

Patients at risk of suicide and their meaning in life experiences

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Abstract

Patients in specialist mental healthcare services who are at risk of suicide may experience their struggles as existential in nature. Yet, research on meaning in life has been relatively scarce in suicidology. This qualitative study aimed to explore how patients at risk of suicide perceived their encounters with specialist healthcare professionals after a suicide attempt (SA), with special reference to meaning in life experiences. The study was conducted in specialised mental healthcare services in Norway. Data were collected via individual interviews with eight patients aged 20–75 years. Using a four-step procedure, the interviews were analysed by systematic text condensation. The participants understood their feelings of shame, self-contempt and challenging life experiences as contributing factors to their SA. They perceived that existential themes in relation to financial difficulties, shame and trauma were resolved, while issues associated with the SA, such as death, loss and beliefs, were given less attention. The participants were either ambivalent about continuing to live or wished to rebuild a meaningful life. Overall, their experiences of meaningfulness were hampered. Assisting patients with meaning in life experiences may help them alter their life interpretations and increase their ability to rebuild their lives as meaningful. The present study should be seen as a contribution to meaning-informed approaches in specialist mental healthcare services. More research is needed to equip healthcare personnel in their overall aims of preventing suicide and supporting patients at risk in their efforts to live a meaningful life.

Keywords

Existential themes, meaning in life, patients at risk of suicide, qualitative study, suicidology

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Patients at risk of suicide may feel trapped in unbearable mental pain and self-hate. As a result, they may contemplate suicide as a means of escaping their torments (Baumeister, 1990; Vatne & Naaden, 2012). The torments may include experiences of a lack of meaning in life (Schnell et al., 2018). The aim of this study was to explore how patients at risk of suicide perceived their encounters with specialist healthcare professionals, with special reference to meaning in life experiences after a suicide attempt (SA).

In line with the World Health Organization (WHO), we define a person as being at suicide risk if they are experiencing ‘a range of behaviours that include thinking about suicide (or ideation), planning for suicide, attempting suicide and suicide itself’ (WHO, 2014, p. 12). According to the WHO (2014), suicide prevention is seen as a global imperative for public health due to the fact that suicide is among the leading causes of death worldwide, with 703,000 estimated suicides and a global rate of 9 suicides per 100,000 in 2019 (WHO, 2021, p. 1 & 4). In Norway, a total of 658 suicides (482 men, 176 women) were registered in 2021 (Norwegian Institute of Public Health, 2022); that incidence of suicide is around 11 per 100,000, which is similar to Sweden and Denmark and also resembles the incidence in Europe, North America and Australia, which together had an average incidence of 11.7 per 100,000 in 2021 (Norwegian Institute of Public Health, 2022). Patients receiving treatment in specialist mental healthcare services have an increased risk of suicide (Walby et al., 2018, p. 8), and between 2008 and 2015, almost half of the people who committed suicide had been in contact with specialist mental healthcare services the year before (Walby et al., 2018). The Norwegian government and health authorities have been working on suicide prevention for several years. In 2019, the Norwegian Surveillance System for Suicide was implemented, a registration system for every suicide among persons in contact with the mental health and substance use disorders services in the 12 months before the suicide. The overall goal of the system is to identify key areas for suicide prevention (Walby et al., 2018). The latest contribution from the Norwegian government is the action plan ‘No one to lose’ (The Norwegian Departments, 2020). This title anticipates a society in which everyone takes responsibility for preventing suicide, thereby implying a public health perspective on this matter in accordance with the global imperative from the WHO (2014).

Different perspectives in suicidology

Suicide is considered a multifaceted and complicated phenomenon (Hjelmeland, 2013). Thus, different perspectives are needed to capture the complexity of the field (Beskow et al., 2015; Cutcliff et al., 2006; Turecki & Brent, 2016). The most influential perspective is the medical (National Centre for Suicide Research and Prevention, 2019), which addresses the risk factors of suicide and elucidates the role of mental health disorders (Lakeman & FitzGerald, 2008). Previous SAs and mental disorders, such as depression, have been identified as the most important risk factors (Bergmans et al., 2017; National Centre for Suicide Research and Prevention, 2020).

Another perspective is the psychological, which focuses on understanding both psychological risk and protective factors against suicide behaviour (O’Connor & Nock, 2014). Here, mental pain, also referred to as psychache or psychological pain, has been identified as a significant predictor of suicide (Shneidman, 1998; Verrocchio et al., 2016). Mental pain is characterised by perceptions of strong negative feelings and changes in the self, encompassing shame, guilt, humiliation, loneliness, fear, angst and dread (Shneidman, 1998; Verrocchio et al., 2016). Baumeister (1990) has underscored this with the self-destructive impulse, whereby suicide becomes the ultimate step to escaping from the self and the world. Behind their various mental illness symptoms and affects, the patient has a core that wants to live. This will to live is regarded as the ally of the therapist (Beskow et al., 2015).

A third perspective is the neurological, which addresses how persons with neurological diseases such as multiple sclerosis and dementia disease in early phase are exposed to SAs and completed suicides (Costanza, Amerio, Aguglia et al., 2020). The pathogenesis of these illnesses may lead to vulnerability to suicide, probably due to hopelessness, which can be seen as a facet of psychic pain.

