The experience of being in acute NHS emergency care following an overdose with suicidal intent:

A phenomenological study

David Lee Anderson

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Abstract

The aim of the study is to reveal, in detail, the lived experience of being in acute NHS emergency care following an overdose with suicidal intent.

Suicide is a significant cause of death in the United Kingdom and the main cause of death for men aged 20-49 years. In some parts of the country, Accident and Emergency Departments have become the default pathway for people in crisis, with Emergency Departments identified as key sites where people who are suicidal attend.

The findings of the literature review indicate that published research into the experience of such individuals in emergency care, is limited. Those studies identified do not distinguish between self-harming and suicidal behaviour, as this research does. Papers also focus on the experience of care and do not seek to reveal the lived experience in depth.

This research uses an interpretive phenomenological approach based on van Manen's work. Semi-structured interviews were conducted with sixteen individuals who were inpatients on a medical admission ward in a Northwest hospital, within 48 hours of their overdose. A thematic analysis of the data indicated six key themes: The fear of death and dying, The hospital - a place of safety, Loved ones a reason to live, Hopelessness, Eclipsed as a suicidal patient, and the Impact of human relationships.

Interpretation of the transcripts is explored via four lenses, the first being aspects of Heidegger's writing on death and temporality. Secondly, the findings are reviewed through the work of Roger's writing on the actualizing tendency, self-structure, and the impact of relationships. This is followed by an interpretation of the analysis in relation to the concepts of kindness and compassion.

This work is discussed and contextualized within wider literature, focusing on four areas that are identified as significant to the participants' lived experience: The fear of death, The role of stigma and shame, Hopelessness, and the Impact of relationships between participants and staff. Implications for practice are outlined, along with details of how this research has/will be used to improve patient experience. Reflexivity is offered.

This research offers a unique contribution to knowledge in revealing aspects of the lived experience of being in acute NHS emergency care following an overdose with suicidal intent. The study captures this experience at depth, while participants are still receiving lifesaving hospital treatment.

Table of Contents

Acknowledgements

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To East Lancashire Health Care Trust, for their support and help.

To my wife Claire, and son Thomas, for their love.

Glossary of terms and abbreviations

Acute hospital: A hospital where a patient receives medical care for *physical* conditions or injuries.

A&E: Accident and Emergency Department.

Attempted suicide: 'A non-fatal self-directed potentially injurious behaviour with any intent to die as a result of the behaviour. A suicide attempt may or may not result in injury' (Crosby *et al.* 2011, p.21).

CDC: Centre for Disease Control.

CQC: Care Quality Commission.

HCHC: House of Commons Health Committee.

HLSC: Healthier Lancashire and South Cumbria.

HRA: Health Research Authority.

IPA: Interpretive Phenomenological Analysis.

Mental disorders: 'Syndromes characterised by clinically significant disturbance in an individual's cognition, emotional regulation, or behaviour that reflects a dysfunction in the psychological, biological, or developmental processes that underlie mental and behavioural functioning.' (International Classification of Disease, 2021, para.1).

MDT: Multidiscipline Team meetings

NICE: National Institute for Health and Care Excellence

NSIS: Non-Suicidal Self-injury.

ONS: Office for National Statistics.

REC: Research Ethics Committee.

Resus: An area within an Accident and Emergency Department where people are taken if they need immediate life-saving treatment.

List of images

1. Introduction

1.1 The aim of this study

The aim of this study is to reveal in detail, the lived experience of being in acute care following an overdose with suicidal intent. In accordance with the phenomenological approach, this study does not seek to categorise or explain the nature of that lived experience, or indeed to generate theory, but rather to convey and explore the experience in-depth (Finlay, 2011).

Accordingly, within this introduction, I consider my initial personal and professional motivations for embarking on this research, seeking to highlight my ‘fore-structure of understanding’ (Holroyd, 2007, p.3) at that point (further reflection is offered within Chapter 14: Reflexivity). Following this, I outline the academic and professional rationale for this study.

1.2 The personal and professional motivation for the study

I took up my present post in 2016 as a counsellor and chaplain in a large acute hospital in the Northwest of England, quickly being given a quality improvement project around improving the experience of mental health patients within our care. This was a group of patients that concerned me. During the morning ward rounds, doctors seemed to walk past these patients, with little or no contact. In the afternoons, these were the patients who frequently had no visitors. Indeed, I sensed such patients trying to shut themselves away from the world around them, as I saw them frequently hiding under their thin blue hospital blankets, curled up in the foetal position. Such perceptions were of course my own, but many of these patients also described to me how they were struggling emotionally.

Downstairs, in the Emergency Department, these were also the patients who often had to wait the longest for an inpatient bed. Mental Health patients would frequently breach the hospitals 4-hour A&E targets in the hospital where I work, their names highlighted in red on the bed boards. Their cubicle door or bed would be marked with a symbol of a red dot (image 1), a symbol that seemed to me to express something about the stigma towards mental health I sensed within the organisation. When patients asked about the meaning of the 'red dot', staff would invariably brush the question aside, but a member of the public knew: 'It means you are bloody mental if you are in there', one person told me.

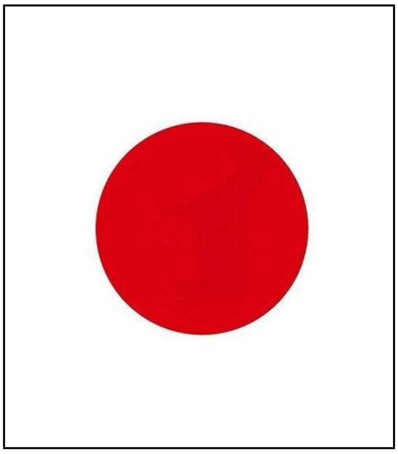


Image 1. Mental health symbol placed on patient door or above bed.

Bringing about change within the Hospital Trust where I work has been challenging, and at times frustrating. I have lost count of the number of senior staff who told me, early on, that 'we are not a Mental Health Trust', when I spoke of improving care for these patients. It is my belief however, that we may not be a Mental Health Trust, but the patients are here, and care we must. Change has happened; we no longer have 'red dots' on patient doors and training is delivered to front line staff around caring for those with suicidal behaviour. There is still a long way to go however, but I am aware that this study is part of that journey for me of bringing about change.

Within the academic world, PhD's are often spoken about as contributing to the wider body of academic knowledge on a subject (Phillips & Pugh, 2010). For me, this study is however, about more than this. As Corbin and Strauss (2015, p.4) note: 'People choose to do research because they have a dream that somehow they will make a difference.' My dream is that this study will enable us to encounter more fully the human individual behind the diagnostic code, to move beyond a culture where we see the ordinary and mundane, to seeing multifaceted human beings. Indeed, to ultimately inform further improvements in our care of this patient group. Furthermore, I also hope this study will enable others to hear the stories that I hear, to be moved as I am moved by the people I encounter, to pause, to wonder, and to even question beliefs and practice.

It is important however, that I acknowledge and remain mindful of such passionate desires throughout this journey, so as to seek to mitigate or bridle their impact, as I seek to glimpse the participants' experience as fully as possible. Due to my role in improvement work, there is a risk I may hear more loudly negative experiences from participants and focus on their descriptions of care, rather than the whole of their experience. Likewise, I am also aware that my work as a counsellor also causes me to be naturally drawn towards emotions and feelings, to notice distress perhaps more than joy. I am also mindful that my concern for this group of patients and my passion for change may cause me to sense their struggles more 'loudly'. Such issues are explored further throughout this thesis and specifically in Chapter 14. Indeed, the production of this thesis has been, to my surprise, a journey of self-discovery.

1.3 The academic and professional rationale for this study

In 2019, there were 5,691 deaths due to suicide in England and Wales, 76% of all such deaths were men (Office for National Statistics, 2020). Indeed, following several years of decline, suicide rates in England and Wales continue to be significantly higher than between 2014-2017 (ONS, 2020). Furthermore, suicide remains the highest cause of death for men aged 20-49 in the UK, and the highest cause of death for all young people (Mental Health Foundation 2020). Significantly, registered rates of suicide among females under the age of 25 years old in England and Wales have also increased by 93.8% since 2012, to its highest figure in 2019, 159 deaths (ONS, 2020). Moreover, it is recognised that the COVID-19 pandemic has had a significant impact on the population's mental health. O'Shea (2020) suggests that an estimated 10 million people in England will require new or further mental health support because of the pandemic. Previous economic recessions have also been linked to increased suicide rates (Gunnell *et al.* 2020). Additionally, Carr *et al.* (2021) highlights how, based on a review of General Practice health records, evidence suggests that during the Covid-19 pandemic, treatment needs for mental disorders may not have been met. Consequently, academics and health professionals predict an increase in the severity of people's mental health conditions in subsequent years, resulting in increased demands for admissions to psychiatric units, and increased presentations to A&E due to suicidal behaviour (Carr *et al.* 2021).

Evidence from people with lived experience, and professionals, suggests that individuals attend A&E in crisis because there is no other comprehensive or responsive 24/7 support available. As one urgent review into the mental health pathway for people who are in crisis reported: 'Emergency services and Emergency Departments have, in some parts of the country … become a default pathway to manage people in mental health distress and crisis' (Healthier Lancashire and South Cumbria 2019, p.23). Indeed, Da Cruz *et al.* (2011) calculated that 43%

of all people who ended their life by suicide in Northwest England, had attended their local emergency department within the past 12 months seeking help, 23% on more than three occasions. Accordingly, The Department of Health and Social Care (2019) continues to identify A&E departments as key sites which people who are suicidal attend, and therefore acute care as having a vital role in the prevention of suicide.

Despite this recognition, very little research into the experience of patients attending A&E following suicidal behaviour has been produced, particularly qualitative research. Instead, research has focused on risk factors associated with suicide, as Hjelmeland & Knizek (2016, p.706) noted: 'Our main point is that we currently have far too little qualitative research and far too much quantitative research of dubious quality and/or usefulness.' Furthermore, Webb (2010, p.5) argues that: 'There is a fundamental flaw at the core of contemporary thinking about suicide; which is the failure to understand suicidality as it is lived by those who experience it.'

