**Reconnecting with oneself while struggling between life and death: The phenomenon of recovery as experienced by persons at risk of suicide**

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**ABSTRACT**

The body of knowledge regarding health and recovery as experienced by patients at risk of suicide is limited. More research is needed into the meaning of recovery and what strengthens the desire to live. The aim of this study was to describe the phenomenon of recovery in a context of nursing care as experienced by persons at risk of suicide. In line with a reflective lifeworld research approach, fourteen patients from a psychiatric clinic in Sweden participated in phenomenon-oriented interviews. Data were analyzed to describe the essence of the phenomenon. The results reveal that the phenomenon of recovery means 'reconnecting with oneself while struggling between life and death'. Three meaning constituents emerged: being in an expressive space and giving voice to oneself, regaining dignity through nurturing connectedness, and finding a balance in the tension between life and death. In conclusion, the meaning of recovery is to experience the ability to manage one's own life. Professional caregivers need to acknowledge patients' lifeworlds, in a way that enable patients to experience themselves as capable of managing their own lives. Professional caregivers should also facilitate the involvement of supportive relatives.

**KEY WORDS**: attempted suicide, mental health nursing, phenomenology, psychiatry, recovery.

## INTRODUCTION

Human beings can experience challenges through life in varied and common ways. Sometimes these challenges lead to existential questions about life and death, and also to experiences of unbearable suffering. When people lose hope for life, suicide might occur to them as a way out (Vatne & Nåden 2012). In line with Orbach's (2008) and Schneidman's (1998) views of mental health problems and meaning in life, suicidality can be understood as an existential crisis rather than as disease. This corresponds to a lifeworld perspective of health, which defines health in terms of experiencing being able to manage one's life (Lassenius et al. 2013, Todres et al. 2014). From this perspective, suicide prevention needs to focus on enabling people to manage their mental health crises, and problems of living. Hence, in this study, recovery is understood as reclaiming one's life by solving or learning to live with problems encountered in life, and to live one's life as meaningfully as possible, given the available personal, interpersonal and social resources (Barker & Buchanan-Barker 2011).

Even though suicidal behavior is not a mental illness, and can occur in different contexts (Cutcliffe & Barker 2002), mental health nurses need to acknowledge that patients struggle with life challenges (Cutcliffe & Stevenson 2008a, Titelman & Wasserman 2009). Thus, expressions of suicidality can also be a way into psychiatric care. Furthermore, mental illness is a common risk factor for suicide (Lönnqvist 2009). In the vast majority of research, suicide has been understood in the context of mental illness, focusing on risk factors, rather than taking its point of departure from the person's perspective (Lakeman & Fitzgerald 2008).

There is, however, some research considering patients' perspectives. Talseth et al. (1999, 2001) describe that persons who have survived a suicide attempt and are then

cared for in psychiatric care, are often relieved that they are still alive, and want help to regain their desire to go on living. Simultaneously the wish to live is challenged by ambivalence about whether or not to go on living (Lakeman 2010a). In this context, severe ambivalence can be understood as an existential challenge that involves not only experiences of failure and shame after a suicide attempt (Wiklander et al. 2003), but also the stigma of suicide and the person's experience of loss of health resources (Vatne & Nåden 2014a). Furthermore, a distanced, one-sided focus on observation and risk assessment, may exacerbate patients' experiences of being vulnerable and exposed to circumstances outside their control. Such an approach may increase experiences of stigma, isolation and hopelessness (Barker 2003, Cutcliffe & Barker 2002). In contrast, positive human interactions and experiences of being understood, reaffirmed, and ability to communicate one's suffering, have been described as necessary for recovery, and are often crucial in overcoming suicidal thoughts and restoring health (Holm & Severinsson 2011, Stefenson & Titelman 2016, Sun & Long 2013).

