Graduate thesis

NTNU
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Appearing strong, feeling weak

A qualitative study of male psychiatric inpatients with high suicide risk: their experiences of a suicidal crisis and the influence of the male gender role

Graduate thesis in Clinical Psychology
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Oda Buholt og Henriette Ofstad

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Abstract

In Norway, there are over 600 cases of suicide annually. Men are particularly overrepresented in these statistics, with two-thirds of suicides being committed by men. Existing literature shows that suicide can occur spontaneously, and there are various psychological changes in the days, hours, and minutes leading up to a suicide attempt. Furthermore, many patients do not disclose their suicidal thoughts when assessed, posing challenges for healthcare professionals in conducting suicide risk evaluations, as current recommendations rely on patient self-reporting. To enhance the ability to identify individuals at high risk of suicide, more knowledge is needed about the experience of the suicidal crisis, especially among men. Qualitative studies on this topic are also scarce in research thus far. With this in mind, the aim of this study was to explore the experiences that men, with a high risk of suicide, had prior to admission to a psychiatric emergency unit. Semi-structured interviews were conducted with eight men, focusing on factors that could have influenced their increased suicide risk. These included how the men experienced their suicidal crisis (thoughts, feelings, preceding life events, and help-seeking), as well as the influence of the male gender role. The data were transcribed and analyzed using thematic analysis.

The results indicated that the participants had several common psychological changes shortly before admission: (1) They experienced numerous and intense negative thoughts and feelings characterized by hopelessness, depression, anxiety, and physical pain, with a perception that such thoughts and feelings became increasingly unbearable and difficult to control. (2) Acute suicidal intention could develop within minutes and was characterized by coping strategies ceasing to have desired effect, a strong sense of being trapped, reduced ambivalence towards suicide, and loss of behavioral control. (3) The participants described a sense of loneliness, where difficulties in utilizing their support network, encountering little understanding, and conflicts in close relationships were highlighted as contributing factors. The expectations of conforming to traditional male gender roles were described as hindering the sharing and seeking of help for their difficulties.

The findings from this study align with existing research in the field, highlighting suicidal behavior as a complex and multifaceted phenomenon. The study demonstrated that suicidal crises can develop rapidly, underscoring the need to consider the overall life situation of the patient and go beyond confirming suicidal intention to assess acute suicide risk. The findings provide valuable insights into factors that may be crucial in acute suicidal crises among men, informing clinical practice and improving the identification of individuals at high risk of suicide.

Key words: *suicide, suicidal men, imminent suicide risk, gender roles, Suicide crisis syndrome, thematic analysis.*

Sammendrag

I Norge forekommer det i overkant av 600 tilfeller av suicid årlig. I denne statistikken er menn overrepresentert, der to tredjedeler av suicid begås av menn. Eksisterende litteratur viser at suicid kan skje spontant, samt at de forekommer en rekke psykologiske endringer inntil minutter før et suicidforsøk. Det er også kjent at mange pasienter ikke forteller om sine suicidale tanker når dette blir kartlagt. Dette skaper utfordringer når helsepersonell skal utføre suicidrisikovurderinger, da gjeldende anbefalinger baseres på pasienters selvrapportering. For å bedre evnen til å identifisere de med høy suicidfare, behøves det derfor mer kunnskap om hvordan den suicidale krisen oppleves, især blant menn. Kvalitative studier på dette temaet er også underrepresentert i forskningen så langt. Med dette som utgangspunkt var formålet med denne studien å utforske erfaringene menn, med høy risiko for suicid, hadde før innleggelse på akuttpsykiatrisk avdeling. Det ble gjennomført semistrukturerte intervju med åtte menn, med spørsmål om forhold som kunne ha påvirket deres økte suicidsrisiko. Disse omhandlet hvordan mennene opplevde sin suicidale krise, (tanker, følelser, forutgående livshendelser og hjelpesøkingsatferd), samt betydningen av den mannlige kjønnsrollen. Datamaterialet ble transkribert og analysert gjennom tematisk analyse.

Resultatene indikerte at deltakerne hadde en rekke felles psykologiske endringer kort tid før innleggelse: (1) Deltakerne erfarte mange og intense negative tanker og følelser preget av håpløshet, depresjon, angst og fysiske smerter, samt en opplevelse av at slike tanker og følelser ble gradvis mer uutholdelige og vanskeligere å kontrollere. (2) Akutt suicidal intensjon kunne utvikle seg i løpet av minutter, og var karakterisert av at tidligere mestringsstrategier sluttet å ha ønskelig effekt, sterke følelser av å være fanget, mindre ambivalens knyttet til å begå suicid, samt tap av kontroll over egen atferd. (3) Deltakerne beskrev en opplevelse av ensomhet. Vansker med å bruke sitt nettverk, å ha blitt møtt med lite forståelse, samt konflikter i nære relasjoner, ble trukket frem som bidragende til denne opplevelsen. Deltakernes egne og andres forventninger til å oppfylle egenskaper tilhørende den tradisjonelle mannlige kjønnsrollen ble beskrevet som å stå i veien for å dele og be om hjelp for sine vansker.

Funnene fra studien sammenfaller med allerede eksisterende forskning på feltet, og underbygger suicidal atferd som et komplekst og sammensatt fenomen. Denne studien viste at suicidale kriser kan utvikles raskt. Dette belyser viktigheten av å vurdere den samlede livssituasjonen til pasienten, og se utover bekreftelse av suicidal intensjon for å vurdere akutt suicidal risiko. Funnene gir verdifull innsikt i faktorer som kan være sentrale for akutte

suicidale kriser blant menn, noe som kan informere klinisk praksis, og forbedre identifiseringen av individer med høy risiko for suicid.

Nøkkelord: *selvmord, suicidale menn, akutt selvmordsrisiko, kjønnsroller, Suicide crisis syndrome, tematisk analyse.*

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Introduction

Definitions

This thesis is based on Nock et al.'s (2008a) definitions of suicide-related behaviors. According to these definitions, suicide refers to the intentional act of ending one's own life. Furthermore, nonfatal suicidal thoughts and behaviors are classified into three categories: suicidal thought, suicidal plan, and suicide attempt. Thoughts of, and desire to, engage in behaviors intended to terminate one's own life is referred to as suicidal thoughts. Suicide plans denote the specific methods a person intends to use for ending their life. Acting on such plans, or in other ways engaging in behaviors that may be injurious to oneself, with some degree of suicidal intent, is referred to as suicide attempt (Nock et al., 2008a). These three terms will hereby be referred to as suicidal behavior unless specification is deemed necessary.

Prevalence of suicide-related behavior and suicide

Worldwide, the World Health Organization has estimated that more than 700000 people die from suicide each year (World Health Organization, 2021). Suicide rates vary significantly cross-nationally, with the highest occurrence in low- and middle-income countries (77% of all suicides). As of 2019, Africa had the highest suicide rates globally, followed by Europe and South-East Asia, with America falling in the middle, while the Eastern Mediterranean and Western Pacific had the lowest rates. Suicide rates also vary significantly with gender, with a consistently higher rate among men than women. Globally, the age-standardized suicide rate, as of 2019, was 2.3 times higher in males than in females (World Health Organization, 2019). Two notable exceptions are India and China, with no clear sex differences (Leira et al., 2020; Rasmussen, 2013). In Norway, two thirds of the annual 600 incidences of suicide are committed by men (Stene-Larsen et al., 2022). The tendency of higher incidences of non-fatal suicide attempts among women and the larger probability of men dying from suicide attempts, is termed "the gender paradox" (Canetto & Cleary, 2012; Canetto & Sakinofsky, 1998).

While suicide rarely occurs among children, an increase in incidences is often seen from puberty and onwards (Rasmussen, 2013). Recent data from the Norwegian register of death causes in 2020 showed that suicide amongst men was most common for the age group 50-59 years, followed by 30-39 years and 20-29 years (Strøm et al., 2021). Additionally, psychiatric inpatient populations are considered to have high risk of suicidal behavior. Walby

et al. (2018a) found that in the period between 2008-2015, 41% of suicides involved individuals who had received inpatient care, with 13% occurring during hospitalization. Moreover, it was reported that 27% occurred after being discharged from inpatient care. An elevated risk of suicide after discharged from psychiatric hospitals has also been reported in international studies (e.g., Goldacre et al., 1993; Prestmo et al., 2020).

Thinking about death and suicide, at one point in life, is not uncommon (Nock et al., 2008b). For some, however, these thoughts will develop into suicidal intention, and ultimately be acted upon. It is difficult to precisely estimate the number of suicide attempts, as many cases are not detected or registered (Glenn et al., 2020; Stene-Larsen et al., 2022). However, a cross-national investigation of 84 850 adults in 17 countries estimated a lifetime prevalence of suicidal ideation, plans, and attempts of 9.2 %, 3.1% and 2.7%, respectively (Nock et al., 2008b). Moreover, in a recent study of suicidal behavior in a Norwegian non-clinical adult sample (N = 4527), 3.6% reported the presence of suicidal thoughts during the past month, while 0.2% reported the presence of suicide attempts in the same period. However, as this study was conducted in the early stage of the COVID-19 outbreak, caution needs to be taken as numbers may differ in a more ordinary societal context (Bonsaksen et al., 2021).

Death by suicide is associated with negative consequences for family members and other bereaved. It is estimated to be ten close bereaved for each death by suicide, approximately 6000 per year in Norway (Stene-Larsen et al., 2022). In sum, these figures indicate that the suicidal issue affects numerous people annually. It is theorized that individuals who have lost someone to suicide undergo a distinct form of grief, which is characterized as a prolonged grief process accompanied by intense and complex emotions. Moreover, this process may increase the risk of somatic and psychological health issues, reduced quality of life, decreased work performance, and an increased likelihood of suicide amongst the bereaved (de Groot & Kollen, 2013; Gordon & McElvaney, 2022; Spillane et al., 2018). Furthermore, a substantial proportion of admissions to psychiatric emergency units are due to suicide risk. Costs related to treatment and lost productivity make up more than 90% of the total financial burden associated with suicide (Mellesdal et al., 2010; Shepard et al., 2016). Ultimately, suicide causes both significant emotional distress for those affected, but it also has considerable effects on the healthcare system and economic costs for society.

Over the past few decades, a significant objective in the field of public health has been to prevent and reduce the number of suicide attempts and suicides in Norway. Such efforts include national guidelines, improved treatment, and enhanced competence among healthcare

personnel (The Ministry of Health and Care Services, 2020; The Norwegian Directorate of Health, 2008). Despite these preventive measures, the overall prevalence of suicide in the general population has remained stable in the last two decades (Ekeberg & Hem, 2019; Nasjonalt senter for selvmordsforskning og - forebygging, 2021; Stene-Larsen et al., 2022).

Barriers to help-seeking among men

One meta-analysis (Walby et al., 2018b), based on 20 studies from 19 primarily Western European and Northern American countries, found that approximately 25% of suicide decedents between 2000 and 2017 had been in contact with mental health services during the year preceding their suicide. The corresponding figures in Norway are even higher, where Walby et al. (2018a) found that 45% of suicide decedents between 2008 and 2015 were in contact with secondary care institutions for mental health or substance use in the year prior to their attempt. However, this finding also implies that 55% of suicide decedents were *not* in contact with these institutions prior to committing suicide. Furthermore, both Norwegian (Walby et al., 2018a) and international (Galdas et al., 2005; Oliffe et al., 2020) studies have reported an observed tendency, where men seek less help from health care services than women, and individuals in the oldest age groups seek significantly less help than individuals in the younger age groups. The fact that men seek help to a lesser extent, while they at the same time have higher suicide rates, makes this a highly relevant topic to investigate in more depth.

Help-seeking can be described as the active behavior of asking others for assistance, in response to a problem or distressing experience (Rasmussen et al., 2018a), or as the task at hand exceeds an individual's experienced coping abilities or resources. A premise for such behavior is awareness and recognition of one's own problems (Lynch et al., 2018). However, the lack of such awareness, or the presence of other barriers, can prevent individuals from seeking help for their struggles.

Several barriers to help-seeking among men have been identified and described in the literature (Rasmussen et al., 2018a), including denial of emotions, challenges related to understanding and regulating one's own emotions and discomfort, as well as expressing this to others (Lynch et al., 2018). This may lead to avoidance and withdrawal, and help is not sought until the situation is predominated by severe and considerable discomfort (Biddle et al., 2004). For some, suicide seems to be the only possible option for dealing with their own situation (Cleary, 2012). Additionally, men may be apt to use adverse coping strategies, such

as abusing substances and/or alcohol, aggression, or other externalizing behavior, to manage their painful situation (Cleary, 2017) (Möller-Leimkühler, 2003). Numerous studies have found negative associations between such coping behaviors and increased suicidal behavior (e.g., Cairns et al., 2014; Möller-Leimkühler, 2003). Additionally, doubting that professional health care will be helpful (Rickwood et al., 2007), and thinking that one's own situation is beyond help, has been proposed to be a deterrent for help-seeking among men (Cleary, 2017).

Another frequently cited barrier in the literature is adherence to traditional gender roles, accompanied by experiences of fear of stigma related to one's own mental health issues (Clement et al., 2015). The traditional male gender role is associated with attributes such as independence, dominance, rationality, control, success, and invulnerability. As such, the threshold for revealing pain and emotions is high, and might be contributing to emotional restriction. Such attributes contrast both admitting a need for, and receiving, professional health care (Möller-Leimkühler, 2003). However, there is lack of research on how traditional gender roles in relation to help-seeking is experienced among young men (Lynch et al., 2018).

Player et al. (2015) interviewed thirty-five men between 18-67 who had attempted suicide. The results showed that how the men experienced stressful life events appeared to be related to aspects of masculine identity (e.g., stoic beliefs associated with avoidant, isolative coping strategies). The men tended to experience their mental illness, and process stress, in a way that made them likely to engage in risky behavior (such as substance use and violence), as well as made them isolate or otherwise fail to address their problems until the suicidal thoughts had reached late stages of development. At this late stage, men who might be prone to impulsivity and reduced fear of pain, may be at risk of suicide attempts. These findings support the observed differences in vulnerability to suicide risk among men.

Rasmussen et al. (2018a) conducted an in-depth study with close family members of young male suicide decedents, without a psychiatric disorder. The aim of this study was to investigate potential barriers to help-seeking prior to suicide. They identified that reluctance was associated with reduced ability to cope with experiences of failure. It was described how the young males prior to suicide experienced not living up to expectations and standards set by themselves or others, with associated strong feelings of defeat and shame. Furthermore, the young men seemed to have had no or little room for expressing their weakness and difficulties with significant others, which was related to fear of being rejected or of needing professional help.

Current practice and challenges with suicide assessment

Healthcare personnel have a crucial role in identifying individuals with high risk of suicidal behavior. Norwegian guidelines state that all patients in mental health care should be assessed for suicide risk. This includes explicitly asking patients about current suicidal thoughts and plans as well as past attempts of suicide (The Norwegian Directorate of Health, 2008). Clinicians should also thoroughly evaluate if the patient presents with risk factors such as psychiatric disorders, substance abuse, loss of self-respect, either lack of or loss of relationships, as well as familial history of suicide. This should result in a suicide risk evaluation, encompassing an overall assessment of the individual and his situation, in addition to implementation of any necessary interventions. Norwegian law states that the assessment of suicide risk, and documentation of this, should be done by qualified personnel in accordance with the requirement for professional soundness. Usually this means that a licensed physician or psychologist is the most relevant (jf. Helsepersonelloven, 1999, §4; Spesialisthelsetjenesteloven, 1999, § 2–2).