A fourth perspective is that of exploring user experiences and investigating patients' reactions after attempting suicide. One study investigating how people live with or get over being suicidal revealed that suicidality represents struggles that are existential in nature, with suicide constituting a coping strategy (Lakeman & FitzGerald, 2008). Another study examined how patients struggle with suicidal thoughts (Berglund et al., 2016), finding that struggles constitute emotional burdens for the individual. Maintaining hope when life is difficult and striving for emotional balance are central (Berglund et al., 2016).

The last perspective to be highlighted is the person-centred one, which implies listening to the narratives of patients at risk of suicide in order to understand their suicidal thoughts and struggles (Østlie et al., 2018). Previous studies have indicated that reconnecting the patient to themselves provides a route to recovery (Hagen et al., 2018; Sellin et al., 2016). A key element that assists in facilitating such a reconnection is building a therapeutic alliance with the patient and showing empathy with the suicide wish (Michel & Valach, 2011; Orbach, 2008).

Conceptual clarification

For patients at risk of suicide in Norway, the need for greater knowledge about existential issues has been highlighted both in the attachment to the government's action plan 'No one to lose' (The Norwegian Departments, 2020) and in research (Knizek et al., 2021; Søberg et al., 2018). A clarification of the term 'existential' has not been included in the action plan. Based on previous research and clinical competence, existential care has been integrated in the national guidelines for patients with life-threatening somatic diseases such as cancer (The Norwegian Directorate of Health, 2019). In these guidelines, the term 'existential' is defined broadly and includes issues such as meaning, death and hope, values, and spiritual and religious beliefs (The Norwegian Directorate of Health, 2019, p. 37). This broad understanding has also been seen as essential in recent studies in the psychology of religion in Scandinavian countries in order to capture the variety of these expressions in secular and pluralistic contexts (Haug et al., 2016; Hvidt et al., 2021; la Cour & Hvidt, 2010; Lilja et al., 2016; Lloyd et al., 2016; Vattø et al., 2020). In the studies by Lilja et al. (2016) and Lloyd et al. (2016), the relation between mental health and the existential dimension for patients in specialist mental healthcare services was explored, and it was found that the latter represents both a burden and a resource for dealing with mental health problems.

A similar broad understanding of the existential dimension was applied in the present study. Here the term 'meaning in life' is seen from an existential perspective, as developed by Schnell (2009, 2021), and it is assessed as the most suitable concept for patients at risk of suicide.

Suicide and meaning in life

Previous studies have found that religious and spiritual factors generally protect against suicide (Wagani & Colucci, 2018). A link between religion and well-being is meaning in life, which can be particularly important in suicide prevention (Wagani & Colucci, 2018). However, the relationship between religion and suicide risk is complex (Lawrence et al., 2016); therefore, further research is needed regarding this relationship.

Meaning in life has received relatively little attention from researchers in the field of suicidology (Schnell et al., 2018; Wagani & Colucci, 2018). It has been investigated as a potential source

of resilience against suicide (Wagani & Colucci, 2018), as has reasons for living (RFL), which is an instrument to identify protective factors against suicide (Bakhiyi et al., 2016). Schnell et al. (2018) found that a crisis of meaning predicts suicide independently of depression in Ecuadorian school pupils aged 15–24 years.

Influential work on meaning-related constructs has been conducted by Frankl, Yalom and Steger within positive and existential psychology (Costanza, Amerio, Odone, et al., 2020; Mascaro, 2014). In a study on these constructs in patients with suicide ideation or SAs, Costanza, Baertschi, et al. (2020) found that the two concepts ‘presence of meaning in life’ and ‘search for meaning in life’ were independent of each other. The former concept was identified as the most central for the actual patient group in terms of indicating levels of suicidal behaviour. A debate also exists regarding the conceptual basis of the construct (Martela & Steger, 2016) and the difference between a happy life and a meaningful life (Baumeister et al., 2013). Scandinavian research on the psychology of religion has emphasised the close link between existential themes and meaning in life in relation to health and illness (Isene et al., 2021). This research has built on Schnell’s (2021) work on meaning in life. A Norwegian study indicated that meaning in life is a construct with cross-cultural equivalence (Sørensen et al., 2019).

Meaning in life has two relatively independent dimensions – meaningfulness and crisis of meaning – both of which are existential in nature (Schnell, 2021). Schnell defined meaningfulness as ‘the basic trust that life is worth living. It is based on a (mostly unconscious) evaluation of one’s life as coherent, significant, oriented and belonging’ (p. 7). A person’s life is considered *coherent* if he or she experiences consistency in life, has overall values that are compatible with daily questions and activities, and has personal values that are harmonious and meaningful to him or her. *Significance* is related to an individual’s perception of their coping ability and influence and impact on their environment. A person’s life is *directed* if he or she is working towards a particular goal or has a clear purpose in life and is pursuing it. *Belonging* refers to a sense of affiliation, a feeling of being connected to something or someone outside oneself, which prevents isolation and disconnection (Schnell, 2021). Crisis of meaning is defined as ‘a judgment of one’s life as frustratingly empty, pointless, and lacking meaning’ (Schnell, 2021, p. 8).

Researcher description

The first author of this study is a hospital chaplain and specialist in practical pastoral service in the health and social sectors. The coauthors are both professionals in pastoral and mental healthcare and experienced researchers in quantitative and qualitative methods within the discipline of the psychology of religion. Regarding the competence in qualitative methods, this included the analytic strategy that was applied in the present study, called systematic text condensation (STC) (Malterud, 2012, 2017). Competence in the research group influenced the sampling procedures, data collection and data analysis. Clinical expertise with the actual patient group was considered as a strength in terms of insight in treatment and care in the context of specialised mental healthcare. In order to enhance transparency and identify bias, the research group had close and critical collaboration throughout the research process (Malterud, 2012; Malterud et al., 2016).