Despite research describing patients' experiences, this kind of knowledge has rarely been used as a basis for nursing interventions (Gilje & Talseth 2013, Talseth & Gilje 2011). The dominant focus has been on observation and surveillance in order to prevent suicidal behaviors (Carlén & Bengtsson 2007, Cutcliffe & Stevenson 2008b), while patients' lived experiences are not sufficiently acknowledged (Fisher & Happell 2009). Even though Cutcliffe et al. (2006) have suggested a three-stage process of healing, based on an understanding of the person's perspective, knowledge about patients' experiences of recovery during hospitalization remains limited, compared with the body of knowledge regarding risk factors of suicide (Cutcliffe & Stevenson 2008c, Lakeman & Fitzgerald 2008, Lakeman 2010b). In order to develop nursing

interventions that support recovery during hospitalization due to suicidal thoughts and behaviors, there is a need to explore recovery as a phenomenon in this specific context. The aim of this study, was to describe the phenomenon of recovery in a context of nursing care as experienced by persons at risk of suicide.

## MATERIALS AND METHODS

The study was conducted with a reflective lifeworld research approach (Dahlberg et al. 2008), based on phenomenological philosophy (Merleau-Ponty 1945/2013). The 'lifeworld' is a world of meaning that includes 'intersubjectivity', and implies that the person shares and experiences the world together with other humans. Human beings access this personal and intersubjective world through the 'lived body'. This philosophical concept accounts for the body as something more than biology, as it puts forth the idea that the ´body´ and the 'mind' are not separate entities but a unity. Furthermore, it is through the body we experience the world and are anchored in the world (Merleau-Ponty 1945/2013). The notion of the lived body and the lifeworld provide possibilities to study the phenomenon in focus from the persons' own 'lived experiences' (Dahlberg et al. 2008). Thus, this approach acknowledges that phenomena in the world – such as recovery – are subjectively experienced by individuals, although there is a common thread of meaning, abstracted and described as 'the essence' (Dahlberg 2006). This essence is the invariable core of the phenomenon, that makes a phenomenon what it is, while so called 'meaning constituents' contribute with descriptions of variances of the essential meaning. Together the essence and the meaning constituents, describe the phenomenon's 'meaning structure' (Dahlberg et al. 2008).

Within this approach researchers need to adopt a 'phenomenological attitude' characterized by 'openness' and 'sensitivity' to the complexities of lived experiences. This includes not only reflection on their meanings, but also the process of bridling the researchers' understanding. The concept 'bridling' (Dahlberg et al. 2008), covers both the meaning of 'bracketing', i.e. restraining one's pre-understanding, and also slowing down the process of understanding as a whole, to avoid making conclusions too quickly.

**Participants and setting**

Participants were recruited from a psychiatric clinic in central Sweden. The inclusion criteria were that participants: (1) were admitted to psychiatric inpatient care related to suicide risk defined by a clinical suicide risk assessment, made by psychiatrists at the psychiatric clinic; (2) were not subject to involuntarily care; (3) had no psychotic symptoms; (4) had no difficulty in understanding information about the project; (5) had a contact person in primary psychiatric care; (6) were at least 18 years old; (7) were able to understand and speak the Swedish language; and that (8) the interview could be conducted within four weeks of admission. Eleven women and three men, aged between 20 and 70, were included in the study. In addition to suicidal behavior, participants suffered from depression, anxiety and/or crisis.

**Data collection**

Phenomenon-oriented interviews (Dahlberg et al. 2008) were carried out by the first author in conversation rooms in a health care setting. As lived experiences can be difficult to articulate, the interviewer supported the narrative not only by being attentive to the story, but also by being present and showing respect and sensitivity to the participant (Wiklund-Gustin 2010). The opening question encouraged participants to describe the phenomenon of recovery. Follow up questions were posed in order to

deepen the description. In this way the interviewer strived to bridle her pre-understanding and remain open and sensitive to the phenomenon. The interviews lasted between 25 and 120 minutes, and were digitally recorded and transcribed verbatim.