When healthcare professionals make assessments of suicide risk, this is largely based on self-reported suicidal behavior (the Norwegian Directorate of Health, 2008). Such assessments depend on the patients' accuracy and honesty in disclosing any suicidal ideation they may experience (Høyen et al., 2022). Several weaknesses to this approach have been discussed in previous literature (e.g., Bloch-Elkouby et al., 2023; Rogers et al., 2022). When Høyen et al. (2022) studied disclosure of suicide ideation among adult psychiatric inpatients, it was identified that 51.5 % of the sample (N = 171) withheld some information on suicidal ideation during admission. Similar observations have been made in international studies, where the results of one report indicated that more than 75% of suicide decedents did not express suicidal intent prior to their attempt, whereof 24.5% were diagnosed with a psychiatric disorder and 22.4% were not (Stone et al., 2018). In addition, Deisenhammer et al. (2008b) discovered that the time between deciding on and completing a suicide attempt could be only ten minutes, which suggests that a suicide attempt may be an impulsive act. Consequently, this makes it difficult for healthcare professionals to correctly recognize which patients are suicidal and renders them prone to making false evaluations (both positive and negative).

Overall, the findings suggest that the currently recommended strategy for assessing suicide risk is not sufficient, and it is necessary to improve our clinical approach (Høyen et al., 2022; Knizek & Hjelmeland, 2018). Due to the higher prevalence of men in the suicide

statistics, and their tendency to seek help less frequently than women, it is especially important to gain a deeper understanding of which factors that contribute to heightened suicide risk among this group (Rasmussen et al., 2018b).

Theoretical background

Long-term risk factors of suicidal behavior

Factors contributing to suicidal behavior are numerous, complex, and not fully understood (Glenn et al., 2020). Current knowledge on risk factors of suicidal behavior primarily concerns long-term risk factors, referring to pre-existing vulnerabilities that may facilitate suicidal behavior (Bloch-Elkouby et al., 2020a; Franklin et al., 2017). Prior suicide attempt and current and/or previous history of mental illness have traditionally been identified as the two best long-term predictors for eventual suicidal behavior (Cavanagh et al., 2003; Cohen et al., 2018; Flint et al., 2021). Several studies suggest that for each prior attempt, the risk of another attempt or completed suicide increases with approximately 30% (DeJong et al., 2010; Oquendo et al., 2002). In addition, the increased risk of suicidal behavior has been shown to be present up to twenty-five years after an attempt (Angst et al., 2002).

A meta-analysis by San Too et al. (2019), comprising a total of thirteen unique studies, found that individuals with a diagnosed psychiatric disorder had nearly an eight-time higher risk of attempting suicide, compared to individuals without a psychiatric disorder. Psychotic disorders, affective disorders, and personality disorders were particularly related to high risk of suicide (San Too et al., 2019). Even though psychiatric disorders are well-known predictors for suicidal behavior, results from the studies by Owens et al. (2003) and Hamdi et al. (2008) showed that respectively 32 % and 44 % of the included participants did not have a diagnosed mental disorder prior to their suicide attempt. These results points to that psychiatric disorders cannot solely explain who is at a risk for suicidal behavior, and thus other factors may also be of importance.

In addition to previous suicide attempts and mental illness, several other factors have been associated with suicidal behavior. One prospective study used loneliness, representing the subjective distress when perceiving deficiencies in social relationships (as opposed to objective social isolation, i.e., living alone), to measure the impact of such distress on suicide ideation. The results showed that 10.5% of participants (N = 15 010; 35–74 years) reported some degree of loneliness, and this was associated with suicidal ideation with an odds ratio of 1.35 (Beutel et al., 2017). Additionally, individual traits such as perfectionism, impulsivity, deficits in problem solving, and maladaptive cognitive style (i.e., tendency towards non-

specific cognitive distortions like dichotomic thinking) have been found to be associated with long-term suicidal risk (Bloch-Elkouby et al., 2020a; Smith et al., 2018). Numerous studies have also shown a correlation between lack of emotional regulatory skills and increased risk of suicidal behavior (Hatkevich et al., 2019; Ong & Thompson, 2019; Rajappa et al., 2012). Other long-term predisposing factors include, but is not limited to, family history of mental disorders, being a victim of violence and abuse (Barzilay et al., 2020), insecure attachment (Palitsky et al., 2013) and loss of a parent to suicide (Gureje et al., 2011).

However, the above-mentioned long-term risk factors are also present in individuals who do not engage in suicidal behavior, and previous studies have indicated that long-term risk factors have limited predictive value for short-term suicide risk (Belsher et al., 2019). This raises important questions about how well long-term risk factors can identify those who are truly at risk of suicide. Consequently, increased attention has been given to the distinction between short-term and long-term suicidal risk factors, and the search for short-term markers of elevated suicide risk (Bloch-Elkouby et al., 2020a; Franklin et al., 2017; Rudd et al., 2006; Ying et al., 2020).

Short-term risk factors of suicidal behavior

Despite far less success identifying short-term as compared to long-term risk factors, several short-term factors have been found to be indicative of imminent suicide risk. This includes utterances or writings regarding a wish to die, death or suicide, as well as looking for methods or ways to kill themselves, as put forth in Rudd et al.'s (2006) review. Furthermore, imminent suicide risk is found to be preceded by increased alcohol and substance use, pronounced negative affect, such as agitation and anxiety (Glenn & Nock, 2014), as well as stressful life events, including interpersonal conflict, legal or disciplinary problems and rejection within romantic relationships (Glenn & Nock, 2014; Nock et al., 2008a). When Bagge et al. (2013) quantified the impact of such events on suicide attempts, the results showed an increased likelihood of a suicide attempt following an interpersonal negative life event (OR = 2.85 (1.51 to 5.35; $p <$. 01). When analyzing different categories of negative life-experiences, it was romantic partner relations (OR = 6.00 (1.77 to 20.37; $p < .01$) or other familiar or social relations (OR = 2.18 (1.07 to 4.45); $p < .05$) specifically, that were related to increased risk of suicide attempts.

Hendin et al. (2007) explored the role intense affects could play in signaling an ongoing suicidal crisis (i.e., acute suicide risk) among patients undergoing therapy. The following nine emotions were covered in the study: desperation, hopelessness, rage, anxiety,

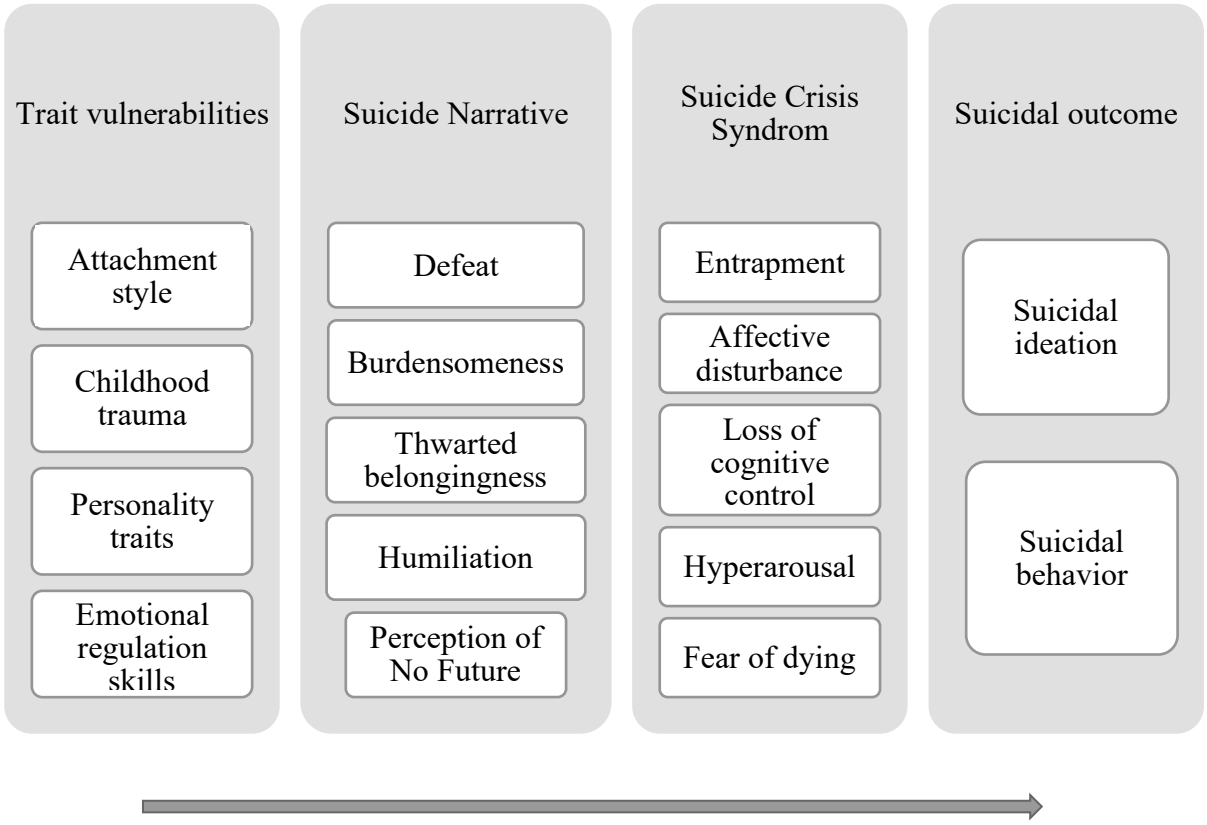
abandonment, loneliness, guilt, humiliation, and self-hatred. Patients who engaged in suicidal behavior ($N = 36$) reported having an average of 4.8 of 9 of these intense affects, in comparison to the control group who had 1.4. The decedents were particularly high on desperation (83.3%), compared to the control group (0%), followed by, and coexisting with feelings of hopelessness (70%), rage (63.3%), anxiety (63.3%) and abandonment (56.7%). As such, Hendin et al. (2007) concluded that the majority of patients who reported experiencing intense desperation also reported an emotional crescendo of various but interrelated painful emotions. The presence of such emotions was also found in Lachal et al.'s (2015) review of 44 qualitative studies questioning youth aged 15 to 29 about their suicide attempts. The participants described feelings of mental or emotional distress and sadness, including mental pain, despair, detachment, and irritability. When reporting distress, this was often described in combination with the experience of failure, such as feeling useless and being incompetent (Lachal et al., 2015).

Overall, this literature review reveals that a multitude of risk factors have been identified as being associated with suicide-related behavior, both in the short and long term. Relatedly, numerous theories on suicide have been proposed, and most of them try to explain the process where a subset of trait-like and long-term factors interact with short-term factors to raise the imminent suicidal risk (Franklin 2017).

The Narrative-Crisis Model of Suicide

The Narrative-Crisis Model of Suicide (NCM) proposed by Galynker (2017) is a diathesis-stress, multistage model of suicide consisting of different empirically validated long- and short-term risk factors. The model is organized into three components: trait vulnerability, the suicidal narrative and suicide crisis syndrome (SCS). The NCM posits that suicide is a volitional process that develops over time. See figure 1 for an adapted outline of the model.

Figure 1
The Narrative Crisis Model of Suicide



Trait vulnerability includes all static risk factors, which are relatively stable over time and distal to acute suicidal behavior. It also incorporates innate temperament factors such as fearlessness and pessimism, as well as early adverse experiences such as childhood trauma, and cultural and social factors e.g., societal acceptability of suicide as a solution to problems (Galynker, 2017). As such, these factors are equivalent to factors described under long-term risk factors previously in the literature review. The suicidal narrative, the second component of the model, is inspired by the theory of narrative identity, in which it is proposed that individuals construct their identity by incorporating their life experiences into an internalized and evolving narrative of self, providing them with a sense of wholeness and purpose in life (McAdams, 2001). The NCM posits that suicidal individuals feel entrapped in their suicidal narratives with ideas of having a worthless past, intolerable present, or no future. Such narratives concern themes such as feelings of defeat and humiliation, and views of themselves and being a burden to others, as well as being incapable of belonging.

According to the NCM, suicidal narratives, combined with trait vulnerabilities, make individuals prone to progress to the third stage of the model, an acute suicidal state. This is likely to occur when individuals face stressful life events, and/or through accumulation of

both long- and short- term risk factors (Bloch-Elkouby et al., 2020a). SCS, the third component of the NCM, is a distinct emotional state characterized by an unbearable mixture of emotional pain, anxiety, entrapment, and loss of cognitive control. The result is the suicidal act, brought on by an emotional urge to end the pain and circular ruminations. The NCM postulates that imminent suicide risk is primarily determined by the intensity of SCS. However, the overall suicide risk is ultimately determined by all three components in the model (Galynker, 2017).

Suicide crisis syndrome (SCS)

SCS has been proposed as a separate suicide-specific diagnosis in the DSM-5 (Galynker, 2017), but has not been included in the manual yet (Yaseen et al., 2019). See Box 1 for a comprehensive overview of the proposed diagnostic criteria for SCS. Entrapment is considered a core symptom of this condition, which is defined by an unbearable and desperate state of being trapped, where death seems like the only solution (A-criterion of the proposed SCS DSM diagnosis). Entrapment is accompanied by four additional symptoms, which include affective disturbances, loss of cognitive control, hyperarousal, and social withdrawal (B-criterion). Both criteria A and B, and each of the four components of criterion B must be present to receive the proposed diagnosis of SCS. The symptoms of criterion B can be manifested in different ways and combinations (Flint et al., 2021; Galynker, 2017). In total, SCS has five components, and each component has been included based on research that shows a strong independent correlation to suicidal behavior (Schuck et al., 2019).

Box 1

Overview of the proposed diagnostic criteria for Suicide Crisis Syndrome

Criterion A: Entrapment

Criterion B: Associated Disturbances

1. Affective Disturbance

Manifested in at least one of the following:

- Depressive Turmoil
- Frantic Anxiety
- Acute Anhedonia

- Emotional Pain.

2. Loss of Cognitive Control

Manifested in at least one of the following:

- Ruminations
- Cognitive rigidity
- Thought Suppression
- Ruminative Flooding

3. Hyperarousal

Manifested in at least one of the following:

- Agitation
- Hypervigilance
- Irritability
- Insomnia

4. Social Withdrawal

Manifested in at least one of the following:

- Social isolation
- Evasive communication.

Research findings on SCS

Past research has outlined the use of each of the SCS components separately in predicting suicide (for a review of supporting literature see Schuck et al., 2019). Entrapment has been theorized to be strongly related to suicide and may play a central role in predicting near-term suicidal thoughts and behaviors. When Galynker et al. (2017) investigated the predictive value of the SCS criteria, among inpatients with a high suicide risk, the results showed that entrapment had the highest predictive value compared to other criteria, with an odds ratio of 10 (Galynker et al., 2017). Additionally, entrapment has been found to mediate the other criteria of SCS (Li et al., 2018; Yaseen et al., 2014). Thus, entrapments' ability to predict imminent suicide risk, highlights its utility as a key characteristic of an acute suicidal state (Schuck et al., 2019).

Recent research has further started to investigate the associations between the five components of the SCS and prospective suicidal ideation. Several noteworthy results were obtained in a study by Yaseen et al. (2019). They found that patients who met the criteria for

SCS had significantly more severe suicidal thoughts during the preceding week, compared to the control group. Prospectively, individuals who met the SCS criteria were almost seven times more likely to have a suicide attempt within 4-8 weeks after discharge. Further, the SCS was predictive of post-discharge suicide attempts, independently of current suicidal ideation and depressive severity amongst the participants. In contrast, both current suicidal ideation and depressive severity were not predictive when controlling for the SCS. Thus, implying that such traditional long-term risk factors are not in isolation informative of acute suicidal risk, but can with advantage be accompanied by the features of SCS. Also, it was reported that the presence of all the proposed SCS- criteria (combined A- and B- criteria) was a stronger predictor of suicidal behavior compared to partial criteria alone, suggesting that each component is necessary to predict an impending suicide attempt.

Bloch-Elkouby et al. (2020b) used a network analysis to examine potential bidirectional relationships between the diagnostic criteria of SCS, exploring whether the symptoms were clustered in a meaningful way, and whether some of the symptoms were more central to SCS than others. The study included 723 adult participants, whereof 500 from outpatient and 223 from inpatient care. The results showed no isolated or unconnected symptoms, indicating that the proposed symptoms are co-occurring and potentially interacting. The results also showed strong connections between most of the symptoms, but also that most symptoms were highly correlated with entrapment and ruminative flooding (Bloch-Elkouby et al., 2020b). This suggests that the symptoms may reinforce each other, as well as seem to feed from entrapment, thus supporting the central role of entrapment in SCS.