Overall, the study was placed within the hermeneutic tradition in the psychology of religion (Belzen & Hood, 2006). The hermeneutical point of departure was the conceptual understanding of meaning in life as applicable to every human being independently of the content of meaning in life experiences and mental health condition. Thus, this understanding was considered as relevant for patients with previous SAs. In order to explore their meaning in life experiences, a functional approach as outlined in the psychology of religion was seen as most appropriate (Schnell, 2009; 2021). This implied an exploration of the role or purpose of meaning in life experiences for the actual patient group.

Aim of the study

Research on the significance of addressing meaning in life perspectives related to suicidality is sparse. Hence, the aim of the present study was to explore how patients at risk of suicide perceived their encounters with specialist healthcare professionals after an SA, with special reference to meaning in life experiences. Central in exploratory studies like this is gaining in-depth knowledge of patients' experiences from their point of view. Thus, a descriptive approach was applied in the analysis.

Materials and methods

The study had a qualitative and explorative research design. This approach, whereby a small group of participants were asked about challenging life narratives and situations after SAs, was well suited for exploring these experiences in depth from their perspective.

The applied analytic strategy was STC, developed by Malterud for medical and health research in Scandinavia (Malterud, 2012; Malterud et al., 2017). STC is one of many thematic analyses (Braun & Clarke, 2021a). Our reasons for the use of STC included its detailed description of a four-step procedure and the fact that the first of these steps is limited to only four to eight themes that provide a tentative overview of the main themes in the material.

Context of the study

The public mental healthcare system in Norway, which is free for all citizens, is divided into three levels. The first is primary mental healthcare, which is organised at the community level. The second level is specialist mental healthcare services, located in hospitals and district psychiatric centres (DPCs) in every county. The third level is highly specialised mental healthcare. The data for this study were collected from patients accessing services at the second level in a county in south-eastern Norway.

Due to the severity of the SAs, most of the participants had initially received inpatient medical treatment before being transferred to a DPC. After being discharged from inpatient psychiatric care, half of the participants had received follow-up care from an outpatient psychiatric unit and primary mental healthcare services. The participants received treatment from interdisciplinary healthcare professionals, most of whom had a mental health specialisation.

Participants and inclusion criteria

The research group sent a letter to the DPC leader, requesting permission to conduct the study and to contact the head psychologist or psychiatrist in the DPC clinics to collaborate with respect to recruiting participants. Eight participants consented to participate in the study after the head psychiatrist or psychologist at the clinic where they were being treated had informed and assessed them as capable of coping both cognitively and emotionally. The therapists informed the first author when a patient had been cleared for participation. The first author contacted the patient via phone to confirm participation and to make an appointment for the interview. The inclusion criteria were a history of one or more SAs, not being psychotic, being capable of reflecting on their SA in their conversations with healthcare professionals, and being interviewed no less than 2 weeks after their latest SA. Participants were recruited from September 2017 to March 2018.

We opted for maximum variation sampling with regard to age, civil status and time since the SA to ensure the widest possible selection. Four men and four women aged between 20 and 75 years were included, and all participants were ethnic Norwegians. Two of them were married, two were

cohabiting, three were divorced, one was single and seven had children. The participants were either employed, in receipt of disability benefits, retired or on sick leave. They were all in specialised mental healthcare treatment at the time of the interview, either living at home with follow-up from a DPC outpatient clinic/primary care service or as patients at a DPC inpatient clinic. The number of SAs varied from one to five per participant. The time between the last SA and the interview ranged from 2 weeks to 10 years. The reasons for the SA and the type of treatment in the aftermath were solely based on self-reported information from the participants. They reported growing challenges over time, including experiences of trauma, different kinds of loss, relational problems, physical pain and depression. The treatment consisted of different therapeutic approaches (supportive, family, in-depth and trauma-oriented), diagnostic assessments, milieu therapy and medication. The methods deployed in the SA were hanging, intoxication, cutting or drowning.

Data collection

The first and last authors conducted the interviews together, using an interview guide. The interview guide consisted of an introductory question, three main questions and a closing question. As an introduction and warm-up question, the participants were invited to tell whatever they wanted to share about the period around their most recent SA. The first main question was about the participants' experiences with the specialist healthcare professionals after attempting suicide. The second main question pertained to the significance of the content of the conversation, including an exploration of what each participant considered important and valuable to his or her recovery following the SA. The third main question allowed participants to share their personal experiences in relation to meaning in life for the period before as well as after their SA. As a closing question, participants were asked whether there was anything they would like to add. Most of the interviews took place in a meeting room in a specialist healthcare context. Two interviews were held in the respective participants' homes. The interviews lasted between 90 and 120 min. Field notes were written after each interview, and the interviews were audio recorded and transcribed verbatim by the first author.