**Data analysis**

The methodological principles in this research involve a dialog between the researchers and the transcribed text, in order to illuminate and describe the phenomenon's meaning structure (Dahlberg et. al. 2008). The recorded interviews were listened to while reading the transcripts repeatedly, to gain an understanding of the contents as a whole. Words or sentences that reflected a meaning relevant to the aim of the study were identified as a meaning unit. The meaning units were then compared, to identify differences and similarities. Similar meanings were grouped into clusters, as a temporary working stage on the way to revealing a meaning structure. The clusters were then discussed between the researchers and reflected on, in order to understand the essential meaning of the phenomenon. This reflective process was characterized by 'bridling' the researchers' understanding, and involved working through the emerging meanings, and understanding each meaning as a figure against the background of the others. When the meanings relevant to the phenomenon had been identified and no contradictions could be found, the essence of the phenomenon was articulated and described. Finally, the meaning constituents that were considered as the variations of the essential meaning were formulated.

**Ethical considerations**

The study was approved by an ethical board (registration number 2013/123-3/4), and was conducted in accordance with the ethical guidelines of the Declaration of Helsinki (World Medical Association 2009). All participants were given oral and written

information about the study, explaining that participation was voluntary, and that they could withdraw at any time without explanation. The research was conducted with respect and responsibility for confidentiality, and protected the participants' integrity and identity. With respect to the risk that sharing one's experiences in an interview could arouse distressing thoughts for participants, an offer to contact the interviewer afterwards was made. All participants had a psychiatric professional network that they could turn to if the interview raised issues that required discussion afterwards. All participants gave their written informed consent before the interview.

## RESULTS

The meaning structure of the phenomenon of recovery in a context of nursing care as experienced by persons at risk of suicide, is presented below, including both the essence and its meaning constituents. In line with this tradition, the presentation of the meaning structure is written in the present tense. This is motivated by a wish to describe how the phenomenon of recovery is understood as a result of analysis, rather than describing what the participants said about it. The use of quotations is intended to illustrate participants' lived experiences. The quotes are attached to names – these are indeed pseudonyms. The use of the concept of 'important others' refers both to professional and informal caregivers. To increase readability the concept 'person' is also used instead of 'persons at risk of suicide'.

The essence of the phenomenon of recovery in a context of nursing care as experienced by persons at risk of suicide in this study, means 'reconnecting with oneself while struggling between life and death'. Reconnecting with oneself means to be involved in questioning how life can become worth living. It is about wanting one's own life back and allowing recovery, by recognizing personal resources that make this

possible. Reconnecting with oneself arises from a mutual relation with important others, who can support a sense of being grounded and belonging within everyday life. This is facilitated when the persons are mutually connected in a shared experience of humanity. Being in recovery is also characterized by a continuous struggle with despair at the edge of life. When the present situation is experienced as unbearable for the person, suicide can appear as a way out. Being in the midst of this struggle for recovery, includes a fear of being left alone, as one not only questions the meaning of life, but also one's ability to handle life. Thus, experiences of being connected to oneself and important others, mean a possibility of moving beyond experiences of fear and mistrust, and facing what matters in life. This facilitates for the person to explore alternatives, as to how life can become worth living. Thus, recovery is grounded in acknowledging one's own experiences, and striving to understand what these experiences mean. The meaning of recovery is further described by its meaning constituents: being in an expressive space and giving voice to oneself, regaining dignity through nurturing connectedness, and finding a balance in the tension between life and death.

**Being in an expressive space and giving voice to oneself**

Narrating one's experiences when struggling between life and death, means to experience a possibility to give voice to oneself. Being in such an expressive space is crucial for experiences of recovery when the person is at risk of suicide. Accessing one's own voice can be challenging, as thoughts of suicide can make it difficult to stand up for oneself, and explicitly put words to one's experiences. Alicia explained:

> I usually explain it in terms of pressing my feelings into a box, just like I am pressing things into a box, so some day… then it will pour out. (…) It's really

> hard for me to put words to my feelings and express what I am thinking and feeling and what it is that is wrong.