Accordingly, this study seeks to reveal the lived experience of inpatients in an acute hospital setting following an overdose. Indeed, within the limits of the literature review conducted, this study is the first to explore this experience in depth. It is hoped that the findings of this study will offer those working within the NHS a deeper and richer appreciation of the experience of the people whom we are called to care for. To perhaps even 'shake us into opening our eyes' (van Manen, 2002, p.250) and to inform future improvement work in this area. The overall outline of the thesis is now presented.

1.4 A guide to the chapters

Chapter one has outlined my personal and professional motivation for this study and the academic rationale for this research.

Chapter two discusses the definition of suicidal behaviour used within this study and the reasons for the choice made, particularly in distinguishing suicide from other forms of self-injury/self-harming behaviour.

Chapter three places the experience of those impacted by suicidal thoughts and behaviour within its historical and cultural context, outlining how individuals have been perceived and treated. This historical overview informs a discussion of the care offered to individuals in crisis and some of the pressures faced within the NHS at the time of this study.

In Chapter four, the current literature around the experience of individuals within emergency care following suicidal behaviour is critically reviewed, with search strategies outlined in Appendix 1. Academic papers located are first reviewed, followed by governmental reports. It is noted, however, that such papers focus on the experience of care received, rather than the whole lived experience of being in hospital following suicidal behaviour. Accordingly, the literature review is extended to locate papers that seek to convey the experience of suicidal behaviour more widely, including a review of a selection of autobiographical accounts (the main themes being identified). Throughout the literature review, the research approaches used within the various studies are discussed, to inform the choices made for the research journey ahead. The chapter concludes with a justification and value of this thesis.

In Chapter five the research approach is discussed under the headings of epistemology, theoretical perspective, methodology, methods and ethics. The rationale for the choices made is justified throughout this section in relation to the title of the study and the literature review. The writings and ideas of key phenomenologists are discussed, including the work of van Manen and his six stages of phenomenological research. The means of assessing the rigour and trustworthiness of phenomenological research are also considered. Finally, research methods are discussed in relation to ethics, details being provided of the data collection.

In Chapter six the findings of the research are summarised for each participant under their pseudonym. These findings are then explored in detail within section seven of the thesis (in the thematic analysis). Six main themes are identified, broken down into twenty-three subthemes, each individually explored. A mind map is included to provide the reader with an overview of the thematic analysis.

Interpretation of the transcripts is presented in Chapter eight, first by exploring the findings through the lens of the work of Heidegger and his writing on death and temporality. Following this, the findings are reviewed through the work of Roger's writing on the actualizing tendency, self-structure, and the role of relationships. Lastly, an interpretation of the analysis in relation to the concepts of kindness and compassion is offered.

In Chapter 9, each of the six major themes identified within the thematic analysis is discussed in detail and contextualized within wider literature from a wide range of sources.

In Chapter 10, implications for practice and the limitations of the study are considered.

Reflexivity is offered in Chapter 11, as I share my personal reflection on my fore-structures relating to my research journey and how these experiences have influenced this study. The study is concluded in Chapter 12.

Accordingly, the definition of suicide used within this thesis is now outlined and discussed.

2. Defining suicide

The lack of clarity, consistency, and uniformity around the classification of suicide and attempted suicide has impacted negatively on research into suicide for many years. This has made effective comparisons between various studies impossible (Silverman, 2016). Indeed, as Silverman (2016, p.11) notes: 'The suicide literature remains replete with confusing (and sometimes derogatory or pejorative) terms, definitions, descriptors and classifications …'. Consequently, attempts have been made to produce and implement a standardized system of nomenclature and classification of suicide and related acts, most notably by the World Health Organization in the 1990s, by Columbia University in 2005, and, in 2011, by the United States Centre for Disease Control (CDC) (Silverman, 2016). In part, due to critical safety concerns around the use/misuse of medication for suicidal behaviour, the CDC system was formally adopted by the United States Food and Drug Administration. Subsequently, this classification is frequently employed by leading researchers (Posner *et. al.* 2017, Muehlenkamp, 2017).

The CDC defines a suicide attempt as: 'A non-fatal self-directed potentially injurious behaviour with any intent to die as a result of the behaviour. A suicide attempt may or may not result in injury' (Crosby *et al.* 2011, p.21). Likewise, suicide is defined as: 'Death caused by self-directed injurious behaviour with any intention to die as a result of the behaviour' (Crosby *et al.* 2011, p.23). Importantly, within these definitions, the distinction between suicidal and non-suicidal self-injurious behaviour is dependent on the intent of the person conducting the behaviour. Accordingly, the act is only classified as non-suicidal if there is *zero* intent to die: the act taking place *entirely* for other reasons than death. Therefore, a self-directed potentially injurious behaviour may be classified as suicide or a suicide attempt if there is at least an element of intent to terminate life. By contrast, within non-suicidal self-injurious behaviour, according to the CDC classification system, there must be *no* intent to end life; the behaviour perhaps being carried out instead to *modify* conscious experience (Muehlenkamp, 2017).

This CDC definition seeks to recognise evidence from clinical practice that suggests that within many suicidal behaviours there is a significant element of ambiguity in terms of meaning and purpose. For example, thoughts of intending death co-existing alongside a longing for intervention and rescue. As Shneidman (1996, p.133) described:

> The prototypical suicidal state is one in which an individual cuts his throat and cries for help at the same time, and is genuine in both sides of the act. … I have never known anyone who was 100 percent for wanting to commit suicide without any fantasies of possible rescue.

It is in recognition of this common state of ambiguity within the suicidal mind that the CDC also included the word 'parasuicide' on a list of 'unacceptable terms', not to be used by professionals and researchers (Crosby *et al.* 2011, p.23). The term parasuicide was first suggested in the 1960s to describe behaviour that may appear suicidal in nature but where there is no intent to die; the behaviour rather being conducted to bring about other changes sought by the individual (Posner *et al.* 2017). It is argued by the CDC (Crosby *et al.* 2011) however, that the use of the term 'parasuicide' is unhelpful as it fails to recognise the ambiguity within suicidal behaviour.

Importantly, the CDC definition also highlights that for behaviour to be classed as a suicide attempt, the behaviour itself does not have to involve any physical self-injury, but rather may simply have the potential for self-injury. The determining factor, therefore, is not the effect of the behaviour, but rather the intent that is linked to that behaviour. For example, if a person took an overdose of tablets, at least in part with the intention to end their life, but did not cause themselves any physical damage, this behaviour would still be classified by the CDC definition as partaking in a suicide attempt (Posner *et al.* 2017). Accordingly, the CDC employs the terms 'self-injurious behaviour', rather than 'self-injury behaviour' within its definition, to indicate how no actual physical harm is required. It is the 'end goal' of the behaviour that determines the classification (Posner *et al.* 2017, p.11).

Despite the widely accepted need for the use of shared and precise terminology when communicating about suicide, within the United Kingdom the National Institute for Health and Care Excellence (NICE 2004, p.7) seems to promote vagueness, defining self-harm as: 'Intentional self-poisoning or injury, irrespective of the apparent purpose of the act'. Within this definition, based on the ideas of Hawton *et al.* (2003), NICE seeks to completely remove the role of intent from its classification, the effect being that NICE combine suicidal and non-suicidal self-injury behaviour, under the single umbrella term, of 'self-harm'. In support of this generalisation NICE (2004) highlights the close links between individuals who self-harm, and death by suicide, noting that people who self-harm are 100 times more likely to die by suicide than the general population in the following 12 months. Furthermore, NICE suggests that this stance of combining suicidal and non-suicidal self-injury behaviour is to 'avoid making inferences about the motivation behind the behaviour' (National Collaborating Centre for Mental Health, 2012, p.14).

Despite such comments however, as Muehlenkamp (2017, p.23) notes:

> Researchers and clinicians have argued that there is an important distinction between suicidal and non-suicidal self-injurious (NSSI) behaviours for some time and it is now largely accepted that NSSI is different from suicidal behaviour.

Indeed, back in the 1930s, Menninger (1938) described self-injury as a coping mechanism to avoid suicide, with more recent research also evidencing that many people who engage in NSSI do not perceive death to be an outcome of their behaviour. For example, research conducted by Nixon *et al.* (2002, p.1337) with 42 adolescent psychiatric inpatients who used NSSI behaviour frequently (78.6% almost daily), found that 47.6% of participants said they engaged in self-harming behaviour 'to stop suicidal ideation or attempt.'.

Likewise, as Muehlenkamp (2017, p.25) argues:

> Specifically, both adults and adolescents self-report that NSSI is used primarily to reduce the experience of intolerable negative emotional or cognitive state, to self-punish, or to generate some type of feeling.

Indeed, as one individual described: ’Self-harm proved to me I was real, I was alive’ (MIND, 2016, p.2).

Accordingly, for the purposes of this study, this distinction is recognised and upheld. Therefore, the CDC definition of attempted suicide is employed: ‘A non-fatal self-directed potentially injurious behaviour with any intent to die as a result of the behaviour. A suicide attempt may or may not result in injury’ (Crosby *et al.* 2011, p.21).

Having determined the working definition of suicide for this study, we now explore the history of the experience of those affected by suicide, to place this research within its historical context. We also discuss the care offered to people impacted by suicidal thoughts at the time of data collection.

3. The care of the suicidal in England

Nolan & McCrae (2016, p.x) reminds us that while as individual human beings ‘we do not live in the past, the past lives in us.’ Accordingly, the experience of being suicidal today is influenced and shaped by our history and culture. Indeed, as Nolan (2009, p.22) argues: ‘Professionals who have no understanding of the past can have only a partial understanding of the present.’ Within this chapter therefore, an overview is offered of the experience of the care of those affected by suicidal thoughts from the Middle Ages until 2019 (the year of data collection for this study). Such an overview is by necessity broad in nature, but seeks to enable an understanding of the past, to aid our ability to grasp the present.

3.1 Post classical history 500-1500

The earliest forms of care provided to those suffering with distress in England was administered through the abundance of religious monasteries that were scattered across the country during the Middle Ages. Alongside their life of prayer and study, those within religious orders also sought to care for the sick through acts of good works, offering a place of sanctuary to those who were distressed. As Nolan (2009, p.22) notes: 'The monastic environment was one of peace and orderliness and was deemed therapeutic for those whose minds were disturbed.'