Analysis

The transcribed material was analysed through STC (Malterud, 2012, 2017). STC comprises the following four steps:

1. A read-through of the material in its entirety, several times, to gain an overview and make a preliminary identification of four to eight themes. This numeric restriction is a central part of the analysis in this step. In the present study, the analysis was accomplished by the first author and two members of the research group followed by discussions and agreement on the selected themes.
2. A detailed reading to identify and code meaning units in terms of text fragments that shed light on the research question. Here the text is decontextualised by removing bits and pieces of the text from their context. In this step, the research group members discussed the content and names of the codes in order to keep the informants' voice in focus.
3. A systematic abstraction of the sorted codes, implying that the empirical data are reduced to three to five code groups. Each code group is further divided into subgroups. A condensation of the content of these groups is made in terms of a summary of the meaning units from Step 2. In addition, central citations that illustrate the summaries are identified. In the present study, this abstraction process continued until a high level of agreement was achieved within the research group.

4. A synthetisation of the code group in terms of analytic text, also including the most relevant citations from Step 3. Here the codes are recontextualised, implying a check that the text reflects the original context and what the informants shared in the interviews with its tensions and nuances (Malterud, 2012). The whole research group collaborated in this step, which led to formulating the results. As reported in the ‘Discussion’ section, an understanding of these results is supported by the theories of meaning in life as developed by Schnell (Schnell, 2021; Schnell et al., 2018). According to Malterud (2016), theory is here used as a lens that provides a limited focus for interpretation.

Ethics

The project was reported to the privacy ombudsman at the Norwegian Centre for Research Data (NSD # 46264) and complied with the ombudsman’s guidelines for data processing. The recruitment sites were responsible for providing follow-up care to any participant who was affected by the interview process. To our knowledge, none of the participants indicated a need for such help. Written consent was obtained prior to the interviews.

Results

The results are illustrated in Table 1, containing the following three main categories: participants’ complex understandings of their challenges which led to the SA, participants’ varied experiences of exploring existential themes with healthcare professionals and participants’ different experiences of meaning in the aftermath of the SA. Each category has two subthemes.

Table 1. Overview of resulting categories and subgroups.

Result categories	Subgroups
Participants’ complex understandings of their challenges which led to the suicide attempt	<i>Experiences of trauma, loss and relational difficulties</i> <i>Feelings of shame and self-contempt</i>
Participants’ varied experiences of exploring existential themes with healthcare professionals	<i>Exploration of important and valuable themes in the conversations led to openness about their situation</i> <i>Existential themes reflected on less often in the conversations</i>
Participants’ different experiences of meaning in the aftermath of the suicide attempt	<i>Rebuilding trust in relationships after the suicide attempt</i> <i>Feelings of continued ambivalence and forming new meaning</i>

Participants’ complex understandings of the challenges which led to the SA

Experiences of trauma, loss and relational difficulties. Common among the participants was an experience of living with growing challenges over time before the SA in terms of trauma, loss and relational difficulties. They described different types of trauma-related experiences, such as sexual abuse and bullying in their childhood and adolescence, physical abuse, previous SAs and life-threatening accidents. These experiences had contributed to their SA, as one of the informants expressed:

During the years, I had a sort of very strong need to leave this world [. . .]. And it’s because of what I experienced as a little girl [. . .] that [. . .] things had become difficult. And I had feelings in my body that I could not manage to put into words.

The participants described varied experiences of losing relationships, such as the death of someone close, broken or reduced contact with family members, or divorce. In addition, the participants underlined how job loss, loss of financial stability or loss of health in terms of a chronic pain condition had led to their SA. To give up work and live in an unpredictable economic situation was expressed as so shameful that it had been kept a secret. In this situation, the very idea of suicide was experienced as calming, as expressed in the following way: ‘When I was completely down [. . .] I could use the suicidal thoughts as a sleep-inducing drug’. There were also participants who expressed that the SA was unplanned and that it just happened. This was described as a kind of ‘blackout’ or ‘overflow’ of difficult feelings.

Most of the participants told of varied difficult experiences with people in their networks, describing them as hurtful or deprecatory. One of the participants said that ‘The daughter-in-law cannot relate to me because of the SA’. This had affected the relationship with the rest of the family and created a feeling of being discriminated against or forgotten. However, the participants also stated that their relationships with friends, siblings, children and partners were important to them.

Feelings of shame and self-contempt. The participants described how feelings of self-contempt and shame had worsened over time, before the SA. Their self-contempt was partly based on a perceived failure to fulfil their own goals and meet the expectations of others, causing devaluation thoughts such as feelings of not being good enough. The participants felt that they were a bother, that no one would miss them or that no one loved them. One participant explained this as follows: ‘I just got it into my head that the whole world would be better off if I wasn’t there. [. . .]. So it wasn’t that I had planned to do it well in advance [. . .] it just crept up on me’. The self-contempt was also described in detail in terms of resistance to reading one’s signature on a paper. Mostly, the participants had kept the seriousness of the problems they were facing and the suicidal thoughts to themselves. Some told that they had not been able to put into words what they felt. In addition, the participants expressed how weariness was intertwined with the shame, and that it had increased in the period before the SA. The weariness was described as loss of strength and an experience of powerlessness, contributing to low daily life functioning and problems getting out of bed in the morning.

The participants who had experienced several SAs described the self-contempt and shame as a painful, incomprehensible and lifelong part of themselves. In order to understand themselves better, therapy was underlined as important.

