview had evoked mental distress and they needed a follow-up consultation. The first author had arranged for a mental health nurse at a psychiatric liaison service at the general hospital to be available for consultation on short notice. None of the participants needed follow-up after the interview. We treated the data in a confidential manner and present the information about the former inpatients in such a way that they are not identifiable. We refer to all the participants as "she" to protect their anonymity.

Findings

The participants reported more positive than negative experiences with the care in the psychiatric wards. Our main focus here is on aspects that could be improved based on what the participants found important. The findings consist of three themes: *"seeking a trusting connection", "seeking dignified care"*, and *"seeking support in their personal development"*.

To contextualize our findings, we describe some aspects of the participants' suffering and suicidality and give voice to some of their pain before we move on to describe the themes. Although the participants' suicidality evolved from very different life situations, their narratives reflect self-devaluation and loss of self-worth. The participants shared thoughts of being *"monstrous" and* of no worth and described patterns of devaluating their achievements, undervaluing their role as a spouse or parent, or having feelings of being a burden or

replaceable. In different ways, the participants struggled with their basic sense of self-worth, for instance: "*still, I am not satisfied with myself* [after an achievement], *and the duration of such a success lasts very short. And then there is something to think about, but what matters then? What am I worth then? And I see that during the hospitalization that I struggled a lot with these questions".* Several participants seemed to struggle with similar existential questions. The participants also reported experiences of disconnecting from people in their life and from life itself. Being suicidal was like being in one's own world or *"bubble".* Their life world was constricted, and even close family members were disregarded. The following is a description of findings with excerpts from the interviews.

a) Seeking a trusting connection

The participants emphasized the importance of having a trusting connection with the care provider, and four of them noted that "good chemistry" was an important part of such a connection: "*it is not everyone you talk to about everything then. It has a little bit to do with chemistry as well. They you feel you get the best contact with*". Several pointed to not being able to talk confidentially with just anyone. It seemed as if "good chemistry" or a good connection involved an experience of closeness, trust, openness and fellowship with the mental health worker. Such a connection or contact entails feeling safe and comfortable enough to open up and talk about personal issues including suicidality: "*it feels very safe to have NN* [the therapist], *because he has . . . knows me and my whole situation [. . .] Yes, so that is very safe then. So, I feel like I can say anything to him then".* She had established a relationship with the therapist several years ago and appreciated that he was her regular therapist when she was hospitalized. The connection with the therapist represented safety for her, and she could talk about anything with him.

Sometimes, the connection or the "chemistry" with the mental health worker did not feel right. For instance, there was a sense of a lack of trust, which meant that the participant did not feel safe or did not want to approach the person for support in times of distress. One participant revealed trying to strangle herself in her room at the hospital and not wanting to talk to the member of the staff assigned to her that day: *"yes, I would not tell it to my contact because I did not have good chemistry with him".* The mental health worker did not represent the safety and care she needed, and she therefore chose not to share her pain and suicidal experiences with that person. Two participants admitted to trying to change one of their contacts among the nursing staff with whom they did not feel a good connection, but their request was denied: "*because I think it is important that those who are in one's own treatment group are someone one has good chemistry with. So, because when they are on duty, they are assigned to you, but then, but they would not* [change her contact]*".* She pointed to the importance of connecting to the staff in her treatment group. However, even if the patients had tried to change a staff member assigned to them, they had to relate to him/her after the request was denied, which was challenging.

This theme shows that a good connection with the mental health worker was very important so that the participants could approach the person and share their suffering and suicidality when they needed. If there was a lack of a good connection with the mental health worker, the participants seemed to withdraw and kept their pain and suicidality to themselves, which might be harmful for their mental health and safety.

b) Seeking dignified care

Dignified care involved encountering mental health workers who treated the patients with respect and made them feel like valuable and unique persons. It was important that the staff was sensitive, took them seriously and recognized their suffering and needs:

> She [the nurse] just came up to me and, 'Yes, I see you are tired now, and it's all right. Just be tired', and I thought that was so good. And it was she who found me with [the means to attempt suicide] that night. [She] sat down and instead of in a way, it was someone I felt in a way . . . accused me a bit sometimes, not accused but sort of like, 'it is foolishness to engage in such things', while she was a little more like, 'yes I understand you are in pain, or I can't really understand how you are doing, but it will get better, I am sure you can make it'. And at the same time somehow, yeah, just was a comforting fellow human being.