Due to its immense power, the church regulated learning during this period, with religion, illness and distress being closely interwoven, no more so, than in terms of mental distress (Barbagil, 2015). Disorders that would today be classified as mental health conditions were conceived to be the result of spiritual distress, caused by external forces on the individual, in the most extreme cases, directed by the devil himself. Therefore, although the church offered refuge to the mentally distressed, it also sought healing for the sufferer, through prayers, acts of penance, and in extreme cases, exorcism (Barbagil, 2015). Some individuals were also subjected to severe forms of physical punishments to drive out the evil spirits that were believed to be possessing them (Barbagil, 2015). Suicide, or voluntary death as it was then termed, was considered the work of the devil. Consequently, the church sought to prevent its occurrence through fear, and the threat of eternal punishment. As Barbagil (2015) notes, during this period voluntary death was considered the greatest of all possible sins and indeed judged worse than homicide; suicide killing not only the person's body but also their soul. Unlike homicide, voluntary death offered the person no opportunity for repentance, and therefore resulted in certain eternal damnation (Augustine, 2003).

The Church also engaged the support of the civic authorities to ensure that the practice of voluntary death was feared and despised within the land, with extreme punishments being inflicted on any individual who sought to end their life in this way, and upon their family. For example, those suspected of having committed voluntary death were subject to criminal proceedings, even if they had died. Their body and soul were tried in a court and if found guilty subjected to a second death, their body being dragged through the streets or hung up in gibbets or from the gallows (Barbagil, 2015). Furthermore, anyone found guilty of voluntary death was prevented from having a Christian burial, any compassionate priest offering otherwise would be severely punished (Barbagil, 2015). Indeed, records recall how on occasions, instead of burial, the deceased's body, following its trial, was placed at a nearby crossroads with a stake driven through it. Passers-by were then encouraged to walk over the corpse to prevent the evil spirit from emerging, while the deceased's family were made to stand and watch the 'spectacle' (Minois & Cochrane, 1999). As Barbagil (2015, p.32) notes: 'With inordinate force, this process expressed the horror, repugnance and aversion felt not only by the civic authorities but by the entire population.'

The relatives of those who took their own life also suffered further distress, the convicted person having their property confiscated (Minois & Cochrane, 1999), and the family viewed as a disgrace by their communities. 'Never again would they be free from the burden of being related to someone who had committed the worst sin and the gravest crime' (Barbagil, 2015, p.70).

3.2 The early modern period 1500-1750

Those who did not choose death, and continued to live with their mental distress, also experienced further suffering when in 1536 King Henry VIII began the dissolution of the monasteries as part of his battle with Rome. By 1540, all the monasteries were closed and therefore also the institutions that offered a place of refuge to the mentally distressed (Nolan, 2009). Consequently, such individuals were left to wander from village and town, seeking out informal forms of charity where possible, which was both scarce and unreliable (Nolan, 2009). For those who could find no such charity, in many cases the only option was prison or the workhouse. As Nolan (2009) notes however, during the late sixteenth and mid-eighteenth centuries, private 'mad houses' sprung up, to respond to the vacuum of care left by the closure of the monasteries. The access and the quality of facilities provided, however, was very much dependant on an ability to pay. The poorest were unsurprisingly subjected to the worst conditions, with the parish paying attendance fees only to supervise and control patients as a means of removing them from the streets. As Nolan (1993) notes, many establishments were run purely for profit, resulting in horrific overcrowded conditions. Indeed, many patients were subjected to what would be termed torture today, as McCrae (2018, p.34) recalls: 'Some were chained to the floor and, instead of care and kindness, they were exposed to the brutality of their "keepers"'.

During this period the power of the church continued to decline, and people began to question it's teaching on voluntary death. Through the influence of the renaissance, the human body which had started to be celebrated in art and science, also began to be studied free from religious ideas and control. For example, the first classifications of mental distress were recorded during this time, based on observations (Morrison-Valfre, 2013). Mental distress began to be considered the result of brain disorders, rather than the result of sin or the activity of the devil. As Morrison-Valfre (2013, p.3) notes however: 'Despite the great advances in knowledge, actual treatment of mentally distressed people remained inhumane.' As the beliefs around the reasons for voluntary death were wrestled away from the church, new ideas also started to be published more widely, first anonymously (Barbagil, 2015). Writers began to suggest that the life of an individual belonged not to God, but to that person. Accordingly, voluntary death was portrayed as an expression of personal freedom, returning to the teachings of the ancient Greeks (Barbagil, 2015). Furthermore, the growth in theatre enabled people to consider such ideas more openly, not least through the work of Shakespeare: 'It was above all in the theatre that the theme of suicide gained prominence and reached a broad public' (Minois & Cochrane, 1999, p.64). For example, in the 15 Shakespearian plays classified as tragedies, Kirkland (1999, p.660) notes that there are '13 definite and 8 possible suicides'. Furthermore, of the 13 definite voluntary deaths, 'at least 7 are depicted as being admirable under the circumstances' (Kirkland, 1999, p.660). Shakespeare presented voluntary death as both acceptable and noble, and never a result of mental insanity, but rather portrayed the act as one conducted by contemplative figures (Zamani & Abbasi, 2015). Indeed, to distinguish this act from homicide, a new word slowly came to be used, the term 'suicide' being first published in 1642 (Barbagli, 2015).

3.3 The late modern period 1750-1945

During this period, mental distress and suicidal thoughts came to be confirmed as a separate branch of medicine and inhumane treatments began to be questioned, with one institution offering a very different approach to the care of the mentally distressed and suicidal. Founded by the Quaker community in 1794 in York, *The Retreat* became the most famous 'madhouse' in the world (Nolan, 2009) due to its pioneering work. Here patients were shown compassion and care, given rights and, distinctively, physical forms of restraint were banned. *The Retreat* did however have a clear moral and religious agenda, that has been criticised by some, the staff working hard to ensure that patients accepted both their beliefs and moral values. The approach offered by *The Retreat* however, suggested a radically new way of caring for the mentally distressed. This was embraced by the great social reformers of health care, including Lord Shaftesbury, the model being instrumental in the passing of the 1845 Lunatics Act. The act sought to compel local authorities to provide specialist facilities for the mentally ill and suicidal, which led to the building of institutions across England, also known as asylums. Importantly, as Nolan (1993, p.34) notes:

> In his speeches on the subject of new provision for the mentally ill, Shaftesbury repeatedly made reference to 'patients', 'hospitals', 'doctors' and 'nurses', apparently equating the proposed asylum system with a hospital system and implying that mental and physical illnesses were largely similar.

Sadly, however, as McCrae (2018, p.35) notes, 'they did not foresee the monster that would be created.'

Although some of the values of *The Retreat* were incorporated into the new asylums, generally 'traditional' approaches to 'caring' for the mentally distressed and suicidal continued to be prolific, including brutal forms of restraint and control, with new 'treatments' often being tried with little or no concern for the patient. As Nolan (1993, p.161) notes, ‘the reality was that many of the attitudes and practices that were current in workhouses, prisons and private institutions were absorbed lock, stock and barrel into the new system.’ Within these new institutions, there were immense staff shortages, partly due to poor pay and awful working conditions, with most asylums being run by untrained staff known as attendants, who were themselves desperate for work and a place to live (McCrae, 2018). The asylums were also expected to be self-financing and therefore labour costs were kept to an absolute minimum, inevitably impacting on the care delivered (Nolan, 1993).

3.4 The contemporary period 1945-2019

Following the Second World War, new forms of treatments for mental distress began to emerge and became part of the mental health care, including electroconvulsive therapy and insulin therapy. Such new treatments required increased knowledge from nurses, and so training improved and in 1948 the NHS was founded. Within its foundation came the cementing of the care of the mentally distressed within the territory of medicine (McCrae, 2018). Despite moving asylums from local authority control to the NHS, the new mental hospitals continued to face immense pressure from overcrowding, staff shortages, and concern about their huge running costs (Nolan, 2009). New medications continued, however, to show the promise of hope, particularly with the advent of antipsychotic medication, with the possibility of patients being able to be considered well enough to live in the community with appropriate support. Partly in response to these new medications, the value of the effectiveness of the mental health hospitals began to be questioned. Furthermore, rocked by scandals of abuse, neglect, and theft (McCrae, 2018), in 1961, the then Minister for Health declared: 'Mental hospitals are doomed institutions, part of a bygone age and must disappear' (cited in Nolan 2009, p.32).

Accordingly, the role of Community Psychiatric Nurses became established, each holding a large case load of patients to care for in the community. As Nolan (2009, p.34) notes however: 'Throughout the 1970s and especially the 1980s and 1990s, the resources made available for community care did not match the speed at which the hospital beds were being closed.' The concept of community care required that 'care' be there in the community for the patients being discharged from the inpatient facilities, and many would argue, that this was not the case (McCrae, 2018). As Nolan (1993, p.162) notes:

> By the beginning of the 1990's, it was apparent that the transition from hospital to community care had been badly planned and was proving an enormous burden on local resources so that in some

> parts of the country, large numbers of mentally ill people were not in receipt of any mental health service at all.

Just as the mental hospitals in the past had been hit by failings and scandals, community care was now rocked in a similar manner (Nolan & McCrae 2016). In 1998, Frank Dobson, the then Secretary for Health declared: 'Care in the community has failed' (BBC News, 1998, para.3). Furthermore, it was argued that those patients who were considered too poorly to be moved into community care, and had therefore been placed into residential facilities, were receiving 'care' that 'amounted to abuse' (Nolan, 1993, p.162), while others were being housed in inappropriate bed and breakfast accommodation (Nolan & McCrae, 2016). As noted by Hannigan *et al.* (2018), during the late 1990s, due to such concerns, the care of the mentally distressed, including those feeling suicidal, became a priority with a raft of new policies.