These initial results show promising support for the utility of the SCS. However, further research has been called for to better understand how each criterion interacts with the other, and in what way the diagnosis can be used to identify individuals who are experiencing this acute mental state. And thus, are likely to engage in suicidal behavior.

Comparing models of suicidal behavior

The NCM bears resemblance to other posited models that try to explain and conceptualize suicidal behavior. Such as the Diathesis-Stress Model by (Schotte & Clum, 1982), which proposes that cognitive rigidity in problem-solving, contributes to a vulnerability to developing hopelessness and suicidal ideation during periods of naturally occurring, but significant life stress. Another well-known theory of suicide is the Interpersonal-Psychological Theory of Suicidal Behavior (IPT) by Joiner (2005). In this theory it is posited that perceived burdensomeness (“I am a burden”) and thwarted

belongingness (“I am alone”) causes suicidal desire (i.e., ideation). The transition from suicidal desire to suicidal behavior occurs when the individual acquires capability, referring to less fear of pain, injuries, and death. Additionally, this capability is dependent on habituation to harmful stimuli, such as self-harm (Galynker, 2017; Joiner, 2005; Van Orden et al., 2010). A third recognized theory of suicide is the Motivational-Volitional Model (Dhingra et al, 2016; O'Connor et al., 2016). It describes the progression of suicide in a stepwise manner over time, consisting of background aspects (e.g., triggers, events, environment), followed by a motivational phase and lastly leading to action. The motivational component is characterized by entrapment, defeat, and humiliation, which play a central role in the development of suicidal intent.

Although these models of suicide have made valuable contributions to the field of suicidology and to the understanding of suicidal behavior, Galynker (2017) also argues that these models have limitations, whereof some also apply to NCM. It is argued that suicide models often have a narrow focus and insufficiently integrate the various factors known to underlie suicide. Moreover, several theories of suicide inadequately address how the suicidal process evolves over time, whereby long-term risk factors interact with short-term stressors and contribute to imminent suicidal risk. However, it is highlighted that SCS has a particular clinical utility, and in this sense differs from the other models, as a self-report questionnaire (SCI: suicide crisis inventory) has been developed to measure the presence of SCS. It therefore enables the identification of high-risk patients in a clinical setting (Bertolote & Fleischmann, 2002; Galynker et al., 2017). When assessing the psychometric properties of SCI, it has been found that it has significant construct validity and is predictive of future suicidal ideation and behavior (Galynker et al., 2017; Yaseen et al., 2010; Yaseen et al., 2012; Yaseen et al., 2014).

Concluding remarks and knowledge gaps

In summary, previous literature suggests that suicide still is a pronounced societal problem, of which men are a particularly vulnerable group. This despite preventive efforts and development in treatment. The progression from suicidal thoughts to suicide is not well enough understood yet, and it has been suggested that this lack of knowledge may contribute to the unchanged suicide rates (King et al., 2020). Assessment of suicidal risk is mainly based on patient's self-reported suicidal ideation. This is challenging, as many do not disclose suicidal ideation when explicitly asked by healthcare professionals. Moreover, it has been reported that the period between deciding on and completing a suicide attempt can be only ten

minutes. To better identify those with a high risk of suicide, more knowledge is needed about how the suicidal crisis is experienced.

Previous studies on suicidal behavior among men is mainly based on quantitative approaches (Cleary, 2012; Lynch et al., 2018). Several researchers have advocated for an expanded and more in-depth understanding of why men are overrepresented in the suicide statistics, as well as broadening of our understanding of reluctance and potential barriers to help-seeking (Rasmussen et al., 2018a). Tucker et al. (2015) argues that "Patients perspectives on the factors that drive their own suicidal thoughts and behaviors may deepen our understanding of how theoretically derived factors manifest for them" (p. 683). Thus, patients' own experiences might be of particular interest, and qualitative methods are suitable to explore this further. From a traditional approach, qualitative observations are considered a necessary and inductive first step in research, which can generate more research using quantitative methods (Binder et al., 2016; Malterud, 2001). Additionally, qualitative research has the potential to expand quantitative research by providing additional insights into mechanisms underlying the knowledge generated from quantitative studies.

Objectives of the present study

The aim of this study is to explore the experiences that men, with a high risk of suicide, had prior to admittance to a psychiatric emergency unit. We will examine factors that might be associated with their increased suicidal risk: how they experience their suicidal crisis (thoughts, feelings, preceding life events, help-seeking) and the influence of the male gender role.

Method

Participants and procedure

Eight participants were recruited from a psychiatric emergency unit in a Norwegian university hospital. Recruitment and completion of interviews were done during a two-week period in September 2022. Inclusion criteria for the study were men 18 years or older who, by current procedures at the psychiatric emergency unit, were assessed by their therapists to have a high suicide risk upon arrival. All participants were inpatients at the time of the interviews, i.e., mental health professionals were responsible for the clinical evaluations and treatment. Participants could have confirmed the presence of suicidal thoughts, plans, and attempts.

However, this was not a requirement to be included in the study as it is known that many don't express, and some even deny, suicidal ideation when explicitly asked (Høyen et al., 2022). It was required that the participants were considered to be sufficiently emotionally stable at the time the interview was conducted and that they were considered competent to give consent to participate. Participants had to master the Norwegian language to such an extent that they could read and understand the information given and complete the interview. Individuals diagnosed with borderline personality disorder were excluded, as suicidal behavior in this group often is associated with attempts to communicate discomfort, as well as a desire to create an attachment to significant others, rather than an intention to end one's own life (Paris, 2002).

Therapists at the psychiatric emergency unit assessed which patients satisfied the above-mentioned inclusion and exclusion criteria for the study. Patients who were considered eligible for participation received oral and written information about the project, followed by a request to participate. All suitable participants had to give written informed consent and were informed that they could withdraw from the study at any point without consequence to their treatment. Emphasis was put on ensuring that the patients did not feel pressured to participate in the study. The researchers were then notified of consenting participants, as well as a suitable time for carrying out the interview. Information regarding the aim of the study and the participants rights (e.g., client confidentiality, voluntary participation, and management of personal data) was repeated before the interview started.

Interviews

The interview guide was semi-structured, with the opportunity to supplement with follow-up and explanatory questions during the interview. Participants were asked questions regarding their thoughts, emotions, physical symptoms, and behavior prior to hospitalization, as well as questions regarding help-seeking and potential barriers for such behavior. See appendix B for the complete interview guide.

The interviews lasted between 50 and 80 minutes and were conducted by authors of this thesis. All interviews were conducted face-to-face at the hospital, and all interviews were sound recorded. Data were collected in a stepwise manner until adequate information was achieved (Malterud et al., 2016) and the researchers assessed the data to have sufficiently addressed the research question. Hence, participants were continuously recruited until the dataset was considered saturated.

Ethical considerations of the study

Does asking about suicide cause harm?

A fundamental principle of ethical research is to maximize possible benefits and minimize potential harm to individuals who choose to participate (World Medical Association, 2013). One such potential harm is the notion that enquiring about suicidal behavior, either in research or clinical settings, can increase or "prime" patients' suicidal thoughts and behavior (Dazzi et al., 2014). This is referred to as an iatrogenic effect (Mathias et al., 2012). Concerns have been particularly expressed regarding the inclusion of individuals in an ongoing crisis (Blades et al., 2018).

Blades et al. (2018) conducted a meta-analysis to examine whether asking about suicide, or exposure to suicide-related content, in research trials, was accompanied by changes in distress, suicide ideation, or suicide attempts. A total of 18 studies between 2000 and 2017 were included. The results showed that being exposed to suicide-content was associated with a significant, but small, reduction in suicidal ideation (g = - 0.13, $p < .001$) and a lower likelihood of engaging in suicidal behavior (OR = 0.71, $p < .05$). The results of this meta-analysis are also in line with several other studies (Dazzi et al., 2014) (Biddle, 2013 #152} (Lakeman & FitzGerald, 2009; Littlewood et al., 2021). As such, these findings suggest that individuals are more likely to derive beneficial outcomes (e.g., altruism, self-understanding), both short- and long-term, from participating in such studies than to experience harm.

Safety procedures

This study implemented safety procedures according to previous recommendations by Littlewood et al. (2021) and Lakeman & FitzGerald (2009), i.e., clear risk assessment of suicidal behavior and emotional stability, as well as obtaining informed consent and informing participants about potential risks related to participation prior to interviews. Any experienced unease or change in suicidal risk after the completion of interviews was monitored and addressed by the health care personnel in the psychiatric emergency unit.

REK and NSD

This study was approved by the Regional Committee for Medical Research Ethics (North region, Norway - REK no: 457836) and the Norwegian National Center of Research Data (NSD no: 247113). See appendix 3 and 4.

Participant characteristics

The sample consisted of eight men aged 25 to 72 years. All but one had at least three years of higher education. Two were on disability benefits, two were students, and one was retired. Three were employed and currently on sick leave. Three men were single, whereas five were married and had children. Six men described a history of mental illness prior to admission, whereof four were diagnosed with a mood disorder. Diagnostic information of the last two men was unknown, but both described loss of ability to function normally due to long-term mental and somatic health problems. At the time of the interviews, six of eight men described common symptoms of depression, and all respondents described presence of anxiety symptoms. All respondents described suicidal thoughts. Five respondents described having had a plan to commit suicide, of which three had made an attempt.

Analysis

Transcription of data

Interviews were transcribed by the authors of the study after the completion of all interviews. As the main purpose of the study was to explore the men's own experiences of their crisis, transcripts included all spoken words. Additionally, certain auditory elements such as false starts, laughs and pauses, as well as gesticulation were included. This inclusion was deemed beneficial as gestures sometimes were the only means of expression, as well as kept the coding close to the participants' statements (Braun & Clarke, 2012).

Thematic analysis

The data was analyzed with thematic analysis (TA), a method used to identify, analyze, and report patterns and themes across the available dataset (Braun & Clarke, 2021). TA was chosen as a method of analysis because it is characterized by flexibility and accessibility and can be applied to several types of research questions within counseling and psychotherapy. The analysis itself can be performed in different ways, reflecting that TA is not a singular method with one set of procedures, but a family of methods (Braun & Clarke, 2021). This flexibility however necessitates that the researcher decides which version of TA to apply, as different variants provide distinct starting points for how the data should be approached and interpreted (Braun et al., 2022). In this study, a Big-Q framework for TA has been used, which rejects the notion of uncovering universal truths and objectivity, but instead emphasizes that meaning is associated with the context in which it arises. The framework of this study was experiential, aiming at exploring and capturing the men's perspectives and

understanding of their own situation. It is put forth that this approach is particularly useful when doing research on participant groups where there is a scarce amount of previous research (Braun et al., 2022).

This study is primarily based on a theory-driven, also known as a deductive or top-down, orientation when analyzing the data material. A deductive approach means that the researcher, during the process of coding and developing themes, bear in mind existing theories or topics that have been identified in previous research (Braun & Clarke, 2006). A deductive orientation may be useful in informing the coding, developing themes more precisely, and enriching the understanding of theoretical concepts. Although coding and analysis were carried out based on an overarching theoretical framework, attention was also paid to codes and themes that arose from the content of the data itself, and was different from the SCS (Braun et al., 2022). As such, this study can also be argued to have elements of an inductive orientation.

Doing the six steps of TA

The analysis in this thesis was performed according to the six steps described by Braun et al. (2021), where each step in the analysis lays the foundation for the next. A thorough description of how we proceeded will be presented in the following. The first step consists of becoming familiar with the data (step 1). A comprehensive review of the data material is essential to get an overview and become familiarized with the data. In practice, this meant delving into the content through repeated readings of transcripts and making notes about observations, however this process already started when performing the interviews and transcribing these.

Thereafter, open and inclusive codes were made to reduce the data, as well as organizing them into patterns (step 2). Each interview was carefully reviewed using open, data-driven coding, with the intention of identifying features of the data material that were of interest to the research question, and at the same time representative of the information in the data material (Braun & Clarke, 2006). All segments of the text informing the research question were marked with codes, thus reflecting concepts or meanings from the interviews. Numerous of these codes captured the explicitly expressed statements of the men, either close to the language they used or the overt meanings in the data, whilst being particularly attentive to stating when interpretations were made. This approach to coding is reflecting coding at a semantic level. However, some codes capturing non-explicit ideas and concepts (e.g., feelings

of entrapment or regarding gender roles) were also included. This kind of coding is referred to as latent coding (Braun & Clarke, 2006; Braun et al., 2022).

Initial coding of the first interviews was carried out separately by both researchers and thereafter compared with each other. This line of action was chosen to ensure that both authors had an equal understanding of the coding process, functioning as a calibration of coding- style. The interviews were thereafter coded collaboratively. To minimize potential preconceptions on initial codes, the researchers' codes were also compared with codes developed by the project's supervisors. See Table 1 for examples of coding of statements made at the start of this phase.

Table 1

Example of initial coding and temporary subthemes from text excerpts

Text excerpts	Initial coding	Temporary subthemes
«I feel really sad [when I no longer bear to play with my children]. I feel like a bad father" (2)	Feels like a bad father when he does not have the energy to play	Depression
"When you have a depression like I have, I think you're afraid that people will think that you are not in your right mind(...)." (4)	Afraid others will think he is not in his right mind if he shares his difficulties	Worries
"It's like an iron grip, (...) it's a form of anxiety that spreads out like this, (...) and when it's really bad, it feels like it can tear you apart."	Anxiety feels like an iron grip tearing him apart	How emotions and worries can be felt in the body

The next step was to place relevant codes together to form more overarching themes (step 3). The meaning of the men's statements was thus extracted from the first codes and recurring information across the interviews was organized and systematized using a table. The statements with related content were placed in the same column, while statements with clearly different content were placed in another. The most representative codes of the men's statements across the interviews were included, with emphasis on including codes with different nuances. Combining codes to create larger and more meaningful patterns, made it possible to identify central concepts that informed the researchers of something relevant about the research question. The developed themes, but also the original data material and discarded codes were reviewed several times during the analysis to ensure that important meaningful content had not been lost (step 4).

Afterwards, the data material was analyzed by defining and outlining themes. This process entailed identifying the core content and meaning of each theme in the data (step 5) (Braun & Clarke, 2006). This step is based on interpretation, where the researchers tried to give meaning to identified patterns, as well as summarize core ideas and meaning to each topic. Furthermore, an evaluation was conducted to determine if the identified themes were relevant and coherent with both the research question and the entirety of the data material. Both through initial coding and theme development, post- it notes were used as a tool to visualize and (re)organize the data material before findings were organized into tables.

Table 2

An example of generating themes from initial codes and subthemes

Initial coding	Subtheme	Theme
Feels like a bad father when he does not have the energy to play	Hopelessness, shame, and inadequacy	Descriptions of negative thoughts and emotions
Afraid others will think he is not in his right mind if he shares his difficulties	Overwhelming anxiety and uncontrollable worry	
Anxiety feels like an iron grip tearing him apart		

The final step in the analysis was to write a report based on the coded and interpreted data (step 6). There is no clear distinction between the analysis and the writing of the report within this method of analysis (Braun & Clarke, 2021; Braun et al., 2022).

Reflexivity

Within reflexive TA, it is recognized that knowledge is situated and constructed throughout the research processes. In qualitative research, the researcher plays a pivotal role in the quality of the scientific knowledge that is discovered (Kvale et al., 2015). This means that the knowledge generated was influenced by what the participants shared during the interview, but also by the existing understandings and beliefs that the researchers held (Malterud, 2001; Patton, 1999; Reid et al., 2018). When interviews are used to collect data material, the researcher becomes "the instrument for analysis" (Nowell et al., 2017). Consequently, it is recommended to provide a description of the researchers' prior assumptions, biases, and level of commitment to the field. This information holds significance in understanding its potential impact on various aspects of the research process, such as the selection of research methods, access to participants, identification of important findings, and subsequent framing and communication of results (Malterud, 2001).