She felt comforted as opposed to other times where she felt she was being treated in a more judgmental way. She valued feeling some kind of companionship with the care provider who offered more of herself than professional expertise. This was also experienced by other participants: "*he* [the therapist] *saw me, as I was [. . .] in a way, he is somewhat like a fellow human being and not just a doctor or a therapist. But he, yes, gives a little bit more of himself*". In order to help the patients feel valuable and unique, it seemed important that the mental health workers used their personal qualities and acted as fellow human beings rather than only professionals.

One participant thought the staff focused more on suicidality and were more supportive now than they had been 15 years ago. This may be related to the increased focus on suicide prevention following the implementation of the *National guidelines for the prevention of suicide in mental health care* (Norwegian Directorate of Health and Social Affairs, 2008). However, although the participant was satisfied with this development, she also noted that the staff should go even deeper into the patient's situation: *"and they* [the mental health workers] *have started to go deeper into it. I think they are somewhat deeper*

now, [. . .] But perhaps even more. [. . .] Go deeper in on the patient. Yes, a bit like . . . Take the patient seriously. Go deeper into the situation, the thoughts". The mental health workers appear to have increased their knowledge and understanding, but it seems they can become even better at exploring the complexity and depth of the person's suicidality. The participants reported several experiences of not being taken seriously:

> . . . I said I had a very bad night and that I was worried somehow before I was going to bed. And then [the nurse] said 'yes, it goes up and down for all of us in life, you know'. And then I tried to communicate that 'I am really having a hard time now', and then she said, 'yes, but you have to think like [a Norwegian singer-songwriter], be an optimist'. And I interpreted it more like yes, 'pull yourself together'. And then I just finished politely and smiled and said, 'thanks for the conversation' and went to bed, that is, I went and sat down in the living room after I had taken medicine until I became so tired that I was sure to get to sleep when I went.

This statement shows a lack of recognition from the nurse, who did not respond according to the participant's needs. It seems the nurse did not get the message or that she dismissed the patient's need for help through quick (albeit not constructive) advice. The participant was left to deal with her pain alone, mainly through the use of sedatives. She revealed that she made several suicide attempts during the hospitalization, and an important question is whether some of the attempts could have been prevented if her suffering and suicidality had been sufficiently recognized by the care providers. Several participants expressed that they at times wanted to talk more about their suicidality and the background of their problems. One had experienced being told there was not enough time to work thoroughly with her problems. Moreover, some staff members seemed reluctant to talk about suicidality:

"*they also told me that 'it* [suicidal thoughts] *is something we do not want to talk about too often because it may give you ideas. If you are not there, we shall not induce those thoughts in you', but perhaps it would have helped me to try to talk about it sometimes".* Thus, it appears that in spite of the efforts to increase the knowledge of suicidality in the services (e.g., through clinical guidelines), some mental health workers still believe in the myth that talking about suicide could evoke suicide thoughts and increase the risk of suicide.

Others reported experiences of insufficient care related to being met with an emphasis on mental disorders and medical treatment. All participants had been assigned one or several psychiatric diagnoses, but three of them were not certain their diagnoses were correct. One admitted to psychiatric hospital for the first time found it difficult to accept the psychiatric diagnosis assigned to her:

> I really got very good information [. . .] about depression, about the first step of taking medicines was also a big step for me. And maybe accepting that I was ill. Taking the first pill was enormously difficult. [. . .] Because it really affected me to accept that. And reading the brochure where it is explained very much as a disease. I did not feel ill. I just felt sad, that I did not want to live anymore. That is something completely different from being ill in the head. So, accepting that is terribly difficult.