When one is able to give voice to this ongoing narrative about one's own life, the hidden can become visible. This involves expressing oneself to professional caregivers that listen and pay attention to the person behind the suicidal behavior, and who also give room for the narrative to evolve. Having space to share one's life history in such a way, allows for experiences of liberation and reduced suffering. Maria experienced: "Just this thing to tell my story again and again, and that they really sit down and listen (…) it's healing inside to get it out one more time." She continues: "It is, despite all, the same history you go through, and you see the whole event once again, so it becomes very difficult, and simultaneously it is a relief to be able to talk about it." Thus, narrating one's experiences can be a challenge, but also a relief that contributes to recovery. Being able to express oneself and to be grounded in one's life history is vital for the person. As described by Sara:

> If you put it into words it usually eases up in some way… it does… it works almost like writing, you write it away from your head like when you have been talking then the worst thoughts disappear if you put words to it.

Being in an expressive space, where one is able to narrate one's struggle between life and death supports recovery. Hence, the personal narrative provides the basis for self-understanding and attribution of meaning in life.

**Regaining dignity through nurturing connectedness**

This meaning constituent is about becoming aware of one's own worth, through engagement with both professional caregivers and supportive relatives. This awareness is intertwined with a sense of being seen and taken into account, which emphasizes connectedness with oneself and important others. Specifically, regaining dignity through nurturing connectedness involves a sense of being reaffirmed as a unique and valuable human being. To be seen and taken into account, also has meaning for one's possibility to feel secure in moments of loneliness. Maria experienced:

> They don't go away until they see that I am calm again. They kind of make sure… 'Do you feel calm now? Can we leave the room now? But we will be back soon and look after you.' Then you know that it is so and that feels quite secure.

The regained dignity becomes evident in close relations with supportive relatives, as experiences of being reconnected with oneself and the world are strengthened. Daniel explained:

> My wife has been very… I don't know what to say, without her I would not have been alive (…) she has been very caring when I have not been able to (…) she has been standing at my side as to say the whole time.

Sara commented: "If you are positive and encouraging like my relatives, then you become more positive yourself. You get time to think after that… thus they are right." The awareness of one's own dignity, and that one is embedded in important relations, is nurtured in the mutual connectedness with the professional caregiver as a fellow human being. Sharing life in this way, means to experience a closeness with the other, in which

one's becoming in the present moment is nourished. This closeness with the other, does not mean that the doubt about one's own value, or that the experience of loneliness disappears from the person. Doubt and loneliness are still present in everyday experiences, but they are balanced by experiences of one's own worth and nurturing relations. Katarina described:

> So this feeling of being worthless, which I still have and have had for a very long time, is not as paralyzing as it usually was, so it is a bit easier to take it, step by step, (…) even if I am still feeling very lonely, I am feeling less alone, and… a little bit appreciated and little… yes, but I am worth something, and I am worthy of help, and I am worth being cared for by someone.

Regaining dignity also means to encounter a sense of respectfulness, in which one is enabled to appreciate one's own value. Being able to experience respectfulness in relation to professional caregivers, means that this connectedness is a resource for personal recovery. This can also be understood as the lived connectedness gives time to reconnect with oneself in a sense of being met as a human being. This sense of connectedness with both oneself and important others supports the experience of belonging in life.

**Finding a balance in the tension between life and death**

Being in a vulnerable situation and struggling with suicidal thoughts, means to experience a tension between life and death. Finding a balance in this tension entails a wish to influence one's vulnerable situation. This balance is not limited to finding a steady state. Rather it is a way of finding one's footings in a multi-faceted reality. This involves allowing a vital rhythm in life, and acknowledging one's varied needs. For

example knowing when one needs to rest and to be active; to be in solitude and to be together. To find the space to become grounded in everyday life and to recover oneself, means that meaning and coherence can be re-established. This rhythm contributes to bearing in life. As Elisabeth stated: “You feel better if you eat on a regular basis and… sleep and so (…). It is like… just routines of everyday life though you don’t have everything that is outside.” Fredrik experienced: “I have learnt that I have great social needs and that it is easier to handle yourself if you have friends and relatives.” To hold on to the possibilities for recovery in everyday life, also involves being allowed to participate at one’s own pace and on one’s own terms. Alicia explained:

> And just that you are allowed to be by yourself, you are left alone (…) but they don’t let you be alone too much, because after a while they come and tell you to come out and eat and so on. And that is… they keep pushing on so you are social. Otherwise I just shut myself in and close the door and… and then I am sitting there, and then nothing will become better, there will be no change.