The process of attending to how the researcher has affected the construction of knowledge is referred to as reflexivity. Transparency about the position, potential biases, and assumptions that the researcher beholds is therefore essential when judging qualitative research, but also to evaluate the authenticity and reliability of the findings (Reid et al., 2018).

Reflections regarding the researchers' positions, in this study, were undertaken prior to recruitment and interviewing subjects. Background with relevance to the field of study can be summarized as follows: prior to this study, both researchers had employment within psychiatric health care, as such both had some practical experience with patients in similar situations. Moreover, both had completed psychology courses with theoretical introduction to the field of suicidology. Prior to interviewing, reflections on expectations regarding the results of the interviews were written separately.

Prior to the data collection a literature search was carried out, in addition to the researcher's receiving guidance from experienced health care professionals. It was in conversation with these professionals that the researchers were introduced to SCS (including criteria and inventory), which functioned as a framework for the thesis, as well as a starting point for developing the interview guide. However, particular emphasis was placed on

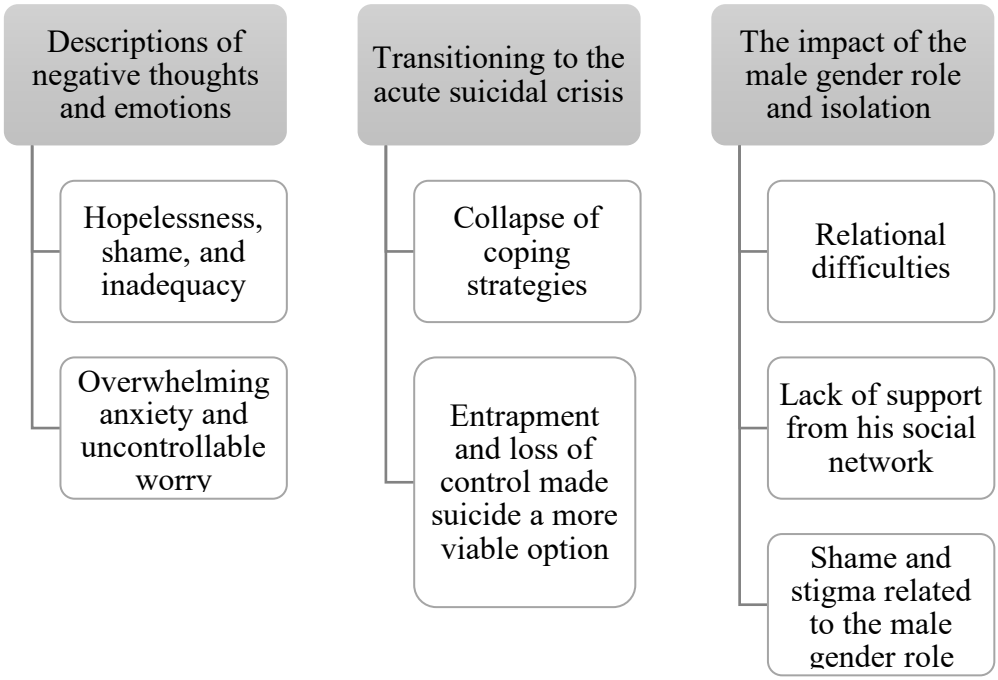
detachment from theoretical assumptions and being open minded to utterances or perspectives deviating from SCS, both in the interviews and through the analysis. The use of a theoretical framework might have contributed to researchers asking questions in line with the theory, while potentially other important aspects were overlooked or given less space. The use of this existing framework can, on the other hand, be considered a strength, where the questions might to a greater extent shed light on risk factors that affect suicidal behavior in the short term, rather than well-known long-term factors.

Results

The results indicated that the participants had a number of common psychological changes shortly before admission, organized into three central and overarching themes: (1) descriptions of negative thoughts and emotions, (2) transitioning to the acute suicidal crisis and (3) the impact of the male gender role and isolation. See Table 2 for an overview of the three themes and their associated sub-themes. Each participant has been assigned a number that corresponds to his order in the sequence of interviews.

Table 2

Overview of the identified themes and subthemes



Descriptions of negative thoughts and emotions

The first theme consists of two closely related sub-themes, concerning the negative thoughts and feelings that the participants experienced in their suicidal crises, both prior to and during admission.

Hopelessness, shame, and inadequacy

All respondents reported various forms of depressive feelings. In addition to symptoms characteristic of clinical depression (e.g., lack of energy, apathy, difficulties with concentration), the men particularly described the feeling that everything felt meaningless.

> *"(...) When you are depressed, it is rather like a vail, like someone has taken off your "glasses", and you see how gray and worthless and meaningless everything is." (1)*

Several men also described feelings of grief related to their current situation, including loss of joy, potential opportunities, and ability to function normally compared to before developing depressive symptoms.

> *"(...) It's hard to put on that face all the time and be happy when you're not happy, and especially when you do something with the children, (...) suddenly even (...) things like that start to become difficult, then you feel this grief (...)." (4)*

As the experience of loss of meaning and joy of life worsened, a feeling of hopelessness also seemed to increase. Many of them questioned whether they would get out of the vicious depressive loop and get better, or if they should just give up.

> *"I don't think I´ll get better. I've actually given up on the idea of feeling good." (8)*

> *"It's that feeling of giving up, even though I have my bunch [family], which I'm very fond of, it's hard when you have so little joy in life." (3)*

Several men described that their grief and depressive state affected how they viewed themselves. A feeling of shame seemed to be particularly prominent, as they described being

shameful for various reasons, such as being on disability benefits, being the weakest link at work, being mentally ill, and accepting help.

> *"And then a new task comes along [at work], which makes me feel discomfort in my stomach (...). Then I push myself to do more things, until it becomes too much (...). Afterwards, I am told "you just have to let us know, (...) we work together on this" (...), but it always seems like I am the weakest link (...) (It) becomes a truth, that I am the weakest link." (2)*

> *"(...) There's a sense of feeling helpless, (...) you get a feeling that you are a problem, actually."(4)*

Furthermore, several men described feelings of inadequacy, believing that they had little to contribute with and offer to others, both prior to and during their crisis. Many also described feelings of guilt, blaming themselves for their current situation and how this had affected their family and friends.

> *"Yes, inadequacy, and feeling very, very, very small, not being able to accomplish things, having little to offer (..) It's damn hard to be proud of getting out of bed when you're in your 30s and have two kids. Then, that (...) also feels wrong, because if those are the expectations others have of me, then I'm not needed (...) one just wants to be (...) a normal human being"(2).*

> *"(...) There's a feeling of guilt, that you're (...) not good enough (...). It's a feeling like you're putting your life, a good and stable life for your children and wife, at risk. So, you feel an extreme sense of letting them down, (...) those closest to you (...)." (4)*

Overwhelming anxiety and uncontrollable worry

All participants described experiencing anxiety and restlessness prior to admission. While some said that they had a gradual increase in anxiety over time, others described a more sudden and abrupt build-up. Anxiety could be experienced as worrying thoughts, but also as uncomfortable or painful physical symptoms, such as headache, chest pain and nausea. In some cases, physical symptoms accompanied worrying thoughts, but they could also appear separately. Although the content of their worries varied, certain concerns were more

often mentioned than others: how their mental health issues could impact their relationships with others (e.g., a fear of being such a burden that their partner would leave them), loss of ability to care for themselves and live a fulfilling life, potential career setbacks, financial consequences, and fear of job loss due to disability or disclosure of their illness.

> *"[I felt pain] in my stomach and chest, in the abdominal area. And it's weird, but it comes immediately when I think about [loss of romantic relationship]. It disappeared if I had a moment of distraction. But then that physical pain came back." (5)*

> *"(...) I have this constant uncomfortable feeling, like something is constantly brewing in the back of my mind and in my stomach (...) it's there all the time. I never get to relax (...)." (7)*

Regardless of the individual's combination of anxiety symptoms and content of worries, all participants described that these were experienced as uncontrollable, difficult to manage and, by some, impossible to stop. Some of the participants described feeling overpowered by their worries, experiencing that their thoughts could spin off from everyday events to thoughts of worst possible outcomes.

> *"Suddenly I feel this depression, and then I get scared, anxious, and restless. Then this anxiety develops into something that gradually takes hold of me, like a shadow that I think I can [but can't] stop." (4)*

> *"There are a lot of catastrophic thoughts. (...) I'm afraid that if everything goes downhill from here, I'll need disability benefits, won't be able to work, (...) that I'm ruining things for those who mean the most to me (...). And I can't put it aside. I'm constantly worrying until it drives me crazy." (4)*

Several experienced that the content of their worries became worse, as well as more frequent prior to admission to the psychiatric emergency unit, and ultimately the worries and physical symptoms felt impossible to suppress. Some of the men stated that this led to suicidal behavior becoming a more viable and final solution to their situation.

> *“The train of thought never stops. [It escalates] from when my partner comes home tired from work, or (...) she doesn't say she loves me back one day. Then “bang” it spins off to us breaking up, she takes the kids, finds a new man, and I'm alone and kill myself anyway. Then I might as well do it now, before the kids have to go through all that crap and before she has to endure it for years (...).” (2)*

Transitioning to the acute suicidal crisis

The second theme covers the changes that the men highlighted as distinctive and contributive to the transition into their acute suicidal crisis. The thoughts and emotions described in theme one was also present during the acute phase.

Collapse of coping strategies

All respondents described using coping strategies when faced with psychological pain or worrying thoughts. Many of them described that they tried to avoid or distract themselves from negative thoughts and feelings, for example by thinking about other things, thinking positively, or physically removing themselves from emotionally unpleasant situations. Three participants also said they drank alcohol or smoked cannabis as self-medication to regulate their emotions, even though it had negative consequences for them and did not feel sustainable.

> *"(...) [I have thought that] it is just in my head, you just have to not think about it." (6)*

> *"I feel a lot of stress and restlessness (...), and alcohol has always been a good buddy. Quick. (...) But then it gets out of hand." (8)*

Many respondents also described using coping strategies that had been recommended to them by healthcare professionals, including exploring alternative explanations for events, sharing their feelings with others, and ensuring good routines. Some mentioned that exercise could make emotions more manageable by muting or pushing them away, but also that it made them feel better afterwards.

Regardless of the type of coping strategy being used, most participants described that these strategies only seemed to work up to a certain point. When the emotional pain was too much to bear, their coping strategies collapsed and left the men distraught and desperate.

"(...) [Coping strategies] worked well, until it didn't work anymore. (...) It just stops. When there are too many events [causing distress and worry] in a row, and your thoughts are racing too fast, you can't deal with one thought at a time. When you're dealing with one [worry], suddenly two more come up, and then you can't begin to unravel it and figure out what most likely happened." (2)

"(...) then I went to work even though I shouldn't have (...). I should have (...) taken sick leave (...). But I went to work to keep up appearances. (...) I got completely exhausted (...) and eventually it all came crashing down (...) then I couldn't go to work anymore either." (8)

Entrapment and loss of control made suicide a more viable option

All but one of the participants experienced long-standing recurrent depressive symptoms, lasting from months to years. Four participants reported the onset of their difficulties occurring between two to five months prior, associated with relationship breakups, significant life changes, and signs of relapse into a new depressive episode. One participant described the experience as descending a staircase, constantly encountering new low points. These cumulative symptoms eventually became overwhelming, leading them or their family members to seek admission to the psychiatric emergency unit. However, for three participants, the timeline for the development of suicidal intention differed. While they also acknowledged long-lasting difficulties, the intention arose acutely over a few days or hours. Two of these participants attributed their suicidal intentions to relational difficulties, while one did not identify a specific trigger.

When describing their experiences of the suicidal crises, several highlighted feelings of being trapped in their illness and current situation. Several aspects were described as contributing to this feeling of entrapment, including not being able to avoid their problems either physically or psychologically, not being able to see a solution to their situation, and the feeling of having an intolerable present, or no future.

" [I felt] despair and (...) that I can't solve this. I can't find a solution (...). Which is a big part of the problem. And there's nothing you can say that fixes anything, there's nothing that can fix things. It's just completely stuck." (7)

> *"I know that I can't live like this, I can't have one or two of those [depressive episodes] per year, I don't want a life where I'm admitted to the emergency unit twice a year. I won't survive that (...)." (2)*

Almost all respondents explicitly described having ambivalent thoughts regarding taking their own life prior to their suicidal crises. Several described a continuous trade-off between whether their life was worth living or not. One respondent additionally described evaluating how much he could allow himself to be a burden for his family. Either way, managing life and recovering from their psychiatric illness was described as a battle, and suicide as a relief from this struggle.

> *"She [Ann Heberlein] has a quote that I relate to (...): "It's not that I want to die, I just don't want to live", and I think that summarizes it, (...) you actually want to live but you don't believe it's going to work out, you don't think it's going to get better (...). You have no idea how you're going to be able to live, death becomes a relief, (...) an emergency exit (...)" (1)*

The potential pain they could inflict on their family or other close ones was described as a barrier for committing suicide. However, several described that when they were in the acute crisis, the ambivalence decreased, and for some became absent, making suicide seem like a better solution than ever before.

> *"And then (...) I knew how that day was going to be. My wife would be completely devastated and cry about it [conflict] all day. I thought "I can't handle this", and then I took off. (...) I thought "whether I live or die - I don't give a damn." (7)*

Several respondents described a state of mental chaos in the acute phase. Their thought processes were described as uncontrollable and relentless, characterized by feelings of desperation, confusion, and despair. Some described that they were not able to redirect their thoughts or see anything beyond their own crisis. When reflecting upon the mental chaos he experienced, one participant said that he could not remember the content of the dialogue with the general practitioner prior to admission. Additionally, he described having no willpower, and that he simply did as he was told regarding admission. Other participants

described experiences of losing control over their behavior, with increased intake of alcohol and other substances, as well as engagement in suicidal behavior.

> *" I stood there [on the ferry] for a long time contemplating just jumping off. At that moment, I was overwhelmed by a feeling of despair and started crying to myself, thinking thoughts like 'Do it, do it, do it.' Then a man came over and said, 'Are you okay?' That's when I snapped out of it." (8)*

> *"Yes, it was there this time [desire to die]. Quite acute. In pure desperation actually. (...) I felt that now my future was in ruins. (...) I didn't feel like I had any alternatives really. (...) It seemed very hopeless. It came very quickly, in just a few days, from Friday to Monday. Over a weekend (...) I've had depression before, but not to that extent. Not so acute and not so desperate, and I´ve also not had the initiative. But maybe I did have it now." (5)*

The impact of the male gender role and isolation

The third theme covers three interconnected sub-themes that explore experiences related to the participants' social life prior to admission. These include challenges in important relationships, a sense of inadequate support from their social network, and encounters with attitudes associated with the traditional male gender role.

Relational difficulties

Several men described having had relational difficulties prior to admission. For four of the respondents, these difficulties were related to the loss of an important relationship: a grandchild, friend, or romantic partner. Even though several stated that they had other meaningful relationships, the loss of this specific relationship was highlighted as particularly significant to their current psychological pain. It seemed as though the loss of these special relationships also meant the loss of an anticipatory future, which in turn seemed to increase a feeling of desperation and hopelessness.

> *"It's probably a couple of years ago now [first admission to the psychiatric emergency unit]. It must have been when I swallowed twenty Vival pills. Then I ended up here. (...) We weren't allowed to see our grandchild, and it was too painful to deal with in a way." (7)*

> *"The reason [of the crisis] is a relationship I had with a woman (...), she ended it because she couldn't handle the distance. (...) Then she found someone new, she moved on. So it was the confirmation of that, which broke me just before the weekend. (...) I felt that the relationship I had planned to build with her, that future was... shattered." (5)*

Three men described being involved in an ongoing conflict within a present relationship, which played a role in exacerbating their crisis. Two of these described attempting to reconcile with the person with whom they had a conflict, without experiencing the desired outcome.