She perceived that the mental health workers understood and approached her suicidality as part of a presumed underlying disorder, which she did not acknowledge. Rather, she felt that her own perspectives of the suffering and suicidality were not taken as much into account as they should have been. Furthermore, four participants questioned the usefulness of the medical treatment they received and said they lacked follow-up consultations about their medication from the physician/psychiatrist. Two of them said they experienced a deterioration

in their mental state when they started taking antidepressants (e.g., increased impulsivity with regard to suicidal acts), and all four reported negative side effects (e.g., blunted emotions/feeling indifferent) and/or lack of efficacy. One had used various psychopharmaceuticals for about 13 years but had stopped taking them about one and a half years ago. She experienced that stopping the medication had had a major impact on her quality of life: "*I got my life back after I quit taking medicine. Very literally, I have . . . And they see it - my family - that I . . . now I live; I [only] existed before".* This is a powerful statement about the potential negative effects of psychotropic drugs. Another participant suggested that mental health workers' belief in medicine is perhaps inflated: "*the only thing I really doubt a little, that has actually to do with the medication. [. . .] That there is really no evidence that it helps. So why do they offer that as the only solution? In addition to - or, maybe it is a bit overrated then. They could have been a little more honest about that".* She wondered why medication seemed to be the main element of the treatment plan even though the effect seems uncertain. She indicated that mental health workers are aware of the uncertain effects of medicine and wished they were more honest.

This theme illustrates the participants' need to be met by mental health workers who recognize their basic value as a fellow human being and who discern and understand their particular needs. However, the participants shared examples of not feeling sufficiently recognized by the care providers. Additionally, they reported a lack of efficacy or adverse effects of psychotropic drugs. The experiences indicate insufficient care, and it seemed as if the participants at times felt that their perspectives and experiences were overlooked, dismissed or overshadowed by the mental health workers' (medical) ideology and clinical routines.

d) Seeking support in their personal development

The participants' experiences illustrate that they were in a process of change involving existential, relational, and practical aspects of their lives. The experiences appeared to be a part of personal development that was influenced by the care they received in psychiatric wards. Four participants said that being suicidal and receiving care had increased their ability to talk about personal issues and their self-awareness, as illustrated by this participant: "*I think it is one of the best things that has happened to me. I have gotten so much more insight into myself. I have become so much more open about personal things. I have started to appreciate a lot more, I think, I think I will appreciate people I have around me more after this when I somehow start coming back".* She experienced that something was gained through the suffering and the mental health care, which contributed to a development on an individual and relational level. She was starting to appreciate other people more, or hoped that she would when she started to *"come back"*, indicating that this was an ongoing process. Another participant shared similar experiences, although she seemed to struggle more to find meaning in life: "*I think I need to go deeper, and find it then. Something that can give me some meaning, really. But I haven't given up. Otherwise, I would not have been here today. Like that. But all in all, oh my, I have learned so much in this past year. Because before I was the kind of person who lived. And walked in the spiral without thinking for a second what it was all about".* She appeared to be in a process of reshaping her sense of self and life. In her quest for meaning she had, among other things, immersed herself in philosophical and spiritual literature, and both she and another participant had benefitted from practicing mindfulness.

Working on relationships with family members, particularly their spouse and children, seemed to be an important part of the development for four of the participants. Some relationships appeared to be changing, and some relationships had to be improved or repaired. One participant described how she, with the support of her therapist, had made an effort together with her husband to create and implement a safety plan:

> And I have, actually together with my husband, made a plan for the whole family and everything. Which is divided into three different phases. [The first] is like a healthy/normal phase; that is green. And then there is a yellow phase; then the sleeping problems occur. And some things that perhaps my family must do if I can't manage to do things. And then there is a red phase; then I am ill. And we have inserted what do we do, how do we do things, who does things, when… [. . .] and how do we get it back to . . . because we would rather be on green then.