In 1999, The Department of Health issued a new ten-year plan for mental health and community services, with the aim of offering better crisis care and home treatment (Hannigan *et al.* 2018). Subsequently, in 2011, the Department of Health issued the report, *No Health without Mental Health* (Department of Health, 2011) which sought to achieve parity of esteem between physical and mental health. This report also sought to reduce suicides and the experience of stigma. Financial support for the Improving Access to Psychological Therapies (IAPT) programme, was also reaffirmed and further endorsed in 2016 (Hugh, 2016).

Despite such commitments however, the Mental Health Taskforce (2016, p.54) found that: 'Mental health services have been plagued by years of underinvestment.' Indeed, the King's Fund stated that 40% of Mental Health Trusts in England saw their budgets cut in 2015/16, despite increasing demand (Brown & Triggle, 2018). During this period therefore, thresholds for access to therapy continued to rise, resulting in patients having to become more distressed before they could access help. Indeed, in 2014 the House of Health Committee (HCHC, 2014) received evidence from one professional that in some areas, 'it has been reported that the

Child and Adolescent Mental Health Service will not see any young person unless they have attempted at least one suicide' (HCHC, 2014, p.30). Such information has also been supported by the Association of Child Psychotherapists more recently: 'We do hear stories of children and young people having to have attempted suicide on a number of occasions actually before they are seen within the service' (BBC News, 2018, para24).

One of the consequences of the lack of early intervention for people affected by mental distress, as noted by Young Minds (2019), is that increasing numbers of people are having to attend acute hospitals because they have nowhere else to go to seek help. For example, in 2010-11 there were 9,372 attendances of young people at A&E due to mental health problems, compared to 27,487 attendances in 2017-2018 (Young Minds, 2019). As the Chief Executive of Young Minds (2019, para.3) commented:

> One of the main reasons that crisis services are overstretched is that young people who are struggling don't get help soon enough, which means that problems escalate. We often hear from young people who've gone to A&E because they don't know where else to go.

In 2018 the government reaffirmed its commitment to suicide prevention, declaring that: 'Zero suicides is our simple but powerful NHS mission' (Hunt, 2018, para.8). Subsequently, in 2019, through the new NHS ten-year plan, mental health was again highlighted as a priority, once more with the aim of achieving parity of esteem with physical health. The plan committed to investment in Mental Health Care being at least £2.3bn higher by the year 2023/24, with more help for people in suicidal crisis (Charles *et al.* 2019).

Despite such long term aims, evidence suggests however that in 2019 (CQC, 2019), the date of data collection for this research, mental health services faced extreme challenges in caring for those affected by suicidal thoughts and mental distress. CQC (2019) warned that quality ratings of mental health services were starting to deteriorate, and, like young people, adults were being forced to become suicidal before they could access help. Furthermore, individuals frequently 'end up in inappropriate parts of the system because of a lack of community services for people in crisis' (CQC, 2019, p.6). In many instances, such 'inappropriate parts of the system', equated to busy A&E departments and acute hospital admission wards (CQC, 2019, p.6).

CQC (2019) reported evidence that community provision for people in crisis was not increasing fast enough to compensate for the reduction in inpatient facilities, with those inpatient facilities that remained, operating in some areas at over 100% occupancy. Furthermore, as McCrae (2018, p.42) notes: 'The threshold for admission is so high that only the most disturbed patients are admitted.' Additionally, CQC (2019), noted that even those patients who were most need of mental hospital impatient care, were forced to wait long periods of time in acute hospitals for a mental health bed. In 2019, the BBC (Dummigan, 2019, para.1) reported in relation to the county where this study was conducted, that: 'Hundreds of mental health patients in crisis are being stranded in Lancashire A&E departments because there is nowhere else for them to go'. Such waits were also occurring during a time when, overall, A&E departments were facing 'unprecedented' demand, with the NHS reporting in 2019, the worst A&E 4-hour target times for all patients since 2006 (Hutchinson, 2019, para.3). At the same time as experiencing increased demand on its services, the NHS was also experiencing a recruitment crisis. For example, the National Audit Office (2020), noted that between July and September 2019 (which includes the data collection period for this study), there were 43,590 NHS nursing vacancies, with the NHS having an overall vacancy rate of 12% in September 2019. Such workforce shortages, as noted by CQC (2019), undoubtedly impact on the quality of care for all patients.

Interestingly, during COVID 19 lockdown restrictions in 2020, Hawton *et al.* (2021) highlights how there was a 37% reduction in the number of adults presenting to acute hospitals due to self-harm and suicidal behaviour, compared to the equivalent period in 2019. As Hawton *et al.* (2021, p.994) comments however:

> The findings of this study are unlikely to be indicative of what will happen in future, particularly when the likely impacts of longer-term consequences of the pandemic develop, especially recession, unemployment, and financial problems, all well known to be associated with increases in suicide and self-harming behaviour.

3.5 Summary

In summary, for centuries society has struggled to care for the mentally distressed and those affected by suicidal thoughts. Such individuals have frequently been subjected to both stigma and harsh judgement, at times experiencing poor and inhumane treatment. History highlights how when individuals have sought refuge or sanctuary during times of distress, they have frequently experienced brutal or inadequate forms of 'care', with community care also failing many people. Consequently, A&E departments and acute hospital wards have frequently now become the only place of safety available to individuals in crisis. Accordingly, it is the experience of such patients that is now explored. Through the literature review, research into the experience of individuals attending acute hospitals following suicidal behaviour is discussed. This is followed by a discussion of papers and writing that enables us to glimpse in depth, the lived experience of being suicidal in the 21st century.

4. Literature Review

4.1 The role of the literature review

The literature review has traditionally been considered as a means of placing the study within its current context and understanding. For example, it seeks to identify and discuss what is known about the topic of research and to highlight the strengths and weaknesses within current thought (Aveyard *et al.* 2016). The literature review also helps to establish the overall rationale for the study and importantly demonstrates its need, highlighting how the author's own research will make a unique contribution to the existing body of literature (Aveyard *et al.* 2016). Within the research process however, the literature review also enables the researcher to engage more deeply with the process of conducting research. For example, to ponder on different methodological approaches and to reflect on challenges and opportunities, therefore building on both the experiences and the findings of previous academics. As Smythe and Spence (2012, p.13) note:

> The purpose of the literature review is therefore not simply to lay down pre-articulated knowledge, merely to show a gap in the literature, or as a means to argue the catalyst for on-going research. The key purpose of such an endeavour in hermeneutic research is to provoke thinking.

The literature review is therefore an orderly process, where the author seeks to undertake a comprehensive search of the evidence around the given topic, and then seeks to immerse themselves within those papers and resources, to gain an understanding and a sense of direction for the journey ahead.

4.2 Integrative literature reviews

Within the field of nursing and health care, integrative literature reviews are increasingly being used as a means of providing a wide-ranging understanding of a specific phenomenon (Whittemore & Knafl, 2005). The integrative literature review seeks to enable a broad range of methodologies and approaches to be brought together, being as inclusive as possible, identifying the maximum number of different sources. Accordingly, in seeking to capture the patient's experience, as fully as possible, of being in acute care following an overdose, this model was adopted. Specifically, it was considered that the broadening of the literature review beyond published academic papers, enabled the greatest opportunity to glimpse the lived experience of those affected by suicidal behaviour as fully as possible. Accordingly, the literature review became formed into four distinct sections, drawing on a wide range of sources:

1. A review of academic papers that seek to provide an insight into patient experience in acute hospital care following suicidal behaviour.
2. A review of government sponsored papers that highlight the experience of patients in acute care following suicidal behaviour.
3. A review of academic papers that seek to provide an insight into the lived experience of being suicidal.
4. A review of autobiographical accounts of the experience of being suicidal, in both written form and via video.

4.3 Academic papers: Patient experience following suicidal behaviour within an acute hospital

Full details of the search strategy, search terms employed, rationale, and results for this part of the literature review, can be located within Appendix one of this thesis (S.1 and S.2). In total, five papers exploring the experience of individuals being in acute care following suicidal behaviour, that fall within these parameters, were located and are now discussed in turn.

4.3.1 Taylor *et al.* (2009) *'Attitudes towards clinical services among people who self-harm: systematic review'*.

This systematic review sought to incorporate thirty-one qualitative and quantitative studies from around the world of people's attitudes towards clinical services following, what the authors termed, 'self-injury' or 'self-poisoning'. The review highlights how many participants described their experience of clinical services as 'negative' (Taylor *et al.* 2009, p.104). As Taylor *et al.* (2009, p.108) note:

> Participants associated negative experiences of management with perceived lack of patient involvement in management decisions, inappropriate staff behaviour and lack of staff knowledge, problems with the format of psychological assessments and issues with access to after-care.

For example, the review noted how participants perceived that they were treated differently by staff due to their self-harming/self-poisoning behaviour, with staff appearing to lack understanding or sympathy towards them. Participants also recounted how they found being in the emergency department, waiting for long periods of time, frightening, leading to increased levels of anxiety. The review also recorded how participants recounted how they were subjected to threats and humiliation by staff. For example, the authors quote one study:

> The last time I had a blood transfusion the consultant said that I was wasting blood that was meant for patients after they'd had operations or accident victims. He asked whether I was proud of what I'd done (Brophy, 2006, p.50).

Taylor *et al.* (2009) notes how some of the studies reviewed suggested that staff threatened to withhold treatment from participants, using the term 'self-inflicted' to describe the patient's injuries. Taylor *et al.* (2009) also highlighted how participants were requested by staff to promise that they would not self-harm again, before receiving treatment. Generally, Taylor *et al.* (2009, p.106), suggests that:

> Overall, the feelings of many people who self-harm are best conveyed by one participant who remarked: 'I was going back to where I started, I felt confused, I thought: "what was the point of coming to hospital"'.

Indeed, Taylor *et al.* (2009) note how some participants said they would not return to hospital again, even following future episodes of self-harming/self-poisoning behaviour. Furthermore, studies indicated that service users found it difficult to access mental health support.