> *"It's completely hopeless. No solution. It's not possible to talk to anyone, you usually don't get a response, or you get a response that you absolutely don't want. You send messages, but it's like sending them out to outer space. You understand that they have probably read it, but there is never any response to anything." (7)*

Lack of support from his social network

The respondents' social networks varied greatly in size, from a small or no social network to having a number of meaningful family- and friend relationships. Regardless of the size of their social network, most men described that they did not seek support in their existing relationships and gave various explanations for this. Some described that they did not want to burden others and would rather maintain a facade by pretending to be fine and by hiding their feelings and current struggles.

> *"Those who don't know me well think that I'm always smiling, always happy, and then I have another side (...) that I've previously become good at hiding." (4)*

> *"(...) Earlier, I was very concerned about appearances. (...) In recent years, I don't know. Still very concerned that my parents believe that I'll be okay, that I'm okay (...). I think about that a lot. (...) So I'm very concerned that at least they should have the impression that I'm okay, because I don't want to burden them with any extra stress, since (...) they have enough." (8)*

One respondent described feeling afraid of being rejected and ridiculed by others if he took the chance to share his feelings.

> *"(...) In some contexts it might be ridiculed if men show emotions and such. It's a sign and a symbol of weakness. (...) There have been many times when I've wanted to show emotions and talk about feelings. And where I haven't done so (...) Because it feels wrong, and I know that if I started crying at work, my colleagues... I think maybe they would run away." (5)*

Furthermore, several respondents described that their psychiatric symptoms made them isolate themselves. One respondent described that his depression made him self-absorbed and pity himself but felt the need to pull himself together in social settings and did not want to burden others with his problems. Pretending like everything was ok, in social settings, was described as tiresome, which in turn reinforced the wish to isolate.

> *"I have probably ignored it [need for social connection]. (...) I don't feel like being with others when I'm feeling down, I feel like a burden. They know me as a happy-go-lucky type who jokes around, is interested, asks questions, and is curious about other people and ideas. So when I'm not like that, I get restless when the focus is on me, I end up avoiding social situations." (1)*

> *"(...) It's exhausting (...) because you have to pull yourself together, to (...) function socially when you have so many negative thoughts. You have to pull yourself together (...) in order to not be so self-focused, so self-centered, because you're extremely self-focused, (...) extremely self-pitying." (2)*

Lastly, some respondents described that they had tried to seek support in their social network, but they were dissatisfied with the reactions they received. They felt misunderstood, not listened to and were offered simplistic solutions to their problems. One man experienced that his family members had been ashamed of his mental difficulties, thereby making it difficult for him to express his negative thoughts and emotions to them.

> *"I can of course talk to her [wife], but she also has this thing of "well, you should think like this and like that". So I become a bit interrupted (...) and she comes with her*

own view. She's not the world's best listener in that way. (...) Otherwise, I have no friends in the whole world. No one to talk to. My wife also has no friends in the whole world. Absolutely no one." (7)

"(...) [Our family] hardly talked about it [his suicide attempt] afterwards, and my wife was told that we shouldn't talk about this to anyone, (...) that's part of the problem (...) nobody wants to talk about the fact that I have mental health problems." (4)

Shame and stigma related to the male gender role

The respondents' reluctance to seek support from their social networks may also have been influenced by their sense of shame and stigma, linked to their perceptions of traditional male gender roles. Several men described that they felt stigma and shame, both related to having a mental disorder, but also linked to experiencing emotions and expressing them. They described experiencing little acceptance of men's emotions, and they believed that they should only show their feelings when there was a good reason for it, such as when a major tragedy had happened. Two men described that crying made them feel embarrassed and weak.

"There is a strong stigma attached to having, or at least showing, mental health problems as a man. Talking about feelings in general. There are only two emotions that are acceptable, which are anger and hunger (...). I have not felt [the stigma] directed towards me, I have never felt that anyone has used my emotions against me. But again, I've never exposed my emotions to anyone either." (5)

"Women cry and comfort each other, but you rarely see two men crying and comforting each other. If so, there must be a big tragedy that has happened somewhere." (3)

"I have also had some reactions where I suddenly started crying. Then (...) I had to get up and leave (...) so the others wouldn't see that I've started crying, (...) I'm a bit weak, you know." (3)

Several men described qualities they associated with the male gender role, and that they wanted to adhere to such descriptions. These qualities included being strong, being able to

solve their own and other people's problems, not burdening others, and wanting to be a provider for their family.

> *"(...) I know that it's a burden to be someone who (...) helps people with their problems. (...) As a man you shouldn't burden people with problems, you should be the one who takes on and solves them. And not be the one who creates and gives problems (...)." (4)*

The men described wanting to put up a facade with other men, their partner, co-workers, friends, and family members. Several described that men are not helping each other or talking about their emotions with each other, contributing to a feeling of men standing alone and having to fend for themselves. Ultimately this was described as contributing to loneliness.

> *"(...) Men try to have a facade towards each other, we're supposed to be a bit tougher than we are. (...) Can't show too much weakness." (8)*

> *"I have just become accustomed to certain habits of always being cheerful, never being a burden to others (...) Maybe it has to do with, that as a man you're supposed to fix things yourself. I've often stood in front of others who are weak, helped them and lifted quite a bit on my own shoulders. In life, all men have to learn that we need help too, all men need help. (...) We often stand quite alone, man by man." (4)*

Related to the desire of adhering to traditional gender roles, several described feeling shame over not being able to manage their own mental health, which in turn made it difficult to ask for help. Consequently, several described that their difficulties were allowed to escalate until psychiatric emergency admission was deemed necessary.

> *"What happens is that you hope and hope and hope that it will pass. You fight (...) until you hit rock bottom. I think that men build up an even greater fear that we will not be able to cope, because it feels more shameful not being mentally strong, as a man. " (4)*

Discussion

The aim of this study was to explore the experiences that men, with a high risk of suicide, had prior to admittance to a psychiatric emergency unit. We examined factors that might be associated with men's increased suicidal risk, including how these men experience their suicidal crisis (thoughts, feelings, preceding life events, help-seeking) and the influence of the male gender role. The results indicated that the participants had a number of common psychological changes shortly before admission. (1) The participants experienced many intense negative thoughts and feelings characterized by hopelessness, depression, anxiety, and physical pain, as well as an experience that such thoughts and feelings gradually became more unbearable and more difficult to control. (2) The development of acute suicidal intention varied in time, and for some over the course of minutes. However, for all participants this suicidal crisis was characterized by coping strategies ceasing to have desired effects, strong feelings of being trapped, less ambivalence about committing suicide and loss of control over one's behavior. (3) The final part of the results sheds light on how the participants experienced loneliness. Difficulties in using their network, being met with little understanding, as well as conflicts in close relationships, were highlighted as contributory causes of this experience. The participants' own and others' expectations to fulfill characteristics belonging to the traditional male gender role were described as standing in the way of sharing and asking for help for their difficulties.

Descriptions of negative thoughts and emotions

The respondents described experiencing a crescendo of various but interconnected painful and negative thoughts and emotions (e.g., inadequacy, hopelessness, shame, guilt, and grief) prior to and during their suicidal crisis. This is in line with findings from Hendin et al. (2007) and Hendin et al. (2010), who reported that deceased patients had three times as many negative and intense affects prior to suicide, compared to the control group consisting of depressed, non-suicidal individuals. Similarly, the results of the current study are also in line with affective disturbance (B-criterion) of Galynkers (2017) SCS.

A particularly prominent emotion described by the participants was shame, which often was related to an experience of falling short of their own standards. Our respondents described thinking that they were inadequate and worthless, and highlighted this as central to their crisis. For example, being unable to work, not being able to contribute at home, or struggling to cope with their own illness evoked such thoughts. This finding aligns with

research conducted by Lachal et al. (2015), who indicated that emotional distress appeared to largely originate from a sense of failure and was related to suicidal behavior. The research group found that failure was evident through the presence of diminished self-esteem, experiences of worthlessness, incompetence, and even self-hatred.

Other prominent feelings described among the participants were intense hopelessness and desperation. It seemed like many had given up hope of ever feeling better. One participant said that he did not expect to recover from his chronic mental illness and expressed doubts about his capacity to endure a life consisting of constantly recurring admissions to the psychiatric emergency unit. The significance of hopelessness in the suicidal experience is in line with Hendin et al.'s (2007) study, where it was reported that hopelessness could emerge eight to six weeks before the suicide was committed. Additionally, Hendin et al. (2007) reported that desperation was an especially prominent feeling shortly before a suicide attempt. In line with Hendin et al.'s (2007) study, the results of this study showed that all respondents experienced increased negative emotionality, and especially desperation, prior to admission. Even though many of the participants experienced an escalation of negative emotions (including hopelessness) over an extended time-period, they seemingly did not become acutely suicidal until they felt desperate. In this context their present anguish was described as intolerable, and they were overwhelmed by a need for immediate relief. Such experiences are also confirmed in other research (Hendin et al., 2010; Maltsberger et al., 2003).

The participants also reported having various worrying thoughts prior to admission. The men described being concerned about numerous aspects, but the majority of their worries revolved around feelings of hopelessness, helplessness, and discomfort in their current life situation (Kerkhof & van Spijker, 2016). For example, one of the respondents described that he had given up on ever feeling better, while another expressed that it would be better if he was dead. A third described that he would not endure being admitted to the hospital multiple times a year, wondering if and when his depression would subside. These utterances can be understood as corresponding to typical suicidal cognitions, identified in the literature, such as: "I have no future", "I am better off dead", "I can't stand my depression", "When does this stop", respectively. These types of concerns are commonly identified as being highly prevalent in suicidal individuals (Kerkhof & van Spijker, 2016). Rogers and Joiner (2017) found a correlation between rumination and suicidal thoughts and attempts (global rumination (k = 13; Hedge's g =.74), brooding (k = 12; Hedge's g = .63). It is postulated that dwelling on such distress, makes suicidal individuals more convinced that their situation is unsolvable and

that there is no way to improve their life circumstances. Thus leading them to think of suicide as the only solution (Galynker, 2017).

Furthermore, many of the participants reported experiencing overarousal and symptoms of anxiety, such as restlessness, panic, and physical pain, prior to admission. These symptoms correspond to hyperarousal in the B-criteria of SCS (Galynker, 2017). Such experiences are supported by previous research, where increased activation repeatedly has been linked to suicidal behavior (Busch et al., 2003; Ribeiro et al., 2014). It has been found that up to 80% of suicide decedents experienced extreme agitation in the week leading up to their suicide (Busch et al., 2003). Schaefer et al. (2012) argue that the presence of anxiety can amplify feelings of worry, guilt, and self-blame, further fueling the desire to escape. It is reasoned that the increased energy and activation associated with overarousal can serve as a driving force for suicidal behavior. In other words, it can provide the necessary energy to engage in suicidal acts (Galynker, 2017; Ribeiro et al., 2014). Therefore, expert clinical consensus identifies agitation as a "warning sign" for imminent suicide risk (Rudd et al., 2006).

Taken together, the results of this study showed that symptoms of depression and anxiety, including rumination and agitation, appeared to be prominent aspects of the suicidal crisis. Moreover, these results can suggest that identifying the intensification of negative affect and desperation can be useful in signaling elevated and imminent suicide risk. Lastly, several participants reported having a diagnosed psychiatric disorder. As highlighted in our literature review, it is well-established that such diagnoses are among the strongest risk factors for suicidal behavior (Cavanagh et al., 2003; Flint et al., 2021), which our results also support.

Transitioning to the acute suicidal crisis

Collapse of coping strategies

The respondents in this study described using both adaptive and maladaptive coping strategies. One respondent described that in the past, he found it helpful to clarify his thoughts and emotions with others to avoid misunderstandings. He also tried to challenge his own thoughts with alternative perspectives. Literature has shown that such cognitive reappraisal and problem-focused coping is beneficial and can have protective effects on suicidal behavior (Horwitz et al., 2018; Nrugham et al., 2012; Ong & Thompson, 2019). However, several respondents also described frequent use of coping strategies that are associated with increased suicide risk, such as avoidance (Alix et al., 2020), self-blame (Horwitz et al., 2018),

suppression of problems, blaming others for their own difficulties (Marty et al., 2010), and consumption of alcohol or other substances (Ayyash-Abdo, 2002; Bilsen, 2018; Cleary, 2017; Möller-Leimkühler, 2003).

The respondents described that as their mental states deteriorated, they experienced a collapse of coping strategies, where previously useful strategies no longer had the same emotionally regulating effect. Interestingly, this collapse seemed to refer to both the protective and non-protective strategies. Based on the respondents' descriptions and relevant literature findings, possible explanations for these results will be discussed in the following.

It has been reported that individuals with suicidal thoughts and behaviors have a tendency to think in an inflexible manner (Giner et al., 2016), and can be ineffective in thinking of alternatives to cope with their distress (i.e., they are unable to generate new or different solutions to their problems) (Williams et al., 2005). Inflexible thinking can furthermore be seen in light of other studies, showing that individuals with prior suicidal behavior have difficulties in retrieving specific autobiographical memories from long-term memory. Instead, they tend to rely on over general memories. This can diminish one’s capacity to solve problems, as specific autobiographical memories can function as a database providing potential strategies to deal with current difficulties (Pollock & Williams, 2001).

The participants also described having little faith that their situation would change and little understanding of why their regulatory strategies stopped working. This may reflect diminished belief in the effectiveness of their coping strategies. Previous studies have suggested that little belief in the usefulness of coping strategies, and one's ability to cope with difficulties, can act as a risk factor for suicidal behavior (Al-Dajani et al., 2022; Czyz et al., 2016). It may seem like a perceived lack of effective regulatory strategies lead the individual to feel powerless in managing his emotional reaction to a situation (Gratz & Roemer, 2004), and contributed to the perception of his situation as inescapable (Pollock & Williams, 2001). It thus seems like these symptoms can create a negative self-reinforcing cycle of suicidal ideation, where deficits in problem solving and lack of belief are increased by the overwhelming feelings of hopelessness and inadequacy, and vice versa (Watkins & Baracaia, 2002). As a result, breaking out of the depressive cycle seems impossible for the individual. Ultimately, suicidal behavior can serve as an alternative problem-solving strategy for these unbearable emotions, and perceived lack of effective regulation strategies (Cha & Nock, 2009).

Increased entrapment and decreased ambivalence

A key result from the analysis was that the participants experienced a strong sense of entrapment in combination with reduced ambivalence immediately before a suicide attempt. The respondents described their life situation as unbearable and impossible to escape from, both physically and mentally. This can be understood as entrapment, the A-criterion of Galynkers (2017) SCS, which is consistently found to be the strongest predictor of imminent suicide risk within SCS (Galynker et al., 2017; Schuck et al., 2019).

Furthermore, several of the respondents described ambivalence towards taking their own lives, which is consistent with previous literature on the suicidal experience (Bergmans et al., 2017; Bergmans et al., 2009; Gordon et al., 2011). Suicidal ambivalence can be described as an uncertain state, where the individual makes decisions about their life and future on a moment-to-moment basis, without a clear commitment to either life or death. The decision to live or die depends on life circumstances and subjective well-being. While being a torturous state of survival, this ambivalence can also act as a lifeline because one could decide to live while holding open the possibility of death (Bergmans et al., 2017). This finding is in line with our results. For example, one of the respondents described a dual feeling of wanting to live, but at the same time not believing that he could manage it. For him death was seen as a relief and as an emergency exit that he could use if he eventually felt like he had to. Our results additionaly revealed that the respondents became less ambivalent as the suicidal intention increased, which in turn seemed to weaken the resistance to committing suicide. For example, one respondent described that as he got a sudden urge to end his life, he was indifferent to whether he lived or died. Several of the respondents described drinking alcohol as a coping strategy in the hours before their suicide attempt, which in turn also can be a contributing factor in reducing ambivalence, as alcohol consumptions is associated with impaired judgment (Borges et al., 2017) and impulsiveness (Pompili et al., 2010).

In SCS (Galynker, 2017), the simultaneous presence of a wish to die and the fear of death is highlighted. However, the participants of our study did not report this fear of death. Their ambivalence was rather due to guilt over inflicting pain on their family or due to a wish to successfully manage their life.