Finding a balance in the tension between life and death, facilitates the choice of alternatives that are meaningful from one’s own perspective. This meaning of recovery emphasizes a reflective turn toward oneself, acknowledging one’s situation and what matters in everyday life. As expressed by Alicia:

> Yes it is also that you are able to… you have time to work through your feelings on your own. Because it is also very important that you are able to do that, that you don’t close yourself in, which I have been very good at doing. When I get time for myself, then I have time to think and then… I have nothing else to think about than myself. So it is of great importance to be able to, and

> just… just be able to think, and go through everything. And in this way you also realize that it is not so dangerous to be alone, you are able to handle it. But it is something you must work on quite a lot.

This self-reflection opens up to find a direction in the present situation. It can therefore be described as a means to understand oneself and the world, in a way that uncovers new aspects of life. Striving to embrace one's experience-based knowledge in this way, gives space to reconnect with oneself in everyday life. Thus, finding a balance in the tension between life and death, facilitates moving towards personal recovery.

## DISCUSSION

The results reveal that 'reconnecting with oneself while struggling between life and death', characterizes the phenomenon of recovery. This description adds nuances to the caring science definition of health given by Dahlberg (2009) and Todres et al. (2014), in which the essence of health is described as experiences of well-being, where the person is able to carry out minor and major life projects. In this study, the major project is understood as life itself. A project that is possible to carry through by reconnecting with oneself, through the narrative about oneself and what matters in life, thereby gaining a renewed understanding of oneself as a capable and dignified person. In line with Dahlberg (2009) and Todres et al. (2014), one suggestion is that recovery in this context can be understood as reconnecting with oneself through movement and stillness, but also by finding a balance in the tension between life and death. This balance facilitates a rhythm in life (Asp 2015), and involves both to be active and to rest; to be together and to be in solitude. Thus, recovery enables persons to reconnect with what can be understood as ordinary life, in contrast to a life where the person has lost his or her

sense of control. This corresponds to Cutcliffe et al.'s (2006) suggestion that mental health nurses can provide meaningful caring responses to patients at risk of suicide, by facilitating processes aiming at 'learning to live again'. Such care requires attention to individual variations, and to implicit or explicit experiences of patients' struggles between life and death. Our study also highlights that it is necessary for patients to be allowed to participate at their own pace and on their own terms. These experiences of recovery can be understood as ways for patients not only to experience meaning and coherence, but also to experience a possibility to control their own life. This is especially important when patients are experiencing severe ambivalence about whether or not to go on living (Vatne & Nåden 2014a). These insights on recovery draw attention to the necessity of engagement in recovery-oriented interventions (Cutcliffe & Stevenson 2008c), and also indicate that mental health nurses should consider what can facilitate patients carry through their projects of living. In so doing, accounting for the patients' perspectives is essential.

According to our results, recovery is a phenomenon that involves being in an expressive space. There is additional support for these processes in the care of the person at risk of suicide, such as when a patient is experiencing shame (Wiklander et al. 2003) or stigma (Talseth et al. 2003). This description is in line with Ricoeur's recognition of human beings as resourceful, with the ability to speak, act, narrate and take responsibility. It also means that human beings are embedded in situations with moral conflicts (Ricoeur 1992). The ambivalence in suicidal thoughts, which previous research has identified (Jordan et al. 2012), is one example of such conflict. If a patient is able to narrate what is at issue in these conflicts, this cannot only contribute to a resolution of the conflict, but also to experiences of being capable. This corresponds to

a perspective described by nursing researchers such as Buchanan-Barker and Barker (2008). From this perspective, recovery does not necessarily means being free from suicidal thoughts. Rather, recovery is a question of reclaiming one's story, as an ability to express oneself with one's own personal words, which can benefit taking a more active role in influencing the direction of one's own care and life. We claim that mental health nurses can provide meaningful caring responses to patients at risk of suicide, by enabling patients to establish an expressive space and give voice to themselves. This includes recognizing that, in a situation where patients are struggling between life and death, narrating their experiences can involve fear of not being taken seriously and of being abandoned and left alone with despair. If nurses are able to create such an expressive space, it can have the potential to strengthen patients' desire to live.