She had included the whole family in the safety plan, which was very helpful to her in vulnerable phases. The plan included an awareness of the warning signs of deterioration in her mental health and supporting strategies from both family members and mental health workers. Another participant's experience was that the process of suicidality and hospitalization had helped her to get her own housing and an extended network in the community: "*she* [the psychiatric nurse in the community] *has helped me so that I can go to a meeting center there. I have a tendency to isolate. [. . .] So, I feel that, they have made a proper network around me that I have not had before".* The participant had made new connections, making her less isolated, and she appeared to be more content with life.

This theme indicates that suicidality and receiving mental health care may be a part of personal development. Reflecting upon their suffering and life situation, the participants communicated strength and abilities to change or develop themselves and their lives for the better. The participants had benefited from the support of family members and mental health workers, and although they reported that some aspects of care could be improved (described in previous themes), they positioned themselves as having the primary responsibility for their own recovery process.

Discussion

The aim of this study was to explore former suicidal inpatients' experiences of treatment and care in psychiatric wards. Although the participants reported more positive than negative experiences of care, they pointed to a number of aspects that can be improved. Our findings indicate that some mental health workers need to focus more on establishing a trusting connection with the suicidal individual, recognizing the patient's value as a human being, and spending more time exploring the complexity of each person's suicidality. Based on the perspectives of the participants, mental health workers should rely less on diagnostics and medical interventions and use more of their personal qualities as empathic fellow beings when they respond to suffering and suicidality. The participants in our study experienced personal development - a process that might be further promoted by an improved care by the mental health workers.

Our findings relate to two prior Norwegian studies about suicidal inpatients' experiences of being cared for by nurses (Talseth et al., 1999) and physicians (Talseth et al., 2001). In Talseth et al.'s studies, experiences of good care were described as *being confirmed* (e.g. the patients and their needs were accepted and attended to), and experiences of poor/insufficient care were referred to as not *being confirmed* (e.g. the patients and their needs were overlooked) (Talseth et al., 1999, 2001). Almost two decades later, and following the implementation of the *National guidelines for the prevention of suicide in mental health care* (Norwegian Directorate of Health and Social Affairs, 2008), our study shows that suicidal inpatients still report several examples of insufficient care. Sometimes, the participants experienced that their suffering and suicidality were not recognized or responded to in a dignified manner. For instance, one participant experienced that her request for care was dismissed with superficial advice (specifically, "*be an optimist*"). In 1994, Neimeyer &

Pfeiffer, made a list of common errors in the way mental health workers respond to suicidal patients, and giving advice, relying on superficial reassurance and employing passivity (avoiding actively engaging in the patient's distress) were on that list that is now 23 years old. Caring for suicidal inpatients may be emotionally demanding (Hagen, Knizek & Hjelmeland, 2016). Thus, providing insufficient care, such as giving superficial advice, may be a way of distancing oneself from strong negative feelings (Neimeyer & Pfeiffer, 1994) and avoiding the discomfort evoked by suicidality (Carlén & Bengtsson, 2007; Talseth, Lindseth, Jacobsson, & Norberg, 1997). However, suicidality may be experienced as a crisis of the self (Webb, 2010), involving weaken self-worth or a total loss thereof (Orbach, 1997; Shneidman, 1980), and suicidal acts may be a way of escaping from aversive self-awareness (Baumeister, 1990). It is therefore crucial that mental health workers aim at reducing the psychological and emotional pain and work to strengthen or recognize the suicidal individual's self-worth. Previous studies have found that recognizing the suicidal patient - in terms of "you exist, you are not alone and your experiences are acknowledged" - is essential (Talseth et al., 1999; Cutcliffe et al., 2006). Such care may increase the person's belief that he/she matters to others in the world, which has been associated with increased self-esteem and decreased suicide ideation (Elliott, Colangelo & Gelles, 2005). Our findings add to this literature by indicating that in order to provide good care and make the patient feel valuable, it is important that the mental health workers employ their personal qualities as empathic fellow human beings and provide the patients with a sense of companionship.