Bereft of mental and behavioral control

The respondents described a loss of control over their thoughts and behaviors shortly before admission. This loss of control seemed to represent an accumulation of the events and emotional difficulties leading up to admission. This is in line with research findings indicating

that, individuals may experience altered states of consciousness, as well as an inclination towards automatic behavior rather than deliberate thinking, prior to a suicide attempt (Pavulans et al., 2012). These observations are also consistent with established models of suicidal behavior, including the NCM and its concept of SCS (Galynker, 2017).

Another aspect related to the loss of control that should be given additional attention concerns the timeframe of deciding to attempt suicide. Specifically, it is worth noting that three participants described that this decision was made very quickly, within a matter of hours or even minutes, and with minimal prior planning. Thus, the decision itself can be regarded as impulsive in nature, despite that they may have had an inner debate whether to live or die over a longer period. Our findings thus demonstrate that the time span between contemplating suicide and carrying out the attempt can be very short, which aligns with Deisenhammer et al.'s (2008) research. This contrasts with the rest of the participants who, at the time of the interviews, had not experienced such an acute development of suicidal intent. They described a more continuous process of weighing the pros and cons of continuing to live and did not exhibit the same degree of loss of behavioral control. For example, some of them actively requested hospitalization, took sick leave, and sought follow-up care from their general practitioner. Some asked for help due to recognizing a gradual loss of control over their behavior.

Taken together, these findings demonstrate the significance control can have in the realization of a suicide attempt. The respondents highlighted the presence of a lack of control shortly before admission, emphasizing the overarching importance of perceived control. The concept of control in this context may possess a dual meaning (Pavulans et al., 2012). On one hand, suicide attempts can be seen as a complete loss of control, a result of chaotic thoughts, behavior, and life circumstances. On the other hand, it can be interpreted as an attempt to regain control, suggesting that suicidal behavior can serve as a means of coping with the current crisis.

These findings highlight how various aspects of control can contribute to individuals becoming and remaining suicidal. Additionally, these findings have significant implications for assessing suicide risk, whereof changes in behavioral patterns or noticeable uncontrollable behavior, could serve as a warning sign of impending suicidal behavior, and call for (re)evaluation of suicide risk.

The impact of the male gender role and isolation

Relational difficulties and lack of support

Several participants experienced conflicts in their relationships prior to the suicidal crisis, and some even suffered the loss of close relationships. These experiences were associated with feelings of rejection, loneliness, lack of belonging, and frustration. This is consistent with literature showing that interpersonal conflict and loss can serve as triggers for suicidal behavior (Glenn & Nock, 2014; Nock et al., 2008a). A cross-sectional study by Bagge et al. (2013) attempted to quantify the impact of such negative events on suicide attempts and identified an increased likelihood of suicide within the next 48 hours following such negative life events. This was particularly true for events involving interpersonal relationships, especially related to romantic partners. This is in line with the participants' experiences, whereof several of them described the breakdown of close relationships preceding their suicidal crisis. Together, these findings highlight how changes and conflicts in interpersonal relationships can serve as triggers for a suicidal crisis and should be given particular consideration when assessing suicide risk.

Experiences of not belonging and being a burden may illuminate why such negative life experiences attains such significance in the suicidal crisis, as highlighted in both Galynkers NCM (Galynker, 2017) and Joiners IPT of suicide (Van Orden et al., 2010). Perceived burdensomeness refers to the belief that one is a burden on others, and that others would be better off if one were not alive. For example, one participant expressed reluctance to confide in his family, citing a desire not to burden them, and believing that they had enough problems of their own. Thwarted belongingness, on the other hand, refers to the perception of feeling disconnected from others, lacking a sense of belonging thus feeling alone. For example, one participant explicitly stated that he had nobody to rely on and felt completely alone. It is postulated that such feelings promote the development of a desire for suicide, where death is seen as a means of escaping painful feelings and situations (Galynker, 2017; Van Orden et al., 2010).

In addition to experiencing negative interpersonal life events, several participants described lacking support from important others. Some described being afraid to seek support from their network due to fear of negative reactions, and previous experiences of being rejected, belittled, and not taken seriously. Thus, one may reason that the participants' repeated encounters with inadequate support might have led them to seek alternative methods of coping. Such reluctance to share feelings or difficulties with others, can be considered unfavorable, as this is reported to intensify perceived distress (Cleary, 2012). As the negative

emotions became increasingly difficult to conceal, the respondents' need to isolate seemed to grow. This in turn could increase the sense of disconnection and loneliness. This is in line with literature findings which consistently show that social isolation is one of the most powerful and consistent predictors of suicidal behavior regardless of population, age, nationality, or clinical severity (Beutel et al., 2017; Conwell et al., 1990; Dervic et al., 2008; Joiner Jr et al., 2009; Motillon-Toudic et al., 2022). Together, this illuminates the potential impact of social disconnection and isolation on a suicidal crisis, both in a short-term and long-term perspective.

Shame and stigma related to the male gender role

The participants described that societal attitudes regarding the male gender role negatively affected their mental health and willingness to seek help for their difficulties. Several participants expressed a wish to appear strong, independent, and capable - traits commonly associated with the traditional male gender role (Clement et al., 2015). The participants described that their current mental health problems, as well as having negative emotions at all, did not match these expectations of what a man should be. They thus reported feeling ashamed and stigmatized for their shortcomings.

Courtenay (2000) and Möller-Leimkühler (2003) have suggested that men experience feelings of shame and inadequacy when they struggle to meet societal expectations of masculinity. Studies also indicate that it is important for men to maintain distinct emotional expressions from women, as similarity in emotional expression is seen as a sign of subordination. In this context emotional behavior is proposed to be regulated by other men, who set the standard for which behaviors are seen as acceptable (Frosh et al., 2002). This may be the case for some of the participants in this study as well. For example, one respondent described keeping up a facade towards other men, pretending to be tougher than he was, not wanting to show weakness.

The wish to adhere to traditional gender roles can be considered in light of socialization practices. It has been argued that attitudes connected to masculinity emerge from boys being taught the importance of displaying strength, as well as hiding emotions and pain (Kimmel, 1994; Connell, 2002; Frosh et al., 2002). This may hinder the development of emotional knowledge and might influence why some men have difficulties in identifying, tolerating, and regulating their own emotions, as well as psychological symptoms (Addis & Mahalik, 2003; Cleary, 2012; Lynch et al., 2018). This seems to coincide with the experiences of the current study’s participants, as they described difficulties in both identifying and

dealing with their discomfort. Consequently, socialization practices and the learned wish to adhere to traditional male traits, may heighten the threshold of expressing difficulties, resulting in emotional underplaying or suppression (Brownhill et al., 2005; Möller-Leimkühler, 2003). This tendency can contradict both the acknowledgment of a need for help and the acceptance of professional mental healthcare (Möller-Leimkühler, 2003). This seems to be true for several participants of this study, as they described having created a barrier against disclosing their struggles to family, friends, and healthcare professionals. Biddle et al. (2004) reported that some men tend to avoid seeking help until their distress becomes severe and unbearable. For example, one respondent described hoping intensely for his problems to just pass and fighting until he eventually hit rock bottom. He explained that his behavior was motivated by shame of not being able to manage his mental health, believing that he should be able to do so as a man. One may reason that this strategy can make these men more vulnerable to developing suicidal behavior and viewing suicide as a potential solution to their problems.

Overall, these findings demonstrate how a wide range of gender-related factors can contribute to the development of suicidal behavior. It is, however, crucial to move beyond oversimplified generalizations about men in order to identify specific at-risk males. There is significant value in understanding the diverse ways in which men across different cultures experience, express, and cope with suicidal thoughts and behaviors. This can allow for better identification and development of optimal assistance for different at-risk groups (Canetto & Cleary, 2012).

Strengths and Limitations of this study

The participants of this study were recruited from a psychiatric emergency unit, thereby making it possible to acquire knowledge about their subjective experiences during, or just days after their suicidal crisis. This may increase the study's ecological validity, as well as reduce the risk of recall bias (Sedano-Capdevila et al., 2021). Although the sample consisted of men only, there was a great diversity in terms of age, marital status, occupational status, and history of mental disorder. However, to understand the transferability of our results, future studies should involve non-help seeking participants as well.

Performing the interviews shortly after a crisis may also entail some drawbacks. Although all participants were assessed as sufficiently emotionally stable to participate, it cannot be ruled out that their psychological difficulties negatively affected their ability to understand questions and/or concentrate during the interview. On a couple of occasions, the participants needed repetition and rephrasing of the questions asked, and some answers did

not relate to the question posed. Additionally, the majority of participants described receiving medication during their hospitalization, and this observed behavior might also be attributed to the side effects of these medications.

Qualitative research methods are suitable in cases where you want to study phenomena where there is little evidence-based knowledge (Tjora, 2017). To the knowledge of the researchers, there are few previous studies that have investigated the experiences of an ongoing psychological crisis. Current research on the topic has mostly been carried out with quantitative designs. In cases where qualitative designs have been used, these have primarily been carried out ad hoc of the crisis or indirectly, via close relatives of the deceased (Cleary, 2012; Lynch et al., 2018; Rasmussen et al., 2014). Consequently, a strength of this study and use of qualitative design, is that it can be a useful supplement to existing research. However, it is important to emphasize that, given the design of this study, it cannot provide any information about the strength of the mentioned risk factors or their predictive value.

Given the higher suicide rates in men, it was desirable to interview men specifically. However, some of the findings may apply to all individuals, regardless of gender or mental disorders, and may not be exclusive to men. However, research using a qualitative design does not aim to draw generalized conclusions, but to contribute with in-depth, detailed descriptions of specific phenomena. Although qualitative methods differ from statistical generalization, as is attempted within a quantitative framework, some would argue that an important goal of qualitative research is to produce applicable knowledge that has a transfer value. One can imagine that the study could have a transferable value in the form of a *reader generalizability* (Tjora, 2017), which in this case implies that practitioners should be able to draw conclusions from the findings, and benefit from and apply these in their own clinical practice.

Implications of the study

This study provides a unique insight into male psychiatric inpatients' experiences related to the nature and progression of their suicidal crisis. The participants in this study conveyed that entrapment, loss of control, intense negative affect, and negative interpersonal life events were significant factors contributing to the development of their suicidal crises. Thus, the participants' shared experiences align with existing literature, emphasizing the importance of considering these risk factors in suicide risk assessments. Although this study cannot determine the predictive value of these experiences, their similarities to other research suggest their significance in understanding and evaluating suicide risk. Hence, a key

implication is that these factors should be particularly emphasized in comprehensive clinical assessments and may be more informative for imminent risk than reported suicidal thoughts or past attempts (Silverman & Berman, 2020).

The assessment of these factors could be particularly valuable in cases where patients are reluctant to disclose their suicidal intent in clinical evaluations. The participants expressed that views on traditional gender roles contributed to reluctance in sharing their difficulties. This resulted in having to deal with their struggles alone. A consequence of this tendency could be that the issues worsen to potentially fatal outcomes, without being noticed by others. This underscores the importance of clinicians having a comprehensive understanding of the risk factors that signal an ongoing crisis, moving beyond confirming or refuting the presence of suicidal thoughts, plans, and methods (Schmitz Jr et al., 2012).

The experiences reported by the participant had several similarities to the SCS, as described in Galynkers model (2017). Thus, this study can give some support to the conceptualization of suicidal behavior through NCM, and application of this theoretical framework in clinical practice. It highlights the potential benefit of approaching suicidal behavior through a framework that considers both short-term and long-term factors. Furthermore, the utilization of such a suicide-specific diagnosis, with the accompanying self-report questionnaire (SCI), can complement clinical inquiry, and supplement standard procedures for evaluating suicide risk.

Lastly, the experiences related to the development of suicidal crises can be valuable in preventive efforts to identify men at acute risk of suicide. Considering that suicidal behavior can develop within minutes or hours, and that many individuals are not in contact with healthcare institutions prior to suicidal behavior, it underscores the importance of non-healthcare actors being able to identify individuals with increased suicide risk. Therefore, providing information about common warning signs of acute suicide risk to workplaces, military services, schools, universities, and the general population can be considered beneficial (Deisenhammer 2008; Rasmussen et al., 2018a; Walby et al., 2018b).

Future studies

As the sample in this study only consists of men receiving professional help, conducting additional studies that explore similar experiences with diverse participant compositions and characteristics could provide valuable insight. It would be relevant to explore whether the suicidal process follows the same development, and whether the same or

other factors act as driving forces of the suicidal crisis. Additionally, questions regarding perceived barriers and helpful resources during a crisis could be pertinent in this context. Potentially relevant participants could include women, men who have not sought professional help, men from diverse cultural backgrounds, and men with various psychiatric disorders. Comparing experiences across different groups can shed light on differences and similarities, which is essential for adapting effective and specialized treatment approaches and interventions.

The use of other research designs is also relevant in this context. By employing quantitative methods, one can assess the strength, and predictive value of the risk factors and experiences identified in this study, as well as their association with each other. Moreover, the use of prospective cohort studies could allow researchers to investigate how the experience and frequency of suicidal behavior changes over time due to interventions or changes in risk factors (Gulsethet al., 2019).

Prior to the study, efforts were made to consider the potential positive and negative consequences of participation. The participants were briefly asked about their experiences related to participation, but these experiences were not prioritized in the results section. However, all respondents expressed that participating in the study was perceived as positive. In this context, several emphasized the importance of gaining more knowledge about suicide and mental health, especially among men, and found it meaningful to share their stories. In light of the ethical considerations of doing research on ongoing crises, it may be interesting and useful to conduct further research on whether participation in similar studies can be beneficial for participants. More knowledge in this context could potentially contribute to increased research on suicidal behavior in the acute phase.

Conclusion

This study explored the experiences that men, with a high risk of suicide, had prior to admittance to a psychiatric emergency unit. Factors that might be associated with their increased suicidal risk were examined. To illuminate the experiences of the suicidal crisis, the men were asked questions regarding thoughts, emotions, recent life events, help seeking, and the influence of the male gender role. This study showed that the participants had several common psychological changes shortly before admission. They experienced numerous intense negative thoughts and feelings characterized by hopelessness, depression, anxiety, and physical pain, which gradually became more unbearable and difficult to control. The

development of acute suicidal intention varied in time, and for some over the course of minutes. However, for all participants, this crisis was characterized by coping strategies ceasing to have desired effect, strong feelings of entrapment, less ambivalence about committing suicide and loss of control. The study also shed light on how the participants experienced loneliness, attributed to difficulties in utilizing their support network, being met with little understanding, and conflicts in close relationships. Fulfilling characteristics associated with the traditional male gender role was described as hindering their ability to seek help and share their difficulties.

There is a pressing need for more comprehensive studies focusing specifically on men and their heightened vulnerability to suicide. Similarly, there is a need for more knowledge on the characteristics of suicidal behavior in the acute phase. This study aimed to address these knowledge gaps by providing insights into the complex and multifaceted factors contributing to the development of suicidal behavior. Thus, highlighting the significance of going beyond self-reported ideation and plans when assessing suicide risk. The findings offer valuable insights into factors central to acute suicidal crises among men, which can inform clinical practices and improve the identification of individuals at high risk of suicide.

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Appendix

Appendix A: Information letter with consent form to informants

NTNU | Kunnskap for en bedre verden

Vil du delta i forskningsprosjektet

"Beskrivelser av psykologiske kriser og hjelpesøking blant menn som er innlagt på akuttpsykiatrisk avdeling"

FORMÅLET MED PROSJEKTET OG HVORFOR DU BLIR SPURT

Dette er en invitasjon til å delta i en studie som undersøker psykisk helse hos menn. Vi er interessert i å høre mer om dine opplevelser nå som livet er blitt svært krevende for deg, og vi ønsker å forstå hva som har bidratt til din nåværende situasjon. Videre ønsker vi å høre om dine erfaringer med å oppsøke hjelp, samt hvilke hjelpetilbud som har vært og eventuelt kunne vært nyttig for deg. At du vil fortelle om dine erfaringer er viktig for at vi som helsepersonell kan bli bedre på å forstå menn i din situasjon, og hvordan vi på best mulig måte kan være til hjelp og støtte i disse situasjonene.