Conversely, Taylor *et al.* (2009) note that positive care was associated with participants perceiving that they were involved in their treatment and decision making, and that staff provided them with 'regular check-ups' (Taylor *et al.* 2009, p.106). Papers also suggested that positive care was linked with staff who they experienced as 'genuinely concerned about them, respected them and did not try to belittle them' (Taylor *et al.* 2009, p.107). Individuals stating that they wanted to be 'listened to and not judged' (Taylor *et al.* 2009, p.108). Furthermore, Taylor *et al.* (2009) noted how participants described that services could be improved through increased staff training and access to local services and after-care support.

It should be noted however, that this systematic review does contain several limitations. First, Taylor *et al.* (2009) combines, without distinction, two types of behaviour: self-harm and suicidal behaviour. As outlined within Section Two of this thesis, it has been argued that such behaviours are different and should therefore be treated as such within research. Likewise, the term ‘parasuicide’ is also employed within some papers reviewed by Taylor *et al.* (2009), however, with different meanings. For example, one study suggesting that parasuicide is attempted suicide or deliberate self-poisoning or self-injury (Kreitman & Chowdhury, 1973). In contrast, another paper stating that ‘parasuicide’ refers to attempted suicide without the actual intention of killing oneself, termed ‘a cry for help' (Dunleavey, 1992, p.213). Accordingly, it could be argued that seeking to combine studies that reflect different types of behaviours within one review, without distinction, is problematic.

Secondly, the large variety of ‘clinical services’, included by the authors in seeking to report on patient experience, could also be considered a limitation. For example, the study combines the attitudes of service users to inpatient observations, psychiatric consultations, dialectical behaviour therapy, emergency departments, care pathways, and psychosocial assessments. It could be argued therefore that merging the findings from such differing clinical services is problematic.

Thirdly, the value of this review is also limited due to the wide range of dates of the papers included, combining papers from 1973 to 2007. As noted above (Chapter 3), the care of individuals suffering from suicidal behaviour has changed over time, along with attitudes. Accordingly, combining studies from a 34-year period, without distinction, may be considered problematic.

Fourthly, within the review by Taylor *et al.* (2009), studies are included, without distinction, which express the views of family and friends of patients, alongside studies that focus purely on the views of patients themselves. In contrast however, wider research indicates that discord between family and friends is commonly associated with both self-harm and suicide (Hawton *et al.* 2006). Despite this, such views are combined and treated without distinction within this review.

Fifthly, seeking to bring together both quantitative and qualitative studies within one review, as recognised by the authors (Taylor *et al.* 2009), is problematic. As highlighted by Gray (2018, p.199): ‘The mere convergence of research results from quantitative and qualitative methods does not necessarily assure validity.’ Indeed, as will be discussed later within this thesis (Chapter 5.2) and noted by Bryman (1988, p.153), ‘quantitative and qualitative research are based upon fundamentally incompatible epistemological positions’, therefore making the integration of such research findings difficult.

Sixthly, due to the format of the systematic review, this study provides little insight into the depth of participants’ experience, with common experiences being highlighted, but not explored in detail. For example, the authors note that patients were subjected to threats, but offer no details of how this was experienced by such patients. Likewise, the authors note that patients valued reassurance from staff about their condition, however the reasons for this are not explored.

Finally, as noted by the authors of this review themselves, 26% of the studies included within the review are considered only acceptable or weak in their design by Taylor *et al.* (2009), therefore raising significant questions of validity. These judgments were based on the Social Care Institute for Excellence's (2006) quality assessment tool and the Critical Appraisal Skills Programme’s appraisal questions (2002).

In summary therefore, the systematic review by Taylor *et al.* (2009), indicated that many individuals affected by self-harm and suicidal behaviour had negative experiences of clinical services, particularly connected to contact with staff. Positive experiences, however, were linked to the perception of genuine care, understanding and respect from staff and involvement in care decisions. Exploring such experiences in greater depth and focus however, would offer greater insight into such perceptions, alongside also seeking to avoid the limitations contained within this study, as outlined above; perhaps most notably, the combining of differing behaviours and services, without distinction.

4.3.2 MacDonald *et al.* (2020) 'Patients' experiences of emergency hospital care following self-harm: Systematic review and thematic synthesis of qualitative research'.

MacDonald *et al*. (2020), sought to provide an updated and comprehensive synthesis of qualitative research published since Taylor's *et al.* (2009) review, into the experience of hospital care following self-harming behaviour. Accordingly, MacDonald *et al*. (2020) searched 11 bibliographic databases and 31 national and international websites linked to self-harm (self-harm being defined as infliction of external surface damage to the body and self-poisoning, regardless of intent). International 'experts' were also contacted for suggestions of studies to be included within the review. In total MacDonald *et al*. (2020) identified 26 studies, from 7 countries, which were subsequently subjected to a thematic synthesis.

A meta theme identified by MacDonald *et al*. (2020), focused on the experience of becoming a patient. Such narratives were largely negative, patients perceiving that their authenticity and legitimacy as a patient was questioned, due to the self-inflicted nature of their injuries and the lack of severity compared to other patients. Individuals perceived themselves as a 'burden', 'unworthy of care' and were 'embarrassed'; feelings that were often heightened by the words and actions of staff (MacDonald *et al*. 2020, p.475f). Some patients also reported frustration at being wrongly classed as suicidal when engaging in self-harming behaviour, or as someone with a mental health condition, leading to perceived stigmatization and shame. The review also highlighted how participants were fearful of receiving 'inappropriate or unnecessarily excessive treatment', perceiving a lack of control (MacDonald *et al*. 2020, p.475); the emergency department, for example, being linked to an asylum or prison. A range of 'hostile encounters with clinicians' was also highlighted, including being denied pain relief and subjected to verbal abuse (MacDonald *et al*. 2020, p.477). Other studies recalled feelings of abandonment and being let down, linked to feelings of hopelessness. The review also highlighted a lack of individual care, patients feeling as if they were on a 'production line' or were 'a lump of meat'; physical injuries being prioritized over their emotional needs which were neglected (MacDonald *et al*. 2020, p.478). Consequently, some patients reported increased feelings of self-harming behaviour after attending emergency departments, and a resistance to seeking further help.

In contrast, positive care was associated with compassion and gentleness, for example, in the treatment of wounds, and the offering of respect and consideration from staff. The review noted how such care reduced feelings of shame and enabled patients to be more open about their difficulties.

Many of the themes within the review reflect those noted by Taylor *et al*. (2009) and highlight negative experiences, particularly in connection with encounters with staff. Similarly, however, MacDonald *et al.* (2020) fail to distinguish between self-harming and suicidal behaviour as this thesis seeks to do, and as some of the participants within the various studies reviewed by MacDonald *et al.* did. Furthermore, the study combines the experience of individuals from seven different countries, with different health care systems, a limitation noted by the authors. Additionally, as the authors also note, the study combines the patient's experiences of different care pathways and different professionals, including hospital care, psychosocial assessments, and discharge care. Perhaps most significantly, the study provides little insight into the depth of the lived experience of individuals as this study seeks to do.

4.3.3 Hughes, *et al.* (2005) *‘Patient experiences of hospital care following self-harm – a qualitative study’*.

In the second study, Hughes *et al.* (2005) sought to identify and describe the experience of those attending two A&E departments in Leeds due to self-harming or suicidal behaviour. The authors invited those who had presented at A&E over a nine-month period, via letter, to return to the hospital to participate in free association narrative interviews.

The study reported that overall, interviewees’ experience of attending A&E following self-harming or suicidal behaviour ‘was largely negative’ (Hughes *et al.* 2005, p.28). For example, Hughes *et al.* (2005) notes that interviewees perceived that they were a low priority when waiting in A&E. Participants also reported that staff were less sympathetic towards them because they had 'harmed themselves', considering them to be a 'waste of time' (Hughes *et al.* 2005, p.8). Participants also described how staff seemed to 'lack an understanding of self-harm' (Hughes *et al.* 2005, p.11), staff expressing 'impatience or annoyance' (Hughes *et al.* 2005, p.12) towards them. Furthermore, such experiences enhanced feelings of 'worthlessness and isolation' (Hughes *et al.* 2005, p.13). Participants also recalled feeling 'conspicuous' during their time in hospital, feeling 'exposed’ and 'vulnerable', perceiving that 'everyone was looking at me', resulting in anxiety (Hughes *et al.* 2005, p.8f). During their care, participants also recalled a lack of privacy, for example, being asked to show and explain their injuries in a public area to staff.

Furthermore, participants also described how they felt anxious and frightened about their physical wellbeing. This feeling was enhanced when they were left alone, several participants expressing 'the need for someone to stay with them' (Hughes *et al.* 2005, p.9). Individuals valued reassurance offered by staff and information, however, they did not always feel that they received this, describing how they needed 'more warm and personal contact with staff’ (Hughes *et al.* 2005, p.11). Indeed, Hughes *et al.* (2005) suggests that positive experiences were linked with staff checking on them, offering reassurance, staff talking to them as if they were a ‘normal person’, and being 'genuine, pleasant, very kind, very calm' (Hughes *et al.* 2005, p.14). Furthermore, some interviewees described difficulties in accessing support following discharge and feeling 'abandoned' (Hughes *et al.* 2005, p.20).

Following such findings, Hughes *et al.* (2005) recommends that training should be delivered to staff, suggesting, for example, that such training should improve understanding and self-reflection around self-harm. Furthermore, Hughes *et al.* (2005, p.30) recommends that training should be given to improve skills around 'understanding patients’ psychological states and with their ability to show empathy', and to improve 'skills in communicating and negotiating with people experiencing emotional distress.’

Many of the themes explored within this study reflect those identified by Taylor *et al.* (2009) and MacDonald *et al.* (2020). The nature of the methodology employed by Hughes *et al.* (2005) however, also offers further insight into these themes, often absent within these systematic reviews. For example, Hughes *et al.* (2005) offer detailed quotations from the interviews conducted.