Our findings indicate strong personal development in the suicidal person, a process that benefits from the support of mental health workers. Experiences of not being understood or not having the opportunity to talk about their suicidality could hinder this process. Many years ago, Carl Rogers wrote about "client-centered therapy", later transforming it into the "person-centered approach" (Rogers, 1980). He pointed out that his clients seemed to struggle

with the questions: *"Who am I, really? How can I get in touch with this real self, underlying all my surface behavior? How can I become myself?"* (Rogers, 1961, p.108). Some participants in our study seemed to struggle with such existential issues. Furthermore, Rogers' key message was that not everyone has capacity for self-understanding and development, and clinicians could promote a person's change and growth by being empathic listeners, understanding, genuine, and accepting (Rogers, 1980). This philosophy is found among researchers and clinicians who have argued for a person-centered approach with an emphasis on the patient's perspectives, a trusting mental health worker-patient relationship (Cutcliffe & Stevenson, 2007; Jobes, 2006; Leenaars, 2004; Rogers & Soyka, 2004), and a narrative approach wherein the person can talk and reflect about their suicidality (Michel et al., 2017; Michel & Valach, 2011). However, in times of managed care and busy schedules, such aspects may be neglected or not prioritized (Michel, 2011). Rather, mental health workers may rely on questionnaires and manualized interviews (Michel et al., 2017) and spend too much time on diagnostics and other clinical procedures as we found in a previous study (Hagen, Hjelmeland & Knizek, 2017). Additionally, fragmented mental health services may challenge the establishment of stable mental health worker-patient connections (Hagen et al., 2017).

In our present study, some participants expressed doubts about the psychiatric diagnosis/diagnoses assigned to them, and four of them reported a limited or ineffective response to antidepressants and other psychopharmaceuticals in addition to negative side effects. In a recent systematic review, Jakobsen et al. (2017) concluded that the potentially limited beneficial effects of antidepressants (SSRIs) appear to be outweighed by harmful effects. Critical voices have been raised against diagnostic practices and the potential adverse effects of psychiatric medication (Gøtzsche, 2013; Whitaker, 2010), and several authors have questioned the overreliance on the biomedical model with regard to how we understand and

manage suicidality (Cutcliffe & Santos, 2012; Hjelmeland, Dieserud, Dyregrov, Knizek & Rasmussen, 2014; Marsh, 2016; Webb, 2010). Even the assumption that 90 % of all suicides are associated with mental disorders (Cavanagh, Carson, Sharpe, & Lawrie, 2003) is strongly challenged by researchers who argue that there is no *valid* evidence for this 90 % statistic (Hjelmeland, Dieserud, Dyregrov, Knizek & Leenaars, 2012). However, psychiatry continues to be heavily influenced by a biomedical ideology that in turn affects how mental health workers understand suicidality and approach suicidal patients (Hagen et al., 2017; Michel et al., 2002). Our study suggests that mental health workers should focus less on medical models and approaches when they provide treatment to suicidal inpatients.

In conclusion, even though there has been an increased focus on suicidality in mental health services, our study illustrates that some mental health workers still need more competence in or should focus more on providing dignified care to suicidal patients. *The National guidelines for the prevention of suicide in mental health care* have increased knowledge among staff in psychiatric hospitals, but the guidelines have a disproportionate emphasis on assessment, management of risk factors (such as mental disorders), and suicide risk and lack guidance on several aspects related to good care. Based on the perspectives of five former hospitalized suicidal persons, mental health workers should first and foremost recognize suicidal inpatients as valuable fellow human beings, make efforts to connect with them, explore and understand their suicidality, and respond to their particular needs as well as promoting their personal development. The dignified care of suicidal patients should be given a higher priority among policy makers, researchers, educators, and practitioners.