Another result is that regaining dignity through nurturing connectedness, involves awareness of one's own worth, and of being embedded in important relations with others. These lived relations contribute to patients being grounded in existence, even while questioning how life can become worth living. The contributions of Merleau-Ponty (1945/2013) provide ontological depth to the understanding of such lived relations. His description of human existence as a lived body, means that human beings are in a context of intersubjective relationships with the world. To be respected and taken fully into account by a professional caregiver is essential; such care can be understood as a resource for patients to experience an anchor in the social world. This is significant for persons who experience hopelessness, or who are in doubt of their own value in the aftermath of attempted suicide (Cutcliffe & Barker 2002). Thus, nurses need to facilitate patients' connectedness to participate in the world as resourceful human beings (Lakeman & Fitzgerald 2008, Todres et al. 2009, Vatne & Nåden 2014b).

**Methodological considerations**

In this research, trustworthiness is a question of whether or not the data are sufficient to answer the research questions. The collected data are based on a sample that met the inclusion criteria and contributed to variations in data. A possible limitation is related to gender (Connell 2009), as the sample is based on three men and eleven women. This is important to be aware of, as suicide risk and recovery processes can differ between women and men (Stefenson & Titelman 2016). However, the result is abstracted to an existential level that focuses on human experiences rather than gender. A related limitation may be that the analysis has not accounted for possible differences between patients with different diagnosis. Such descriptions could have contributed with insights that could guide clinical practice. However, following the methodological approach, the analysis is concerned with the meaning structure of the phenomenon on a general level. Thus, the analysis and the description of the phenomenon focus on what is common in different peoples' experiences, rather than comparing participants' backgrounds. What is important is that participants have different backgrounds, and thus are able to contribute with data describing the phenomenon from different perspectives within this specific context. This contributes with rich data, from which the essence of the phenomenon of recovery in the context of nursing care as experienced by persons at risk of suicide, has been abstracted. Thus, the research approach applied in this study, in which attention is paid to describe the phenomenon while accounting from the perspectives of persons (Dahlberg et al. 2008), can be seen as one of its main strengths.

Objectivity and validity were established through the researchers' open attitudes, their ability to bridle their understanding, and their sensitivity to the phenomenon (Dahlberg et al. 2008). In this context, objectivity relates to openness in allowing the

phenomenon to show itself. This scientific attitude (Norlyk & Harder 2010) supports the researchers' ethical reflections (Bishop & Shepherd 2011), which are central in research with vulnerable individuals (Lakeman & Fitzgerald 2009, Liamputtong 2007). The interviewer's awareness of intersubjectivity (Boden et al. 2015), supported critical reflections on feelings throughout the research process. This is considered as a resource for the attention paid to participants' experiences and the phenomenon itself (Cavalcante-Schuback 2006).

The essential meaning and its meaning constituents form a kind of general understanding (Dahlberg et al. 2008), that makes a contribution to research with insights into the meaning of recovery. As recovery is complex, this general understanding (Todres et al. 2014) needs to be applied with openness to nuances of the encounters with individuals.

**Clinical implications**

The results contribute to knowledge about the phenomenon of recovery in a context of nursing care as experienced by persons at risk of suicide. Traditional interventions which focus on assessment and observation, need to be complemented with nursing interventions that can contribute to recovery. When a person is at risk of suicide, mental health nursing can offer a possibility to help patients to reconnect with themselves, while struggling between life and death, and to help patients take into account contributions from supportive relatives. This is important in psychiatric care that strives to be genuinely supportive for patients at risk of suicide. Such care requires attention, openness and sensitivity to individual variations, and to patients' implicit or explicit experiences of struggling between life and death. This could support patients in a way that contributes to their experiences of being capable of managing their own lives. This

calls for an ethical sensitivity, and mental health nursing responsibility to acknowledge patients' lifeworlds. We also emphasize the need for further research, expanding the documentation of the development of caring interventions that take into account the lived experiences of persons at risk of suicide.

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