It should be noted however, that this study by Hughes *et al.* (2005, p.4) experienced significant recruitment difficulties, which resulted in the abandonment of the initial aim of interviewing a ‘broad spectrum of people’. For example, only 10% of patients contacted agreed to participate, only half of whom attended for interview (n.45), a third of whom could not recall any details about the experience. Interestingly, these recruitment issues highlight the potential challenge of engaging participants affected by self-harm and suicidal behaviour in research. Within the study by Hughes *et al.* (2005), further potential limitations can also be identified. For example, the authors fail to note the time between the attendance at the A&E department and the interviews being conducted. Clearly such information would be useful, as the longer the period between the attendance and the data collection, the greater the capacity for the account given to be further from the lived experience as perceived in A&E (Galvin & Holloway 2015). Indeed, the larger the period, the greater the probability that the participants are offering their reflections on their experience, rather than an account of the experience as perceived while within the A&E department. Additionally, although offering greater detail of the experience than Taylor *et al.* (2009) and MacDonald *et al.* (2020), this study also frequently fails to reveal in depth many of the experiences noted. For example, Hughes *et al.* (2005) mention that interviewees feared dying, however fail to expand on this in detail.

Moreover, the importance of ethical considerations, in terms of research methods, can, concerningly, be seen within this study. For example, in this study, the recruitment letter to the potential participants was signed by the lead clinical consultant for the A&E department. Such a recruitment method is ethically questionable, with boundaries being blurred between medical care and research (Liamputtong, 2007). For example, would such a signature result in potential participants feeling under pressure to take part in the study? Furthermore, although the research was conducted by Leeds University, there is no indication within the published study, or the participant's information sheet included within the Appendix of the study, that this research received ethical approval from the Health Research Authority or the Universities Internal Ethical Review board.

Overall, therefore, although this study is helpful in highlighting a range of negative and positive experiences of patients affected by self-harm or suicidal behaviour, it contains limitations in terms of the focus of this thesis. The lack of distinction between self-harm and suicide is again problematic, along with the lack of depth in terms of the participants' experience, and the absence of information regarding the time between the attendance at the A&E department and the follow up interview. This study, however, is perhaps most helpful in highlighting the need for careful ethical consideration within the recruitment of participants and the challenge of engaging this participant group in such research. An issue, therefore, explored in further detail in Chapter 5.8.

4.3.4 Owens *et al.* (2016) *'Needs and fears of young people presenting at accident and emergency department following an act of self-harm: secondary analysis of qualitative data'.*

To access a greater number of patients' experiences of attendance at A&E following self-harm or suicidal behaviour, Owens *et al.* (2016) employed social media to recruit participants aged between 16-25 years old, to an on-line discussion forum. Seventyseven young people were recruited via an existing on-line self-harm group and invited to discuss their experiences of care. Thousands of comments were analysed and subjected to thematic analysis.

Young people wrote of feeling ashamed when arriving at A&E and longing for staff to show them kindness and understanding, yet participants shared numerous accounts of negative experiences. For example, young people described how they were denied pain relief, told that they were 'as bad as people who make hoax ambulance calls', 'selfish', 'inconsiderate' and that they were 'wasting time that could be used for *real* patients' (Owens *et al.* 2016, p.288). Some participants also described being denied treatment, as they had caused their injuries: 'They refuse to treat me!! … basically, cos it's self-harm … I feel like giving up. What's the point if no-one wants to try to help' (Owens *et al.* 2016, p.288). Other participants described being excluded from discussions regarding their treatment, being spoken about as if they were not present. Furthermore, participants linked such experiences to enhanced feelings of shame and worthlessness, one young person describing how they wanted 'to go home, hide under the duvet and die of shame' (Owens *et al.* 2016, p.290).

Several positive encounters with staff, however, were also noted within the study. For example, experiences of staff being non-judgemental, sensitive, and genuinely seeking to understand, were all greatly valued by participants. The forum posts also suggested that participants appreciated staff engaging with them about 'random stuff' (Owens *et al.* 2016, p.188). Indeed, overall, the experience of the A&E department was closely aligned to the participants perceived relationship with staff members.

Due to the method employed however, the value of the study for the focus of this thesis is perhaps limited. Firstly, it is impossible for the investigators to confirm that those posting comments had authentic experiences, having attended A&E following suicidal behaviour. Furthermore, the interactive nature of the on-line discussion between the young people may have encouraged exaggeration of experiences (Bell & Waters, 2018), a factor acknowledged by the authors themselves. Additionally, Owens *et al.* (2016, p.286) based their definition for self-harm on *outcome*, rather than *intent*: 'Self-harm refers to any act with a non-fatal outcome in which an individual initiates a behaviour or ingests a substance with the intention of causing harm to themselves.' Consequently, such a definition encapsulates individuals who have self-harmed with no intention of ending their life, but also those who have harmed themselves with intent to die but survived. Owens *et al.* (2016), therefore fails to distinguish between self-harming and suicidal behaviour. Finally, due to the nature of social media posts, the experiences recorded, although reflecting those of other studies, lacked depth; many of the comments being short, abbreviated lines. Overall, however, the study highlights the negative experiences of this group of young people attending A&E departments, and therefore the need for further research in this area, again, at depth, is evident.

4.3.5 Anderson (2018) *'Enhancing acute hospital care for patients who have self-harmed* '.

The final paper identified within this first part of the literature review is a qualitative study of 40 patients within Blackburn Hospital of their experience of acute care due to self-harm or suicidal behaviour. This paper was written by myself and peer reviewed. A strength of this paper is the acceptance rate; 95% of those invited to take part in semi-structured interviews participating. Furthermore, participants were interviewed while they were approaching discharge, but still patients within the Admission Ward, and therefore still experiencing hospital care.

Thematic analysis found that overall, experiences were more positive than identified in other studies above, perhaps due to the response rate, with only a third of participants speaking about negative experiences. As in other studies, negative feelings were connected to feelings of shame and being a drain on resources. Negative accounts with staff were also highlighted, as in other studies, with some patients recalling being told that they were wasting resources and did not deserve a bed. Participants also reported feeling a burden, and 'wasting everyone's time' (Anderson, 2018, p.28). In contrast to the studies noted above however, many more positive encounters with staff were recorded, with patients particularly identifying student nurses to be helpful as they appeared to genuinely listen and care. For example: 'The nurse last night said she had been thinking about me, and then she gave me this (a leaflet). That absolutely made my day' (Anderson, 2018, p.28). Being touched by staff in a caring manner also impacted positively on participants: 'She gave me a hug and it meant everything' (Anderson, 2018, p.28). Overall, as within other studies noted above, the experience of being in acute care seemed greatly influenced by the perceived relationship between the participant and staff members.

A limitation of this study however, as with others noted above, was a lack of depth of experience revealed, the paper noting positive and negative experiences, but failing to reveal these in detail and their meaning for the participants. Furthermore, the interviews within this study focused on the participants experience *of* care and did not explore other factors that contributed to the patients lived experience of being *in* care. For example, the physical space that they were in, and the way their past, and perception of the future, impacted on the experiencing of their present. Furthermore, as within other studies, the research failed to distinguish between participants within acute emergency care due to self-harming behaviour with no intention to end their life, and those whose actions included intent to die. Finally, it is also recognised that as this paper is written by myself, blind spots to further limitations are inevitable.

4.3.6 Summary

This first aspect of the integrative literature review highlights frequent negative experiences for this patient group, with participants experiencing distressing comments from staff and poor standards of care. Participants also recalled experiencing shame in hospital and what may be termed as stigma (see Chapter 9.2) from staff. They described how the busy A&E environment and long waits increased their feelings of anxiety, linked to feeling vulnerable and exposed. Individuals perceived that they were treated differently because of their self-harming or suicidal behaviour. Participants also highlighted difficulties in accessing mental health support outside the hospital. Overall, the studies related positive experience of participants when being cared for by non-judgemental staff, who were perceived as being genuinely kind, in very human ways. Positive experiences were also associated with participants feeling informed and reassured about their care and physical wellbeing. Individuals valued being treated in the same way as other patients.

This aspect of the literature review of academic papers of patient experience in acute emergency care due to self-harm or suicidal behaviour highlights, however, that published research within this field is limited; only 5 studies being located that included, within the search parameters, this focus. Furthermore, none of the papers recognised the important distinction between self-harm and suicide, something which this thesis seeks to do; all the papers combining self-harm and suicidal behaviour under one broad heading. Additionally, none of the papers explored the lived experience of being in acute hospital care in depth, failing to reveal that experience as fully as possible from the perception of the participants. Other methodological approaches, for example, phenomenology, may have achieved this, and therefore enabled more of the lived experience to be glimpsed. Accordingly, the need for further research within this area that seeks to reveal such experience at depth, along with making the important distinction between self-harm and suicidal behaviour, is evident. The review also indicates the potential challenges of recruitment with this patient group, and importantly, the need for careful ethical consideration in terms of research methods.

4.4 Governmental papers: Patient experience following suicidal behaviour within an acute hospital.

4.4.1 Search strategy

Alongside academic papers, the integrative nature of the search strategy sought to identify governmental papers exploring the patient experience in emergency care following suicidal behaviour. Details of the search strategy (S.2) are in Appendix one; two reports being located. These are now discussed.

4.4.2 Care Quality Commission (2015) *Right here, right now.*

In 2015 the Care Quality Commission (CQC, 2015) published a report entitled *Right here, right now*; the results of an enquiry into people's experience of help, support and care when experiencing a mental health crisis; a mental health crisis being a situation when someone needs urgent help due to mental distress, for example having strong self-harming or suicidal thoughts (Mental Health Foundation, 2021). This study sought to understand if people were getting the right care at the right time, investigating variations in services across the NHS, along with assessing the quality of the care provided by different agencies. Within the study, CQC used its statutory powers to conduct 15 local area inspections during the winter of 2014/15, alongside surveying every NHS Mental Health Trust. The CQC also requested, over a six-week period, comments from people about their experiences of care, with 1,750 responses being received. 985 responses came from previous patients, 545 from carers/relatives and 226 from groups. A few of these comments are contained within the report. Alongside this qualitative work however, each group who responded to the 'call for evidence' was invited to complete a questionnaire expressing their views in quantitative terms.

Tailored questionnaires were produced for each group of participants. Interestingly, as CQC (2015, p.66) notes:

> One of the clearest findings from our call for evidence was that people are not satisfied with how A&E departments respond to people in crisis. A&E departments received the lowest score of any service.