Participants’ varied experiences of exploring existential themes with healthcare professionals

Exploration of important and valuable themes in the conversations led to openness about their situation. The topics addressed in conversations with healthcare professionals helped in assessing the participants’ abilities to find and engage in work, assisting with financial difficulties, understanding relationships, processing traumatic experiences, and increasing self-insight in light of the diagnoses and problems. Most of the participants described the themes raised by healthcare professionals during their conversations as important and valuable to them, expressing that ‘They could not have done a better job’. In-depth conversations concerning sensitive topics helped the participants to talk about the complexity of their situations. Most of the participants also stated that topics dealing with shame and self-contempt were central, but requiring sensitivity in their conversations. This was described as hard work both for the healthcare professionals and for themselves. The hard work was related to topics that were difficult to share for the participants: ‘It was such a sensitive topic, that I really didn’t want to talk about it, but she had such a . . . “We will make it!” she said’.

A few participants experienced lack of understanding or hurtful comments from the healthcare professional in relation to their SA, such as a judgement that 'It is you who is to blame for this'.

The theme of loneliness was mentioned by some of the participants. It was mentioned as an open question or as a statement from the therapist, like 'You are really lonely!' One of the participants related that when the therapist found that the participant's personal network was small, this was used as a starter for building a trustful relationship with the therapist and important for their further dialogue.

Some of the participants reported that they met the hospital chaplain during their stay. They found these conversations helpful in different ways in terms of experiencing the hospital chaplain's non-judgemental attitude and affirmative manner as crucial for the recovery process, having feelings of being seen and understood in the conversation, and having positive experiences of joining a group focusing on existential topics and led by the hospital chaplain.

Existential themes reflected on less often in the conversations. Several of the participants expressed that specific existential themes were reflected on less during their conversations with healthcare professionals, such as their stance on beliefs and life, and the implications of loss, loneliness and death. The latter theme concerned the participants' thoughts and feelings about death in general and specifically as a solution for their lives. This included the view of not being a burden to anyone and that euthanasia was seen as a resolution in case of serious disease, the significance of a near-death experience for the understanding of death as a transition to a good place, and longing for death itself, in representing a peaceful place without any worries and problems.

A few participants reported that they missed topics on their stance on beliefs and life, as expressed in the following way: 'Nobody has asked me if I have a belief, or what I believe in'. The belief also included life values and rituals. In the latter case, the opportunity to visit the local church during a hospital stay at Easter was expressed as important. Life values were related to good life energy that led to helping others in need.

Loss of friends caused by serious disease and suicide, leading to loneliness, were mentioned as experiences that were little reflected on in the conversations. This was expressed in the following way:

- Researcher: Is loss a theme you have talked about while you have been here? [. . .] You've lost a lot.
- Participant: We haven't really discussed that. Not really discussed the subject, not until you mentioned it.
- Researcher: Do you think it would have been important to discuss it?
- Participant: I think it would have been really good.

A nuance in these experiences was that of highlighting the qualities in the therapeutic relationship as more important than exploring existential themes in terms of being seen, listened to, and having the opportunity to 'blow out'.

Participants' different experiences of meaning in the aftermath of the SA

Rebuilding trust in relationships after the SA. Rebuilding trust in their relationships – with partners, children, sons- and daughters-in-law, friends and parents – after attempting suicide was central but challenging for the participants. One participant, who had attempted suicide quite recently, expressed this in the following way: 'What is most painful is that he says he can't relate to me and does not trust me. He even finds it difficult to continue my relationship with my grandchild'.

Some of the participants expressed that mistrust was important to work with in their close relationships, as well as feeling guilty about the difficulties they had inflicted, especially with respect to their children. In this connection, rebuilding trust had been a recurrent and arduous issue for many years. As one informant said, 'My relationship with my son has been very difficult because it has been hard for him to trust me, so I've worked hard to get him back'. Some described how their partners' need for control had increased out of their desire to prevent another SA as a challenge: 'This control makes me feel I'm losing my freedom'. Others felt the opposite and found this dynamic reassuring. Some informants also mentioned a need to gain some distance from close relationships in order for them to move forward.

Feelings of continued ambivalence and forming new meaning. The participants were either ambivalent about continuing to live or wished to live and rebuild a meaningful life. Feelings of ambivalence emerged when participants voiced uncertainty about the future and talked about whether they were contemplating another SA. Whether they wanted to live or attempt suicide again was described as situationally determined, relating to general uncertainty and the burden of their suicidal thoughts. Death was described as a peaceful rather than a threatening prospect. One of those who expressed uncertainty about wanting to live said the following:

I can never be absolutely sure, as I said, but I think it's going OK now, although it's sort of not completely alien to me in a way.

Several of the participants stated that they were happy to have survived, as expressed in the following way:

Researcher: Are you glad you are here right now?

Participant: Yes, I am, I have said that I did something I should not have done, and thanks for living today! My time was not there, it did not work.

They recognised that a particular healthcare professional had helped them out of the crisis thanks to the understanding, attitude and expertise they had shown in their conversations. This relationship formed the basis of new recognition and insights into themselves and others and led to greater acceptance of themselves and their lives. Some described the SA as a wake-up call. Different types of challenges had created situations the participants found untenable, leading to a necessary process of change. This process of change also brought about the aspiration to share their experiences in order to help others obtain the right help, to throw light on the subject, or to give something back to society as a token of gratitude.