HVA INNEBÆRER PROSJEKTET FOR DEG?

Deltakelse i denne studien vil innebære å møte til et intervju, hvor du forteller om tanker og følelser som har vært fremtredende hos deg i tiden før innleggelsen på akuttpsykiatrisk avdeling. Intervjuet vil ha en varighet på ca. 45 minutter, men kan deles opp i to omganger dersom det blir behov for det. Intervjuet gjennomføres av Oda Buholt og Henriette Ofstad, som er psykologstudenter på 5. året ved NTNU. En ansatt ved den akuttpsykiatriske avdelingen kan også være til stede under intervjuet, dersom du ønsker det. Intervjuet vil gjennomføres i egnet lokale på den akuttpsykiatriske avdelingen i løpet av den perioden du er innlagt. Intervjuet vil så langt det lar seg gjøre gjennomføres fysisk, men på grunn av usikkerhet rundt COVID-19 og smitteverntiltak kan det hende det blir nødvendig å gjennomføre intervjuet digitalt via videoverktøyet Skype for Business.

Det vil gjøres lydopptak av intervjuet, som i etterkant vil skrives ned som tekst (transkriberes).

MULIGE FORDELER OG ULEMPER

Målet med studien er å øke kunnskap om menn sine opplevelser av å gå gjennom psykologiske kriser. Slik informasjon er viktig for at helsepersonell skal få en bredere forståelse for menn i din situasjon, og for at vi i fremtiden skal gi best mulig hjelp til de som trenger det.

Deltagelse i studien tar tid (ca. 45 minutter), og noen kan oppleve intervjuet som slitsomt eller utfordrende. Ettersom vi ønsker å stille deg spørsmål om din nåværende situasjon vil samtalen kunne berøre temaer som kan oppleves sensitive og krevende for deg å snakke om. Foruten det, vurderes det ikke til å være noen store ulemper eller risiko forbundet med å delta i studien.

Dersom du opplever vanskelige tanker, følelser eller bekymringer knyttet til prosjektdeltagelsen mens du er innlagt, kan du ta kontakt med personalet ved den akuttpsykiatriske avdelingen. Dersom du opplever vanskelige tanker, følelser eller bekymringer knyttet til prosjektdeltagelsen *etter* utskrivelse, kan du ta kontakt med overlege Arne Vaaler ved den akuttpsykiatriske avdelingen, prosjektleder Torun Grøtte (se kontaktinformasjon på siste side) eller benytte deg av det hjelpeapparatet som etableres rundt deg ifm utskrivelse. Kontaktinformasjonen til Arne Vaaler vil bli utlevert under intervjuet.

FRIVILLIG DELTAKELSE OG MULIGHET TIL Å TREKKE DITT SAMTYKKE

Det er frivillig å delta i dette prosjektet. Dersom du ønsker å delta, undertegner du samtykkeerklæringen på siste side. Du kan når som helst og uten å oppgi noen grunn trekke ditt samtykke. Det vil ikke ha noen negative konsekvenser for deg eller din behandling hvis du ikke vil delta eller senere velger å trekke deg.

Dersom du ønsker å delta i studien gir du beskjed om dette til den som har informert deg om studien ved den akuttpsykiatriske avdelingen, som så vil videreformidle ditt ønske om å delta til oss.

Dersom du trekker tilbake samtykket, vil det ikke forskes videre på dine helseopplysninger. Du kan kreve innsyn i opplysningene som er lagret om deg, og opplysningene vil da utleveres innen 30 dager. Du kan også kreve at dine helseopplysninger i prosjektet slettes, med mindre

opplysningene allerede er inngått i analyser eller brukt i vitenskapelige publikasjoner, jfr. helseforskningsloven § 16.

Dersom du senere ønsker å trekke deg eller har spørsmål til prosjektet, kan du kontakte prosjektleder Torun Grøtte (se kontaktinformasjon på siste side).

HVA SKJER MED OPPLYSNINGENE OM DEG?

Opplysningene som registreres om deg skal kun brukes slik som beskrevet under formålet med prosjektet, og planlegges brukt til 2024. Eventuelle utvidelser i bruk og oppbevaringstid kan kun skje etter godkjenning fra REK og andre relevante myndigheter. Du har rett til innsyn i hvilke opplysninger som er registrert om deg og rett til å få korrigert eventuelle feil i de opplysningene som er registrert. Du har også rett til å få innsyn i sikkerhetstiltakene ved behandling av opplysningene. Du kan klage på behandlingen av dine opplysninger til Datatilsynet og forskningsinstitusjonens personvernombud.

Alle opplysninger vil bli behandlet uten navn og fødselsnummer eller andre direkte gjenkjennende opplysninger. En kode knytter deg til dine opplysninger gjennom en navneliste, og det er kun prosjektleder Torun Grøtte og psykologstudenter Oda Buholt og Henriette Ofstad som vil ha tilgang til denne listen. Lydopptak vil umiddelbart etter gjennomføring og transkribering tas ut av enheten og lagres som en kryptert fil på St.Olavs hospitals server. Datamaterialet vil kun behandles av psykologstudenter (Oda Buholt og Henriette Ofstad), prosjektleder (Torun Grøtte) og biveileder (Katrine H. Holgersen).

Publisering av resultater er en nødvendig del av forskningsprosessen. All publisering skal gjøres slik at enkeltdeltakere ikke skal kunne gjenkjennes.

Etter at forskningsprosjektet er ferdig, vil opplysningene om deg bli oppbevart i fem år av kontrollhensyn. Deretter slettes både lydopptak og transkripsjon av dette.

FORSIKRING

Som deltaker i studien er du forsikret gjennom NTNU som selvassurandør. Som pasient hos St. Olavs hospital er du også dekket av ordinære juridiske pasientrettigheter.

GODKJENNINGER

Regional komité for medisinsk og helsefaglig forskningsetikk har gjort en forskningsetisk vurdering og godkjent prosjektet (saksnummer: 457836). På oppdrag fra NTNU og St. Olavs

hospital HF har Personverntjenester Sikt vurdert at behandlingen av personopplysninger i dette prosjektet er i samsvar med personvernregelverket.

Forskningsprosjektet blir gjennomført som et samarbeid mellom Institutt for psykologi v/NTNU og akuttseksjonen, avd. Østmarka, St. Olavs hospital. Etter ny personopplysningslov har databehandlingsansvarlig Institutt for psykologi ved NTNU og prosjektleder Torun Grøtte et selvstendig ansvar for å sikre at behandlingen av dine opplysninger har et lovlig grunnlag. Vi behandler opplysninger om deg basert på ditt samtykke.

KONTAKTOPLYSNINGER

Dersom du har spørsmål til prosjektet eller ønsker å trekke deg fra deltakelse, kan du ta kontakt med prosjektleder Torun Grøtte, tlf: 979 55 377, e-post: torun.grotte@ntnu.no.

Dersom du har spørsmål om personvernet i prosjektet, kan du kontakte personvernombudene ved St. Olavs hospital eller NTNU:

- Kjetil Sørensen (St. Olavs hospital): kjetil.sorensen@stolav.no
- Thomas Helgesen (NTNU): thomas.helgesen@ntnu.no

JEG SAMTYKKER TIL Å DELTA I PROSJEKTET OG TIL AT MINE PERSONOPPLYSNINGER BRUKES SLIK DET ER BESKREVET

Sted og dato

Deltakers signatur

Deltakers navn med trykte bokstaver

Appendix B: Interveiwguide

INTERVJUGUIDE

Innledende informasjon om hvem vi er, intervjuet og informantenes rettigheter som deltagere

Hei. Vi heter Henriette Ofstad og Oda Buholt. Vi studerer psykologi på NTNU og er snart ferdig utdannede psykologer. Vi skriver i år en avsluttende oppgave om psykisk helse hos menn. Vi er interessert i å høre mer om dine opplevelser nå som livet er blitt svært krevende for deg. Vi ønsker å forstå hva som har bidratt til din nåværende situasjon. At du vil fortelle om dine erfaringer er viktig for at vi som helsepersonell kan bli bedre på å forstå menn i din situasjon, og hvordan vi på best mulig måte kan være til hjelp og støtte i disse situasjonene.

Vi har stor forståelse for at du befinner deg i en vanskelig situasjon nå. Vi synes det er veldig modig av deg å snakke med oss om dette, og setter stor pris på at du vil stille opp her i dag.

Du har fått et informasjonsskriv i forkant av denne samtalen, der det blant annet stod litt om om formålet med samtalen og noe praktisk informasjon om taushetsplikt o.l.Før vi går i gang med å stille deg spørsmål vil vi først gjenta noe av denne informasjonen.

Varighet på intervjuet samt opptak- og lagring av informasjon:

Vi vil gjerne stille deg noen spørsmål om dine opplevelser den siste tiden. Opplevelsen er bare din, og det finnes ingen gale svar. Vi vil gjerne at du forteller så detaljert du klarer, og vi setter pris på alle betraktninger du har rundt spørsmålene som blir stilt. Intervjuet vil vare i ca. 45 minutter.

Vi, og alle som jobber med denne oppgaven, har taushetsplikt, som betyr at den informasjonen du gir oss ikke vil deles med andre. Intervjuet vil bli tatt opp, slik at vi kan fremstille din opplevelse på en så korrekt måte som mulig. Når vi lagrer og skriver om samtalen vår vil informasjon du gir oss anonymiseres, slik at man ikke kan spore svarene dine tilbake til deg. Når som helst i løpet av intervjuet har du mulighet til å trekke deg fra studien eller la vær å svare på ting du ikke vil svare på.
Hvis du trenger at vi gjentar eller forklarer spørsmålene nærmere, eller trenger en pause i løpet av intervjuet så bare si ifra. Har du noen spørsmål før vi begynner intervjuet?

Innledende spørsmål/"oppvarming"

1. Hvor gammel er du?
2. Hvor kommer du fra?
3. Hvem bor hjemme hos deg?
4. Er du i jobb nå/vært det tidligere? Hva jobber du med?
5. Kan du fortelle om noe eller noen du setter pris på?

Spørsmål om bakgrunn for innleggelse /oppløpet mot krisen

1. Kan du fortelle meg litt om hva du strever med, og grunnen til at du er her på akuttposten?
    a. Hvem henviste deg til akuttposten?
        i. Ønsket du selv å bli innlagt eller var dette på noen andres initiativ?
2. Har du opplevd noen endringer i livet den siste tiden som har påvirket deg i stor grad og som du tenker har hatt betydning for at du ble lagt inn på sykehuset? (humør, fysisk- og psykisk helse, økonomi, aktivitetsnivå, sosiale relasjoner)
    a. Kan du fortelle litt om hva dette er?
        i. Når skjedde denne endringen(e)?
        ii. Hvordan tror du denne hendelsen har påvirket deg? (positivt, negativt, ingen endring)
        iii. Hvilke følelser/tanker vekket dette i deg?

Spørsmål om "suicide crises syndrom"

Innledning: Vi vil nå stille deg noen mer detaljerte spørsmål om de tankene og følelsene du har hatt før innleggelsen og som du kanskje opplever i dag. Vi vil gjerne høre din historie og det du mener er viktig i denne sammenheng. Vi vil igjen presisere at det ikke finnes noen gale svar.

Spørsmål om følelser

1. Kan du fortelle om hvilke følelser du kjente på i dagene før innleggelsen? (Skam, skyld, tristhet, sinne, avsky, redsel, apati, irritabel)
    a. Hvilke følelser kjente du mest på?
    b. Kan du si litt mer om hvordan det var for deg?
        i. Noen kan kjenne på en sterk følelsesmessig smerte, har du kjent på dette?

2. Jeg lurer på hvordan disse følelsene utviklet seg. Kom de f eks plutselig eller snikende? Kom og gikk de, eller var de der hele tiden? Føltes de like intense hele tiden?
3. Hvordan reagerte du når du fikk disse følelsene?

Entrapment

1. Mange i din situasjon forteller at de opplever å være fanget og helt fastlåst i sin situasjon. Har du opplevd dette?
    a. Kan du fortelle litt mer om dette?
2. Kan du fortelle litt om hvilke tanker du har rundt døden?
    a. Har livet noen gang vært så krevende at du har tenkt på at du ikke lengre ville leve?
        a. (Hvis ja) Har disse tankene vært tilstede de siste dagene før innleggelsen?
3. Hvis ja på spørsmålet over:
    a. Noen erfarer at når de har tanker om å ville dø, har de samtidig en frykt for å dø og har tanker om å ønske å leve. Har det vært slik for deg?

Spørsmål om tanker og bekymringer

1. Hva slags tanker og bekymringer hadde du i dagene før du ble innlagt?
    a. Opplevde du at det var vanskelig å stoppe din bekymring eller at det var vanskelig å flytte fokus over på noe annet?
2. Hvordan kunne du merke denne bekymringen i kroppen din? (Hodeverk, magevondt, muskelsmerte, kvalme, anspenthet, brystsmerte, rastløshet, prikking i fingrene, mer oppmerksom, sterkere sanseinntrykk, vanskelig å sovne, osv.)

Mestringsstrategier

1. Vi har nå stilt deg noen spørsmål om dine tanker og følelser. Jeg lurer på om du har forsøkt å dempe disse på noen måter? (mestringsstrategier som rus, unngåelse, distraksjon, mat, TV/spill)
    a. Hvordan har disse strategiene fungert for deg?

Sosial fungering

Mange som er i en vanskelig livssituasjon merker at dette påvirker deres sosiale liv og kan oppleve endringer knyttet til f eks hvor ofte man er sammen med andre, hvem man er sammen med og hva man føler/tenker når man er sammen med andre.

1. Hvordan har dette vært for deg?
    a. Hva er grunnen til dette?

Spørsmål om hjelpesøking

Introduksjon: Avslutningsvis vil vi stille deg noen spørsmål om det å be hjelp når man har det vanskelig.

1. Hva tenkte du om å oppsøke hjelp for dine psykiske plager, før du mottok hjelp?
2. Hvilke forhold påvirket at du fikk hjelp?
    a. Var det noe som hindret deg i å oppsøke hjelp?
    b. Og motsatt, var noe som gjorde at du fikk hjelp?
2. Før denne innleggelsen, hva slags hjelp har du fått for dine vansker?
    a. På hvilken måte var dette til hjelp eller ikke for deg?
        i. Kan du si litt mer om hvordan og på hvilke måter?
    b. Hvilken hjelp tror du hadde vært best for deg i din situasjon?
3. Hvis du ser tilbake i tid - hva tror du skulle til for at du hadde oppsøkt hjelp tidligere?
4. Vi vet at mange menn synes det kan være vanskelig å be om hjelp, og snakke om, sine psykiske vansker. Tror du ditt syn på hva en mann burde være har påvirket dine vansker på noen måter?
    a. Og videre, påvirket ditt ønske om å be om hjelp?
5. Hva er viktigst for deg for at du skal få det bedre?

Avsluttende spørsmål

1. Er det noe mer du ønsker å legge til før vi avslutter?
2. Har du noen spørsmål til oss?

Avsluttende kommentar

Takk for din tid og at du har svart så utfyllende og ærlig på spørsmålene vi har stilt deg. Vi ønsker deg lykke til videre i din prosess.

Appendix C: Processed submission assessment from the Regional Committees for Medical and Health Research Ethics (REK)

Region:	Saksbehandler:	Telefon:	Vår dato:	Vår referanse:
REK nord	Lill Martinsen	77620753	21.06.2022	457836

REK nord
Besøksadresse: MH-2, 12. etasje, UiT Norges arktiske universitet, Tromsø

Telefon: 77 64 61 40 | **E-post**: rek-nord@asp.uit.no
Web: https://rekportalen.no

Torun Grøtte

Prosjektsøknad: Beskrivelser av psykologiske kriser og hjelpesøking blant menn som er innlagt på akuttpsykiatrisk avdeling
Søknadsnummer: 457836
Forskningsansvarlig institusjon: Norges teknisk-naturvitenskapelige universitet
Samarbeidende forskningsansvarlige institusjoner: St. Olavs Hospital HF
Prosjektsøknad godkjennes

Søkers beskrivelse
Formålet med denne kvalitative studien er å undersøke menns opplevelser av psykologiske kriser i forkant av innleggelse på akuttpsykiatrisk avdeling, samt menns tanker om hva som kan fremme og/eller hemme hjelpesøking for psykiske vansker.