The limitations to the current study need to be acknowledged. This is a small qualitative study based on interviews of five persons. Future research should further study the dignified care of suicidal patients, particularly what such care means to people with lived experience of suicidality. We need more qualitative research, including field studies in

psychiatric hospital wards, where interview data can be complemented with observational data.

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Interview guides

Intervjuguide A: Til tidligere innlagte pasienter

Innledning
Informasjon om hva undersøkelsen innebærer vil bli gitt, og deltakeren får mulighet til å stille spørsmål. Det understrekes at deltakelse er frivillig, og at informanten kan avslutte intervjuet eller når som helst trekke seg fra studien uten å oppgi grunn. Det påpekes at deltakeren kan formidle det han/hun ønsker om temaet (gjerne så konkret og detaljert som mulig), og at han/hun kan unnlate å svare på spørsmål. Informanten forsikres om all informasjon vil bli anonymisert og behandlet konfidensielt. Samtykkeerklæringen undertegnes hvis dette ikke allerede er gjort. Samtykke til bruk av båndopptaker innhentes.

Bakgrunnsopplysninger
Dato intervju:

Kjønn: Mann Kvinne Alder:

Tidspunkt for døgnopphold i psykiatrisk avdeling:

Hovedspørsmål:

1) Kanskje har du tenkt en del på temaet for intervjuet før vi møttes i dag? Kan du fortelle litt om hva du har tenkt?

2) Kan du begynne med å fortelle om situasjonen din og hvordan du hadde det da du ble innlagt?

3) Hvordan opplevde du det å være innlagt i en psykiatrisk sengepost etter å ha forsøkt å ta livet ditt/hatt alvorlige selvmordstanker?

4) Kan du beskrive en dag fra da du var innlagt? Hvordan var rommet du fikk? Kan du huske hvordan det føltes å oppholde seg/sove der?

5) Hvordan opplevde du møtet med miljøpersonalet (psykiatriske sykepleiere)? Kan du fortelle meg litt om hva dere snakket om? Opplevde du å få prate om det du synes var viktig?

6) Hvordan opplevde du møtet med din behandler (psykiater eller psykolog)? Kan du fortelle meg litt om hva dere snakket om? Opplevde du å få prate om det du synes var viktig?

7) Hva tenker du var det viktigste for deg når du var innlagt?

8) Hva innebærer en god relasjon med en helsearbeider for deg?

9) Kan du fortelle meg om en situasjon hvor du opplevde spesielt god kontakt eller en god relasjon med en helsearbeider?

10) Kan du beskrive en situasjon hvor du opplevde dårlig kontakt eller en dårlig relasjon med en helsearbeider?

11) Opplevde du på noen tidspunkt under oppholdet at situasjonen din eller din psykiske tilstand endret seg? Hvordan (økt eller redusert selvmordsatferd)? Hva skjedde/Hva bidro til det?

12) Hva innebærer god hjelp for deg? Har du noen tanker generelt om hva god psykisk helsehjelp til selvmordstruede personer innebærer?

13) Kan du avslutningsvis si noe om hva du synes er det viktigste å få sagt noe om (i forhold til temaet) til andre, for eksempel til personer som har behov for psykisk helsehjelp som følge av selvmordsproblematikk eller fagfolk som skal hjelpe?

Eksempel på utdypende spørsmål som vil bli brukt underveis:

14) Hvordan? Hvorfor?
15) Kan du fortelle meg mer om det? Hva skjedde?
16) Hvordan opplevde du det?
17) På hvilken måte?
18) Hva tenker du om det?
19) Hva betydde det for deg?
20) Få bekreftet innhold: Hvis jeg har forstått deg riktig så tenker du at….?

Avslutning:

- Hvordan har du opplevd å bli intervjuet om dette?

Takk for din deltakelse!