Discussion

The present study explored how patients at risk of suicide perceived their encounters with specialist healthcare professionals after a SA, with special reference to meaning in life experiences. The participants were heterogeneous regarding age, gender, civil status, work relations, time since the most recent SA and number of SAs. In addition, there were two features common to the participants. First, they were ethnic Norwegians with Norwegian as their mother tongue. Second, they were all living in a cultural context characterised by secularism and pluralism in relation to the existential dimension (la Cour & Hvidt, 2010; Lilja et al., 2016; Lloyd et al., 2016; Vattø et al., 2020). Due to these diverse and common characteristics, a broad understanding of the existential dimension was required. Thus, we selected the term 'meaning in life', as developed by Schnell

(2021), as the preferred term. The results indicated that the participants' understandings of the challenges leading to their SA were complex, comprising feelings of shame and self-contempt, trauma, loss and relational difficulties. Furthermore, the participants experienced the resolution of existential themes in relation to financial difficulties, shame and trauma, while issues associated with the SA, such as death, beliefs and loss, were given less attention. The participants expressed different ways of dealing with meaning in the aftermath of their SA: some rebuilt trust in their relationships and formed new meanings, whereas others expressed feelings of continued ambivalence.

Meaning-informed approaches as suicide prevention in specialised healthcare

The findings are in line with the central knowledge in suicidology that the reasons behind suicide are complex and multifaceted (Hjelmeland, 2013), implying that different perspectives are needed to capture the complexity of the field (Beskow et al., 2015; Cutcliff et al., 2006; Turecki & Brent, 2016). In the present study, knowledge from the medical, psychological, neurological, person-centred and user perspectives was applied, primarily from the latter perspective. Research on the user perspective, investigating patients' reactions after attempting suicide, has revealed that suicidality represents struggles that are existential in nature (Lakeman & FitzGerald, 2008) and that the maintenance of hope is central (Berglund et al., 2016). Yet, research on meaning in life has received relatively little attention from researchers in the field of suicidology (Schnell et al., 2018; Wagani & Colucci, 2018).

The findings in the present study can be seen as a contribution to meaning-informed approaches for patients at suicide risk, who are receiving help from specialised mental healthcare services. Suicide prevention is the overall aim of this work. According to the Norwegian Surveillance System for Suicide, patients using these services have an increased risk of suicide due to the fact that almost half of those committing suicide had been in contact with specialist mental healthcare services over the preceding year (Walby et al., 2018). Therefore, approaches aimed at suicide prevention in these services are paramount. The WHO (2014) highlights suicide prevention as a global imperative for public health, and this agenda has been implemented in the latest action plan from the Norwegian government (The Norwegian Departments, 2020) and in national health reports on suicide (National Centre for Suicide Research and Prevention, 2020). Despite the fact that the suicide rate in Norway resembles that of the other Scandinavian countries and the average rate of Europe, North America and Australia, with 11.7 incidents per 100,000 people in 2021 (Norwegian Institute of Public Health, 2022), the rate is still higher than the global rate for 2019, which was 9 per 100,000 (WHO, 2021).

The attachment to the action plan highlights the need for more knowledge regarding existential issues (The Norwegian Departments, 2020). However, a clarification of the term 'existential' is missing, which implies an unclear understanding of the term. This is in contrast to the national guidelines in palliative care (The Norwegian Directorate of Health, 2019) and research on the psychology of religion in Scandinavia (Haug et al., 2016; la Cour & Hvidt, 2010; Lilja et al., 2016; Lloyd et al., 2016; Vattø et al., 2020). Here, the term has been elucidated and studied in different populations, including patients with mental health problems (Lilja et al., 2016; Lloyd et al., 2016). In these studies, the term existential is understood in a broad sense and includes existential issues, values, and spiritual and religious beliefs. With a broad understanding, the existing variety in secular and pluralistic contexts is captured (Hvidt et al., 2021). In the present study, our understanding of the term existential was proven to be suitable for the participants, who were recruited from specialist mental healthcare services in a county in south-eastern Norway. The selected term was 'meaning in life', as developed by Schnell (2021), which contains the two dimensions of meaningfulness and crisis of meaning. This was based on research findings that meaning in life is a construct with cross-cultural equivalence in Norway (Sørensen et al., 2019).

Participants' struggles with meaningfulness

Participants perceived their SA as owing to a series of difficult life events since early childhood as well as being related to profound experiences of lacking meaning in life. These experiences can be understood in relation to the user perspective in suicidology (Berglund et al., 2016; Lakeman & FitzGerald, 2008), which addresses the existential nature of suicidality. The condensed messages from the interviews can be expressed as follows: I felt that my life had no significance or purpose, I did not belong anywhere, my life had no direction or hope, I had come to a dead end, and my life was fragmented and painful. These messages touch upon a variety of meaning in life experiences. Thus, a broad understanding of these experiences was seen as necessary for the understanding of the participants' struggles with meaningfulness.

The claims of some of the participants that they were solely a burden to their family and friends, and that the world would be a better place without them, can be understood as a depressive self-evaluation (Baumeister, 1990). However, from an existential perspective, they indicate meaning in life deprivation (Schnell, 2021). The concept contrasts with what research on meaning in life identifies as central elements of meaningfulness, such as experiencing life as coherent, significant, and directed and as providing feelings of belonging (Schnell, 2021).