To områder vil bli særlig vektlagt:
1) Hva slags tanker, følelser, kroppslige fornemmelser og atferd opplever deltageren i dagene før innleggelsen på akuttpsykiatrisk avdeling?
2) Hjelpesøkingsatferd: Hvilke faktorer var viktige for at deltageren søkte hjelp for psykisk helse? Opplevde barrierer?

Datainnsamling vil foregå gjennom semi-strukturerte intervju av 8-12 menn som er nylig innlagt på akuttpsykiatrisk avdeling, samt vurdert til å ha høy suicidrisiko ved innkomst. Data vil transkriberes og deretter analyseres ved hjelp av tematisk analyse. Med denne studien håper vi å kunne løfte frem menn sine subjektive opplevelser av å stå i en psykologisk krise, samt frembringe kunnskap som kan gi økt forståelse for overrepresentasjonen av menn i selvmordsstatistikken, samt hva som skal til for å

identifisere og hjelpe flere suicidale menn før de forsøker å ta sitt eget liv.

Vi viser til tilbakemelding mottatt 24.05.2022 og 07.06.2022. Tilbakemeldingen er behandlet av sekretariatet i Regional komité for medisinsk og helsefaglig forskningsetikk REK nord på delegert fullmakt fra komiteen, med hjemmel i forskningsetikkforskriften § 7, første ledd, tredje punktum. Vurderingen er gjort med hjemmel i helseforskningsloven § 10.

REKs vurdering
Prosjektleders tilbakemelding vurderes å være iht. komiteens merknader.
Vedtak
REK har gjort en helhetlig forskningsetisk vurdering av alle prosjektets sider og godkjenner det med hjemmel i helseforskningsloven § 10.
Prosjektet er godkjent frem til omsøkt sluttdato 31.12.2024.
Av dokumentasjonshensyn skal opplysningene oppbevares i fem år etter prosjektslutt. Enhver tilgang til prosjektdataene skal da være knyttet til behovet for etterkontroll. Prosjektdata vil således ikke være tilgjengelig for prosjektet.
Prosjektleder og forskningsansvarlig institusjon er ansvarlige for at opplysningene oppbevares indirekte personidentifiserbart i denne perioden, dvs. atskilt i en nøkkel- og en datafil.
Etter denne femårsperioden skal opplysningene slettes eller anonymiseres. Komiteen gjør oppmerksom på at anonymisering er mer omfattende enn å kun slette koblingsnøkkelen, jf. Datatilsynets veileder om anonymiseringsteknikker.
Vi gjør oppmerksom på at før prosjektet igangsettes må det foreligge et behandlingsgrunnlag for behandling av personopplysninger. Dette må forankres i egen institusjon.

Sluttmelding
Prosjektleder skal sende sluttmelding til REK på eget skjema via REK-portalen senest 6 måneder etter sluttdato 31.12.2024, jf. helseforskningsloven § 12. Dersom prosjektet ikke starter opp eller gjennomføres meldes dette også via skjemaet for sluttmelding.
Søknad om endring
Dersom man ønsker å foreta vesentlige endringer i formål, metode, tidsløp eller organisering må prosjektleder sende søknad om endring via portalen på eget skjema til REK, jf. helseforskningsloven § 11.
Klageadgang
Du kan klage på REKs vedtak, jf. forvaltningsloven § 28 flg. Klagen sendes på eget skjema via REK portalen. Klagefristen er tre uker fra du mottar dette brevet. Dersom REK opprettholder vedtaket, sender REK klagen videre til Den nasjonale forskningsetiske komité for medisin og helsefag (NEM) for endelig vurdering, jf. forskningsetikkloven § 10 og helseforskningsloven § 10.

Med vennlig hilsen

May Britt Rossvoll
sekretariatsleder

Lill Martinsen
seniorrådgiver

Kopi til:
Norges teknisk-naturvitenskapelige universitet
St. Olavs Hospital HF
arne.vaaler@stolav.no

Appendix D: Approvement from Norwegian center for research data (NSD)

Vurdering av behandling av personopplysninger

Referansenummer
247113

Vurderingstype
Standard

Dato
23.06.2022

Prosjekttittel
Beskrivelser av psykologiske kriser og hjelpesøking blant menn som er innlagt på en akuttpsykiatrisk avdeling

Behandlingsansvarlig institusjon
Norges teknisk-naturvitenskapelige universitet / Fakultet for samfunns- og utdanningsvitenskap (SU) / Institutt for psykologi

Felles behandlingsansvarlige institusjoner

- St. Olavs Hospital

Prosjektansvarlig
Torun Grøtte

Student
Henriette Ofstad og Oda Buholt

Prosjektperiode
11.07.2022 - 31.12.2024

Kategorier personopplysninger

- Alminnelige
- Særlige

Lovlig grunnlag

- Samtykke (Personvernforordningen art. 6 nr. 1 bokstav a)
- Uttrykkelig samtykke (Personvernforordningen art. 9 nr. 2 bokstav a)

Behandlingen av personopplysningene er lovlig så fremt den gjennomføres som oppgitt i meldeskjemaet. Det lovlige grunnlaget gjelder til 31.12.2029.

Meldeskjema

Kommentar

Personverntjenester har en avtale med den institusjonen du forsker eller studerer med. Denne avtalen innebærer at vi skal gi deg råd slik at gjennomføringen av prosjektet ditt er lovlig etter personvernforordningen (GDPR).

Personverntjenester har på vegne av din institusjon vurdert at behandlingen av personopplysninger i dette meldeskjemaet er lovlig. Hvis den gjennomføres slik den er beskrevet i meldeskjemaet med dialog og vedlegg.

Dette betyr at du kan starte med prosjektet ditt.

BAKGRUNN

Prosjektet er vurdert og godkjent etter helseforskningsloven § 10 av Regionale komiteer for medisinsk og helsefaglig forskningsetikk (REK) i vedtak av 21.06.2022, deres referanse 457836 (se under Tillatelser).

TYPE OPPLYSNINGER OG VARIGHET

Prosjektet vil behandle alminnelige personopplysninger og særlige kategorier av personopplysninger om helseforhold frem til 31.12.2024. Etter prosjektslutt skal opplysningene oppbevares i fem år av dokumentasjonshensyn. Enhver tilgang til prosjektdataene skal da være knyttet til behovet for etterkontroll. Prosjektdata skal da ikke være tilgjengelig for prosjektet. Prosjektleder og forskningsansvarlig institusjon er ansvarlig for at opplysningene oppbevares pseudonymisert (av-identifisert) i denne perioden, dvs. atskilt i en nøkkel- og en datafil. Etter disse fem årene skal data slettes eller anonymiseres.

LOVLIG GRUNNLAG

Prosjektet vil innhente samtykke fra de registrerte til behandlingen av personopplysninger. Vår vurdering er at prosjektet legger opp til et samtykke i samsvar med kravene i art. 4 nr. 11 og 7, ved at det er en frivillig, spesifikk, informert og utvetydig bekreftelse, som kan dokumenteres, og som den registrerte kan trekke tilbake.

For alminnelige personopplysninger vil lovlig grunnlag for behandlingen være den registrertes samtykke, jf. personvernforordningen art. 6 nr. 1 a.

For særlige kategorier av personopplysninger vil lovlig grunnlag for behandlingen være den registrertes uttrykkelige samtykke, jf. personvernforordningen art. 9 nr. 2 bokstav a, jf. personopplysningsloven § 10, jf. § 9 (2).

PERSONVERNPRINSIPPER

Personverntjenester vurderer at den planlagte behandlingen av personopplysninger vil følge prinsippene i personvernforordningen:

• om lovlighet, rettferdighet og åpenhet (art. 5.1 a), ved at de registrerte får tilfredsstillende informasjon om og samtykker til behandlingen

• formålsbegrensning (art. 5.1 b), ved at personopplysninger samles inn for spesifikke, uttrykkelig angitte og berettigede formål, og ikke viderebehandles til nye uforenlige formål

• dataminimering (art. 5.1 c), ved at det kun behandles opplysninger som er adekvate, relevante og nødvendige for formålet med prosjektet

• lagringsbegrensning (art. 5.1 e), ved at personopplysningene ikke lagres lengre enn nødvendig for å oppfylle formålet.

DE REGISTRERTES RETTIGHETER

Personverntjenester vurderer at informasjonen om behandlingen som de registrerte vil motta oppfyller lovens krav til form og innhold, jf. art. 12.1 og art. 13.

Så lenge de registrerte kan identifiseres i datamaterialet vil de ha følgende rettigheter: innsyn (art. 15), retting (art. 16), sletting (art. 17), begrensning (art. 18) og dataportabilitet (art. 20).

Vi minner om at hvis en registrert tar kontakt om sine rettigheter, har behandlingsansvarlig institusjon plikt til å svare innen en måned.

UNNTAK FRA RETTEN TIL SLETTING

I utgangspunktet har alle som registreres i forskningsprosjektet rett til å få slettet opplysninger som er registrert om dem. Etter helseforskningsloven § 16 tredje ledd vil imidlertid adgangen til å kreve sletting av sine helseopplysninger ikke gjelde dersom materialet eller opplysningene er anonymisert, dersom materialet etter bearbeidelse inngår i et annet biologisk produkt, eller dersom opplysningene allerede er inngått i utførte analyser. Regelen henviser til at sletting i slike situasjoner vil være svært vanskelig og/eller ødeleggende for forskningen, og dermed forhindre at formålet med forskningen oppnås.

Etter personvernforordningen art 17 nr. 3 d kan man unnta fra retten til sletting dersom behandlingen er nødvendig for formål knyttet til vitenskapelig eller historisk forskning eller for statistiske formål i samsvar med artikkel 89 nr. 1 i den grad sletting sannsynligvis vil gjøre det umulig eller i alvorlig grad vil hindre at målene med nevnte behandling nås.

Personverntjenester vurderer dermed at det kan gjøres unntak fra retten til sletting av helseopplysninger etter helseforskningslovens § 16 tredje ledd og personvernforordningen art 17 nr. 3 d, når materialet er bearbeidet slik at det inngår i et annet biologisk produkt, eller dersom opplysningene allerede er inngått i utførte analyser.

Vi presiserer at helseopplysninger inngår i utførte analyser dersom de er sammenstilt eller koblet med andre opplysninger eller prøvesvar. Vi gjør oppmerksom på at øvrige opplysninger må slettes og det kan ikke innhentes ytterligere opplysninger fra deltakeren.

FØLG DIN INSTITUSJONS RETNINGSLINJER

Personverntjenester legger til grunn at behandlingen oppfyller kravene i personvernforordningen om riktighet (art. 5.1 d), integritet og konfidensialitet (art. 5.1. f) og sikkerhet (art. 32).

St.Olavs Hospital HF er felles beandlingsansvarlig institusjon. Personverntjenester legger til grunn at behandlingen oppfyller kravene til felles behandlingsansvar, jf. personvernforordningen art. 26.

For å forsikre dere om at kravene oppfylles, må prosjektansvarlig følge interne retningslinjer/rådføre dere med behandlingsansvarlig institusjon.

MELD VESENTLIGE ENDRINGER

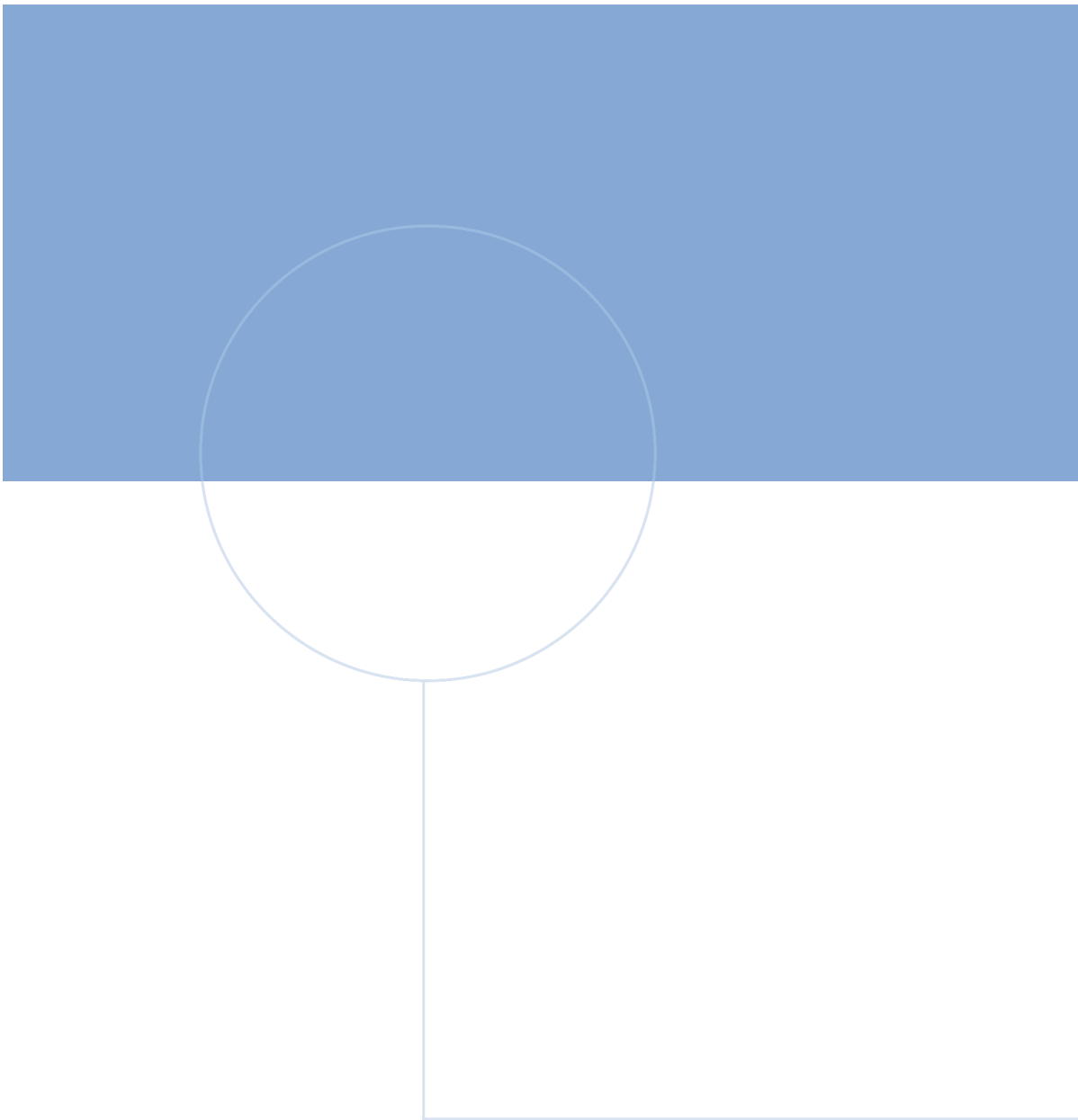
Dersom det skjer vesentlige endringer i behandlingen av personopplysninger, kan det være nødvendig å melde dette til Personverntjenester ved å oppdatere meldeskjemaet. Før du melder inn en endring, oppfordrer vi deg til å lese om hvilken type endringer det er nødvendig å melde: https://www.nsd.no/personverntjenester/fylle-ut-meldeskjema-for-personopplysninger/melde-endringer-i-meldeskjema

Du må vente på svar fra Personverntjenester før endringen gjennomføres.

OPPFØLGING AV PROSJEKTET

Personverntjenester vil følge opp underveis (hvert annet år) og ved planlagt avslutning for å avklare om behandlingen av personopplysningene er avsluttet/pågår i tråd med den behandlingen som er dokumentert.

Lykke til med prosjektet!



NTNU

Norwegian University of
Science and Technology