CQC (2015) found that only 36% (n=316) of people who attended A&E in crisis felt that they were treated with warmth and compassion, compared to 88% when having contact with the voluntary sector or charities. Likewise, the report noted that within the A&E setting, only 33% of participants felt that they were not judged for their suicidal behaviour. Within their comments, patients also highlighted how they believed that they were perceived as a burden by others, an inconvenience and, at times, treated with 'visible contempt' (CQC, 2015, p.66).

This study, therefore, offers a valuable, but broad insight into patient experience of A&E departments. The report does, however, contain some limitations. For example, the 'call for evidence' by CQC was, by its very nature, based on self-selecting volunteers responding to that request, often via publication within national charities and organisations. People connected with such charities and organisations may be the most likely to be campaigning for change within the mental health system and crisis care, and therefore may not be representative. Indeed, as CQC (2015) recognised, people who respond to requests for information may be those who hold strong opinions on issues, particularly negative ones. It is possibly for this reason, that within the study itself, CQC (2015) found disparity between the evidence supplied in response to their call for information from the public, and the evidence found during inspections. For example, CQC (2015) reported excellent care and support during the 15 local area inspections of A&E departments. Furthermore, in terms of the focus of this thesis, the use of questionnaires to express lived experience, although easily quantifiable, fails to reveal that experience in depth; something which other methodologies may seek to illuminate and convey. For example, it would be helpful to understand further what participants understood when they said they were not treated with ‘warmth and compassion’ within A&E departments, and the meaning they ascribe to this (CQC, 2015, p.6). Overall, therefore, this study highlights again the need for further, in depth, research in this area; CQC (2015) finding that patients in crisis experience the most distressing care, when attending A&E departments, compared to all other services.

4.4.3 Healthier Lancashire and South Cumbria Integrated Care system (2019) *Urgent mental health pathway review within Lancashire.*

In May 2019, an urgent Mental Health Pathway Review was published by Healthier Lancashire and South Cumbria (HLSC, 2019) into mental health services within Lancashire, the county in which the research for this thesis was conducted. The review was conducted independently by Northumberland, Tyne and Wear NHS Foundation Trust, in response to increased demand and serious operational difficulties. Many of the services that people encounter when experiencing a mental health crisis in Lancashire were reviewed, including the police, mental health community teams, crisis services, emergency departments and mental health inpatient units. Alongside analysis of service data, a range of ‘listening’ events were held around the county attended by 100 service users and carers, 105 members of staff, 50 GPs and 65 members of the voluntary, community and faith groups (HLSC, 2019, p.13). The report was described as ‘very difficult reading’ by the Chief Executive of Lancashire Care NHS Foundation Trust (Healthier Lancashire and South Cumbria NHS Foundation Trust, 2019, p.1) who apologised for the experiences described within the report, stating that ‘services have, in many instances, fallen way short of what we aspire to, and that our patients and families deserve.’ Most of the comments and subsequent recommendations within the review were targeted at Lancashire Care Foundation Trust, who are the main provider of mental health services within Lancashire. Four recommendations however, focused on Emergency Departments in Lancashire.

The report notes how service users and their carers felt that an Emergency Department was 'not an appropriate place' for people experiencing a mental health crisis (HLSC, 2019, p.15). The Emergency Department was however the *only* place that people could go to when feeling suicidal, mainly because the Crisis Services were so unresponsive and, on occasion, offered nothing more helpful to the suicidal person than the suggestion to go and have 'tea and a bath' (HLSC, 2019, p.31). Within the Emergency Departments in Lancashire itself, service users and carers also spoke of how they: 'Don't always receive compassion, respect or a quick response', security staff being highlighted particularly as being 'obtrusive and inappropriate at times' (HLSC, 2019, p.15). Furthermore, service users and carers noted patients were required to wait for long periods of time, on trolleys in corridors, frequently having overnight waits to see the Mental Health Liaison Team. The recommendations also particularly highlight the need for the Emergency Departments to 'build skills and improve culture in front-line staff in relation to mental health' (HLSC, 2019, p.74).

Overall, this report offers a glimpse into the state of mental health service provision within Lancashire and highlights the many difficulties and challenges that impact on the experience of individuals in crisis. The need for greater compassion and understanding seems to be a common thread throughout, particularly longed for by service users and their families and carers.

In seeking to understand the experience of patients affected by suicidal thoughts within the acute sector, this review, however, contains several significant limitations. Whilst obtaining the views of service users and carers via the 100 attendees at the listening events, the report fails to state how many of those who attended these meetings spoke and shared their views; an attendance of 100 people does not necessarily equate to 100 people sharing their views. Furthermore, the report fails to offer a breakdown of the percentage of service users and carers who attended the listening events and the proportion of these two subgroups which spoke, and therefore how the views of these two groups are reflected within the report. The views of family and friends may not always be the same as service users. Furthermore, it is possible that individuals affected by suicidal feelings could feel uncomfortable sharing their experiences within a focus group, and therefore this report may not capture the lived experience as much as other data collection methods. The very nature of such open listening events, or focus groups, may also result in individuals being influenced by other people's presence and previous comments (Bell & Waters, 2018). Additionally, the report fails to note the period between the participants attendance at A&E and attendance at the focus group. It is possible, that the longer this period, the less accurate the participants' accounts are, compared to those perceived at the initial time of attendance.

Furthermore, the lack of depth within the report in terms of people's experiences, restricted to bullet points, also fails to capture the richness of the lived experience. For example, the comment within the report that states that the Emergency Department is not an appropriate place for someone in a mental health crisis, does not enable us to understand what it is about that space or environment that makes it feel inappropriate. Finally, the review only explored the experience of care within the Emergency Department and therefore only one aspect of the acute emergency pathway. The most common method associated with suicidal behaviour, is overdose (Joiner, 2005), accordingly most patients who attempt suicide and attend the Emergency Department require admission. The experience of individuals admitted to a hospital ward, however, is not included within this report.

4.4.4 Summary

This second part of the integrative literature review highlights the negative experiences many patients encounter when accessing emergency care due to suicidal feelings or behaviour. Indeed, CQC (2015) discovered that of all the agencies involved in the care of people in crisis, highest levels of negative care are experienced in the A&E departments. Both studies, however, fail to reveal this experience in detail, for example, failing to describe what participants mean by a lack of warmth and compassion. The review of the report by HLSC (2019), also highlights methodological issues in the use of focus groups in seeking to reveal lived experience, and the need to distinguish the views of patients from those of family and friends. The review also noted how the period between attendance at hospital and the collection of data is not recorded, raising questions of the accuracy of these accounts, compared to the lived experience at the time of attendance. The reports also fail to explore the experience of such patients on the hospital wards.

4.5 Academic papers: The lived experience of suicide

Reflecting on the papers located so far within the literature review, it was noted that the studies identified had predominantly focused on revealing the experience of acute hospital *care*. For example, how patients experienced staff interactions and waiting times. The purpose of this study was, however, seeking to reveal the whole of the lived experience of being in hospital following suicidal behaviour. It seemed important therefore, to seek to illuminate some of the other possible emotions that individuals may have following suicidal behaviour, and may therefore experience in hospital following an overdose. For example: What thoughts occur after an overdose? Accordingly, to connect with the lived experience of being suicidal itself, the focus of this part of the literature review was to explore the lived experience of suicide, first through academic papers, followed by autobiographical accounts. Importantly however, there is no intention to prioritise the academic papers by placing them first.

4.5.1 Search strategy

Full details of the search strategy employed for this literature search can be found within Appendix 1 (S.3); 10 studies meeting the criteria. Three of these studies explored people's experiences of being suicidal, regardless of psychosocial background. Seven studies explored sub-groups of people affected by suicidal thoughts, namely: veterans (Montross *et al.* 2014), people aged over 65/70 (Crocker *et al.* 2006 & van Wijngaarden *et al.* 2015), and men, broken down further to men affected by sexual abuse/violence (Sigurdardottir *et al.* 2012 & Tryggvadottir *et al.* 2019), men affected by substance abuse (Biong & Ravndal, 2007) and men affected by psychosis (Gajwani *et al.* 2017). All the studies that focused on a sub-group adopted a methodological approach that was broadly phenomenological in nature and employed interviews as a means of data collection. Pavulan's *et al*. (2012) study was unspecific in terms of recruitment, beyond the requirement that participants must have engaged in suicidal behaviour. Within this study, Pavulan's *et al*. (2012) also used interviews to collect data, followed by content analysis. Finally, two studies were more varied in their design: One inviting a written response to the question of 'why suicide?' from inpatients admitted to a mental health unit due to suicidal ideation or behaviour (Kraft *et al.* 2010); the second, analysing comments made on an on-line forum around suicide following a radio programme (Dodemaide & Crisp, 2013). The number of participants within the studies included in this section of the literature review, ranged from 4 to 52. Accordingly, a summary of the main themes identified is offered below, followed by a discussion of the limitations and research approaches employed.

4.5.2 The only means to be free from emotional pain and find peace

All the academic studies reviewed portrayed emotional pain to be at the very core of the lived experience of being suicidal. Suicide was described by many individuals as a way to end 'unbearable emotional pain' (Dodemaide & Crisp, 2013, p.312), a means to depart from 'inner suffering' (Tryggvadottir *et al.* 2019, p.6), 'a release from the living' (Biong & Ravndal 2007, p.252), a way 'to shut it off basically' (Gajwani *et al.* 2017, p.1122), an 'escape route' (Tryggvadottir *et al.* 2019, p.6), an action to end the agony that was 'affecting their entire life, of which there was no alleviation in sight' (Sigurdardottir *et al.* 2012, p.688). Suicide was therefore identified by many individuals as the means to be freed from pain, a way 'to sleep indefinitely'; the method to 'block things out … [to] switch off' (Crocker *et al.* 2006, p.644), 'a way to find peace' (Tryggvadottir *et. al.* 2019, p.6). For many of the participants within the studies reviewed, it was believed that the pain was only set to continue or intensify, the future being described as dark: 'I see nothing, I see nothing but blackness' (van Wijngaarden *et al.* 2015, p.261). Without suicide, the future was perceived to be one of further torture and distress: '"I was going down and down and down"' (Crocker *et al.* 2006, p.642). As noted by Pavulans *et al.* (2012), to remain alive would mean accepting the endless suffering of each day.