Coherence is a state in which overall values and values in daily life are consistent and offer a fundamental reason to live (Schnell, 2021). The fundamental experiences for the participants in our study prior to their SA included such events as losing their jobs or close relationships and consequently their self-respect. According to the participants, healthcare professionals talked to them about how to deal with their losses. However, these professionals paid less attention to specific meaning in life aspects, such as loss of meaning and how such experiences had affected the participants' identities, beliefs or overall values. By contrast, belief frameworks can be of value in change processes and difficult life situations (Sørensen et al., 2015). It is also known that religious beliefs can have both positive and negative significance for suicide (Costanza, Amerio, Odone, et al., 2020; Lawrence et al., 2016; Wagani & Colucci, 2018). In palliative care, a focus on existential themes is part of the patient-centred approach (The Norwegian Directorate of Health, 2019); however, in suicidology, meaning in life issues are less articulated, even though they may be protective factors against suicide (Wagani & Colucci, 2018).

Participants' narratives in the current study underscored their devaluation of self in terms of not managing to meet their own expectations or the expectations of others. Devaluation can create a negative self-understanding (Beskow et al., 2015; Michel & Valach, 2011) or an expression of mental pain as explored within the psychological perspective in suicidology (Shneidman, 1998; Verrocchio et al., 2016). Our findings showed that most of the participants recognised that topics dealing with shame and self-contempt were central in their conversations (O'Connor & Nock, 2014). *Significance*, according to Schnell (2021), refers to a value-laden evaluation of oneself. In this regard, healthcare professionals listening to patients' existential thoughts and feelings can help them to understand the suicide process (Martela & Steger, 2016; Orbach, 2008). There were participants who shared positive experiences in relation to the hospital chaplain, such as feelings of being understood and seen. For one participant, the meeting had proven to be of significant influence. Some participants also underscored the meaning in particular of the healthcare personnel facilitating the process of learning to live again (Sellin et al., 2016).

Some of the participants felt their goals for life had been greatly reduced or had become invisible due to trauma or loss experiences. Schnell's (2021) third concept, *direction*, which involves being goal-directed and having a purpose in life, is central to experiencing meaning. The achievement of goals is therefore central to finding meaning in life (Martela & Steger, 2016). Michel and Valach (2011) highlighted the fact that people at risk of suicide often have short-term goals, and

their meaning in life disappears. However, linking the past, present and future may be a way of guiding present actions and providing a way to find meaning (Baumeister et al., 2013). Regarding direction in life, hope may be of relevance because hopelessness is a known risk factor for SA for patients with both mental and somatic disorders such as neurological diseases (Costanza, Amerio, Aguglia, et al., 2020; O'Connor & Nock, 2014).

Most of the participants in this study emphasised what their relationships meant to them by describing their wounded feelings and relational loss. In Schnell's (2021) terminology, the need for *belonging* refers to the need for affiliation as protection against disconnection. The participants' low self-esteem and shame negatively impacted their sense of belonging (Vatne & Naaden, 2012). These feelings were experienced by the participants, who observed their perception that no one loved them or would miss them if they disappeared. Loss of relationships and disconnection are considered risk factors for suicide (O'Connor & Nock, 2014). According to the participants, the healthcare professionals they had encountered focused on the importance of rebuilding trust in their close relationships. Having interpersonal and affective relationships but also repairing broken relationships is a significant way to gain meaning in life (Costanza, Amerio, Odone, et al., 2020; Sørensen et al., 2015). Connecting patients at risk of suicide to themselves and the world can be a crucial factor in preventing disconnection (Cutcliff et al., 2006), as emphasised by the person-centred perspective in suicidology (Hagen et al., 2018; Østlie et al., 2018). The connection may also strengthen the patients' ability to manage their lives (Sellin et al., 2016). Thus, after an SA, belonging may be important for rebuilding meaningfulness.

Participants' process of rebuilding meaning in life

Participants in the current investigation fell into two groups when it came to rebuilding meaning for the future: one group wanted to rebuild a meaningful life, whereas the other was ambivalent about the future. Ambivalence has been identified as a component of suicidality (Vatne & Naaden, 2012) and as central to patients with recurrent SA (Bergmans et al., 2017). This emotional state was described by several participants in this study and represents an important risk factor within the medical perspective in suicidology (National Centre for Suicide Research and Prevention, 2019). Ambivalence is regarded as a state of emotional flux and uncertainty about one's destiny (Bergmans et al., 2017). When patients are in a state of existential ambivalence, their ability to experience life as meaningful may be undermined, leading to a crisis of meaning, which has been identified as a risk factor for suicide (Schnell et al., 2018). As discussed earlier, some of the participants in the present case struggled with finding a direction for the future. A challenge experienced by half of the participants in the study was that specific themes, such as death in relation to the SA, as well as beliefs, loneliness and loss, were given less attention in their conversations with healthcare professionals. This probably implied that important information regarding both meaningfulness and crisis of meaning were not addressed.

The participants who wished to live and rebuild a meaningful life perceived that their SA had provided a new perspective on life. When related to meaningfulness as defined by Schnell et al. (2018), this new perspective included changes such as feelings of increased *significance and belonging* due to an acceptance of self and trust in close relationships. Another change was related to *direction* in terms of wanting to give something back to others in the future. Meaning in life is understood as a dynamic and subjective rather than a static situation (Schnell, 2021). Abruptions in meaning in one situation may give rise to new ways of understanding and handling life challenges in another.