Intervjuguide B: Til helsearbeidere

Innledning
Informasjon om hva undersøkelsen innebærer vil bli gitt, og deltakeren får mulighet til å stille spørsmål. Det understrekes at deltakelse er frivillig, og at informanten kan avslutte intervjuet eller når som helst trekke seg fra studien uten å oppgi grunn. Det påpekes at deltakeren kan formidle det han/hun ønsker om temaet, og at han/hun kan unnlate å svare på spørsmål. Vedkommende kan også be om å få innhold slettet, d.v.s at det ikke blir med på transkripsjonen. Informanten forsikres om all informasjon vil bli anonymisert og behandlet konfidensielt. Samtykkeerklæringen undertegnes hvis dette ikke allerede er gjort. Samtykke til bruk av båndopptaker innhentes.

Bakgrunnsopplysninger
Dato intervju:

Kjønn: Mann Kvinne Alder:

Profesjon og yrkeserfaring:

Før start: Det presiseres at fokus er deres personlige erfaringer, og at de skal forsøke å gi så detaljerte beskrivelser som mulig, forsøke å beskrive som om jeg er en utenforstående som ikke har erfaring fra feltet og som er uvitende om det de jobber med (også prøve å sette ord på det de kanskje tenker er opplagt/selvsagte ting).

Hovedspørsmål:

1) Kan du begynne med å fortelle meg om arbeidsdagen din? Hvordan opplever du å jobbe i en psykiatrisk sengepost?

2) Hvordan opplever du møte med pasienter innlagt etter selvmordsforsøk eller alvorlige selvmordstanker? Kan du fortelle meg litt om hva du snakker med dem om når du møter ham/henne for første gang? (Miljøpersonale: Snakker du med pasienten om deres selvmordsproblematikk?)

3) Hva tenker du er din viktigste oppgave når det gjelder å hjelpe pasienter innlagt etter selvmordsforsøk eller alvorlige selvmordstanker?

4) Hva innebærer en god relasjon med en suicidal pasient for deg?

5) Husker du et tilfelle hvor du opplevde spesielt god kontakt eller en god relasjon med en selvmordstruet pasient? Hva skjedde da?

6) Kan du huske et tilfelle hvor du opplevde dårlig kontakt eller en dårlig relasjon med en selvmordstruet pasient? Hva skjedde da?

7) Har du opplevd at en av «dine» pasienter har gjort selvmordsforsøk eller tatt livet sitt? Hva tenkte du da? Hva tenker du om det nå i ettertid? Fikk du tilbud om oppfølging/støttesamtale etterpå?

8) Har du noen tanker om hva god psykisk helsehjelp til suicidale personer innebærer?

9) Kjenner du til de nasjonale retningslinjene om forebygging av selvmord i psykisk helsevern som ble utgitt i 2008? Hvilke erfaringer har du/ditt arbeidssted med retningslinjene? Påvirker retningslinjene ditt arbeid og møte med selvmordstruede pasienter?

10) Har du noen tanker om hvordan ledelsen på ditt arbeidssted håndterer selvmordsproblematikk hos pasienter, er det fokus på selvmordsforebyggende arbeid?

Oppsummering:

11) Kan du avslutningsvis si noe om hva du synes er det viktigste å få sagt noe om i dag? For eksempel til andre helsearbeidere som skal hjelpe selvmordstruede pasienter eller til ledelse/myndighetene som har ansvar for helsetjenesten?

12) Er det noe du vil tilføye? Noe som vi ikke har snakket om, som jeg ikke har spurt om?

Avslutning:

13) Hvordan har du opplevd å bli intervjuet om dette?

Eksempel på utdypende spørsmål som vil bli brukt underveis:

1) Hvordan/Hvorfor?
2) Kan du fortelle meg mer om det? Hva skjedde?
3) Hvordan opplevde du det?
4) På hvilke måte?
5) Hva tenker du om det?
6) Hva betydde det for deg?
7) Få bekreftet innhold: Hvis jeg har forstått deg riktig så tenker du at….?