Suicide and suicidality imply two different approaches: the former is about an act, whereas the latter is about suffering and mental pain (Lakeman & FitzGerald, 2008; Verrocchio et al., 2016). Such suffering can be seen as existential by nature (Lakeman & FitzGerald, 2008). It can be

challenging for healthcare professionals to find a language that expresses the patient's existential suffering (Knizek et al., 2021; Søberg et al., 2018; Vatne & Naaden, 2012). A related issue is lack of knowledge, as addressed in the action plan 'No one to lose' (The Norwegian Departments, 2020). According to the participants in this study, a focus on meaning in life experiences in relation to death, beliefs, loneliness and loss may be important in their life situations. As a clinical implication, we suggest that healthcare professionals take patients' meaning in life experiences into account (Costanza, Baertschi, et al., 2020; Mascaro, 2014), exploring and supporting what they consider meaningful in relation to the elements of coherence, significance, direction and belonging (Schnell, 2021; Sørensen et al., 2019). In addition, addressing issues related to a crisis of meaning is a part of this approach. Another possible clinical approach is to help patients to identify and deal with the burdens while simultaneously supporting the resources inherent in their meaning in life experiences (Schnell, 2021). This is in line with research on the clinical psychology of religion in Scandinavia (Lilja et al., 2016; Lloyd et al., 2016), which has found that these types of experiences represent both burdens and resources for dealing with mental health problems. The overall aim in these approaches is to prevent suicide by enhancing patients' ability to rebuild their lives as meaningful.

In line with this, future research should seek to assess and explore meaning-informed approaches to mental healthcare. Moreover, future research should aim to examine why some meaning in life issues are more difficult to reflect on in conversations than are others. In future clinical trials, it could be hypothesised that the implementation of exploratory conversations emphasising meaning-in-life aspects – such as the sources of meaning card method (la Cour & Schnell, 2016) – would improve patients' awareness of meaning in life and mental health (Schnell, 2021) and reduce the risk of suicide.

Methodological considerations and limitations

The participants in this study belonged to a vulnerable patient group, as defined in the Declaration of Helsinki (The Helsinki Declaration, 2021). Thus, the participants' mental health conditions – specifically whether or not they would be able to complete an interview – were considered during the research. No interviews were cancelled.

Had the purpose of the study been to investigate a homogeneous sample, an objection to the material could be that intervals between the SA and the interview varied. However, meaning in life and suicide constitutes a new research field, and a qualitative exploratory design with a diverse group and a small selection of participants was found to be suitable (Creswell, 2013).

In qualitative studies, there is always a risk that participants underestimate, conceal or forget problems, especially given the time between the SA and the interview. This risk could have been reduced by the use of member checking, namely giving the participants the opportunity to respond to the interview text (Creswell, 2013, p. 250).

Concerning external validity, the sample was purposefully selected in order to provide answers to the research question. Thus, the inclusion criteria were followed strictly for all the included participants. When supported by theory and previous research, the findings may have transferability to patient groups in similar healthcare contexts at risk of suicide (Malterud, 2016).

The Norwegian context, with a multitude of meaning in life experiences, may have influenced the research process due to the fact that the members of the research group are all from Norway. In line with the hermeneutical point of departure in the study, it was seen as impossible to gain a full overview of preunderstandings and bias and their impact in the study (Belzen & Hood, 2006). In order to increase transparency and identify bias, the members of the research group had regular meetings throughout the process. In addition, observation–triangulation was used, which means

that the research group consisted of different professions collaborating in the analysis. This observation–triangulation strengthened the internal validity (Creswell, 2013, p. 251).

Malterud et al. (2016) applied the concept of information power instead of saturation when evaluating sample size, arguing that a purposeful sample of 6–10 participants might contribute with sufficient information power to fulfil the study's aim. Braun and Clarke (2021b, s. 212) recommended applying the concept 'information power' instead of 'saturation'. They argued that saturation is not a particularly useful or theoretically coherent concept when it comes to reflexive thematic analysis. According to Malterud et al. (2016), sufficient information power depends on the following criteria: 'study aim, sample specificity, use of established theory, quality of dialogue, and analysis strategy' (p. 1753). In the present study, the criteria were regularly taken into consideration in the research group in order to evaluate the development of the study knowledge.

Conclusion

The present study has shown how the experiences that led to SA were complex for patients at risk of suicide and how meaning in life issues, both meaningfulness and crises of meaning, were prominent in their narratives of suicidality. Furthermore, the participants in this study did not regard some of these existential matters as being adequately addressed by healthcare services and deemed conversations about specific existential issues insufficient. Based on user experiences after SA, the present study supports the overall view in suicidology that multiple perspectives, including medical, psychological, neurological, person-centred and user perspectives, are needed to capture the complexity of being at risk of suicide.

Due to the fact that meaning in life has received relatively little attention in suicidology, the present study should be seen as a contribution to meaning-informed approaches in specialised mental healthcare services. Hence, a clinical implication of the findings is that these approaches can help healthcare professionals to address meaning in life deprivation and strengthen patients' processes for rebuilding meaning in their lives. This is in line with past studies' findings that conversations about specific existential issues represent a challenge for healthcare professionals working in the field. Nevertheless, we deem the Norwegian government's action plan to be an important step forward when highlighting the need for greater knowledge regarding existential issues.

Hence, in order to shed light on these important aspects of being at risk of suicide as well as providing the best mental healthcare services possible, further research (both qualitative and quantitative) is needed. This will add valuable knowledge and equip healthcare personnel in their overall aims of preventing suicide and supporting individuals at risk in their efforts to live a meaningful life. The knowledge of meaning in life generated here might also facilitate the development of a model of interdisciplinary existential care in the field of suicidology.

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