Notably, for those affected by suicidal thoughts, the objective of suicide was described not to be dead, but rather to be free of pain, as Biong and Ravndal (2010, p.251) note, suicide was 'a seeking [to] escape from a painful life more than a wish to die.' For this reason, suicide was often portrayed as something extremely attractive, almost irresistible: 'Now, you will take these [pills], like that, and then you will lie down on the bed and then you will disappear and then everything will be all right' (Pavulans *et al.* 2012, p.6). Death was therefore identified as the means to find much wanted peace: 'When a person feels like that, there is just certain stillness … there is such a romantic stillness in death' (Tryggvadottir *et al.* 2019, p.6). Indeed, it was due to this alluring desire to find peace and to be free from suffering that, as noted by Tryggvadottir *et al*. (2019, p.6), for some individuals suicidal thoughts became part of everyday life, '"just like drinking water"'. Furthermore, once the decision to end their life had been taken, this was also described as bringing with it a feeling of serenity (Montross *et al.* 2014), individuals knew that soon the pain would be over. Importantly, for those affected by suicidal thoughts, suicide was perceived to be the only option, there was 'no other solution' (Pavulans *et al.* 2012, p.5) to the unbearable present that they were living, suicide was 'the only way out of endless suffering' (Pavulans *et al.* 2012, p,6).

4.5.3 Isolation and loneliness

In describing the pain which the individuals were seeking to escape, the theme of isolation and loneliness was frequently highlighted. For example, van Wijngaarden *et al.* (2015, p.260) in their study of elderly people affected by suicidal thoughts, the authors note the description given to this pain by one individual: 'I feel like a sawed-off tree. Completely sawed-off. But a sawed-off tree still has roots. I have no roots anymore, no strong bonds anymore, and no close connection to life anymore.' Likewise, Tryggvadottir *et al.* (2019, p.7) notes how males who had experienced suicidal thoughts following sexual violence felt the need to keep their thoughts hidden, increasing this sense of isolation: 'We are men, we are not supposed to talk about this and we are not allowed to express ourselves about emotions – this is the cost of manhood.' For others, the fact that they had no one to share their feelings with, linked to the belief that people did not care about them, which further increased their motivation to take their life: 'I didn't think anybody would miss me. I thought no one will care, I'll end it all (Crocker *et al.* 2006, p.644). 'I love people but I'm just sitting here all alone' (van Wijngaarden *et al.* 2015, p.261).

4.5.4 Loved ones

Just as thoughts of isolation seemed to significantly be connected to the pain that individuals were seeking to escape through suicide, close connections to friends and family also seemed to be a reason to continue living. As noted by Pavulans *et al.* (2012, p.5): 'The most recurrent argument against committing suicide was that it would hurt one's significant others.' As one individual recounted: 'I think I was standing there for perhaps an hour when I decided not to give up, I did not want to, I did not want to leave my boy' (Tryggvadottir *et al.* 2019, p.6f). By contrast, love was also identified as a reason to end their life for some individuals, to free loved ones of the burden of their presence: 'The things that spoke for suicide were so many more, for instance … my family would be better off without me, since my influence on their lives was negative' (Pavulans *et al.* 2012, p.5). Likewise, Tryggvadottir *et al.* (2019, p.6) notes similar thoughts: 'I was so lousy and terrible, and it would be best for these people to just get rid of me.' Likewise, Crocker *et al.* (2006, p.644) notes how one elderly individual believed that he was just making 'extra work' for people.

4.5.5 A rational choice you can take

As a result, suicide was often experienced as a rational and logical choice. For example, van Wijngaarden *et al.* (2015, p.262) in his study of the experience of elderly people with suicidal thoughts, notes how the thoughts of the future and the belief that further suffering was inevitable, resulted in suicide being the logical choice to be made:

> Look at the condition of those old ladies in the building opposite. Gaunt and half dead, pointlessly driven around in a wheelchair, it is simply horrible … In my eyes, it has nothing to do with being human anymore. They don't even know it; they just go through the process and then suddenly the "black car" arrives again. It is a stage of life, I simply don't want.

Likewise, Pavulans *et al.* (2012, p.6) notes the comments of a 20-year-old woman: 'I've suffered for so many years. At some point you have to draw the line and say that "I don't have the energy to live for the sake of others, I want to live the way I want to". And that is not to live at all.' Suicide was often described as a considered response to a long-term situation: 'It's not like you have a problem on Monday and attempt suicide on Friday' (Pavulans *et al.* 2012, p.7).

Within many of the studies reviewed, suicide was therefore perceived as a means to retain, or take control of, a situation, a means of empowerment, an option which remained open, even during a time when the individual concerned had little other power or capacity to bring about change in their life. For example, Crocker *et al.* (2006, p.643) in their study of older people who had recently attempted suicide, recalls one such comment:

> I thought, well the doctor was giving me tablets for it, but they weren't doing nothing for it, it was there, the pain all the time. So, I thought if they won't do nothing then I will, and I just took all the tablets I had.

That choice is there: 'you can end it if you choose to' (Gajwani *et al.* 2017, p.1122).

4.5.6 A fear of death

Within the papers reviewed, one study mentioned, briefly, the notion of being fearful of death. Sigurdardottir *et al.* (2012, p.692f) recounting how the fear of death prevented a suicide: 'I had constant suicidal thoughts once, but I lacked the courage to pull the trigger, more than once and more than twice when I aimed at my head.'

4.5.7 Limitations

In seeking to reveal the lived experience of being suicidal, it should be noted that a number of these studies do contain several limitations in their pursuit of this goal. First, within many of the studies reviewed there was a significant period between the suicidal behaviour or feelings being experienced, and the interviews being conducted, for example up to ten years (Montross *et al.* 2014). Kraft's *et al.* (2010) study exploring written responses to the question 'why suicide?' was the only study that obtained all responses from participants within a relatively short time, within 48 hours of admission following suicidal ideation. It is possible, that the longer the period between the suicide attempt and the research being conducted, the more likely it is that the participant may share their *reflections* on the experience of being suicidal, rather than the actual lived experience as felt at the moment the phenomenon occurs. Perhaps causing them, therefore, to move away from the original 'unadulterated phenomena' (Nelms, p.2015, p.3).

A further possible limitation of the studies included within this review is perhaps the approach taken by the majority of studies (7 out of 10) to focus on particular sub-groups. Such an approach makes it difficult to distinguish between what thoughts and emotions are related to the experience of being suicidal, and what is the consequence of other significant and powerful factors related to that sub-group of individuals. For example, in Tryggvadottir's *et al.* (2019) study of men's suicidal thoughts following sexual violence, it is possible that the thoughts of isolation identified by the participants may relate principally to the experience of being a male victim of sexual violence, rather than being suicidal.

It should also be noted, that as the focus of this thesis is the experience of being in emergency acute care following suicidal behaviour in an NHS hospital, only two of the studies reviewed were undertaken within this country. Although studies included were from within Europe, the United States and Australia, even here the impact of culture on individual experiences should be considered. For example, van Wijngaarden's *et al.* (2015) study was conducted within the Netherlands, which, as acknowledged by the authors, has an open attitude towards self-directed death, as evidenced by the permitting of euthanasia under certain circumstances. Such cultural influences differ from those found within the UK, and could therefore impact on the lived experience.

In terms of data reliability, it should also be noted that Dodemaide's and Crisp's (2013) study based on comments taken from a public on-line forum may not be considered as robust as other studies identified within this review. Within Dodemaide's and Crisp's (2013) study it is impossible to authenticate if the comments posted on the public forum are from people who have actual lived experience of being suicidal. Likewise, as participants could see previous posts this may have also influenced and impacted the comments individuals wrote, perhaps encouraging people to concur with previous experiences, rather than using their own words and thoughts. Furthermore, as acknowledged by Dodemaide and Crisp (2013) themselves, limitations also arise within this study due to the on-line site being subjected to moderation. Participants were also restricted to the number of characters that they could post, thereby restricting their views. Additionally, there was no means of seeking clarification of comments made, limiting the richness of the accounts. This last limitation can also be found within the study conducted by Kraft *et al.* (2010), which sought to use a written response to the question 'Why suicide?' to reveal the lived experience. By contrast, the use of interviews, as employed by most of the studies reviewed, offers an enhanced opportunity for clarification and confirmation of the phenomenon being explored. Finally, it should also be acknowledged that the studies by Kraft *et al.* (2010) and Sigurdardottir *et al.* (2012) sought to combine, without distinction, the views of participants who had suicidal ideation and those who had engaged in suicidal behaviour.

4.5.8 Summary

In summary therefore, this aspect of the integrative literature review highlights how qualitative research that explores the phenomenon of suicide from the sufferer's perspective, is limited. The 10 studies that were identified suggest that, at the heart of the suicidal experience, is deep emotional pain that is perceived as unbearable and only set to increase in the future. Suicide, therefore, is perceived as the only method to escape this present and future agony; a means to be free from this, and forthcoming pain, a pain closely linked with feelings of isolation and loneliness. Suicide is, consequently, perceived as a logical, rational act for the individual concerned, given their present and future experience, a means to find a peace, that they would otherwise not have. Importantly, suicide is perceived as the only option, the only means to be out of pain, the only way to take control of the situation. Loved ones can become a reason to live, but also a reason to die. Fear of upsetting and hurting family and friends causing some individuals to struggle on, but also causing others to free their loved ones from the burden of their presence, through death, as they perceive it; suicide being an act of love for many.

Furthermore, this aspect of the literature review highlights the powerful impact of phenomenological studies, employing the use of interviews, in revealing the lived experience of suicidal behaviour; enabling the depth and emotion of that experience to be illuminated. This was particularly the case when compared to studies that employed on-line forums and written answers to questions as a means of data collection. Furthermore, in many of the studies reviewed, the length of time between the data collection and the suicidal behaviour occurring may also have caused aspects of the lived experience to be lost, as first perceived. These are issues that must therefore be considered further, in terms of the research approach and methods suitable for this thesis (see Chapter 5).

4.6 Autobiographical accounts: The lived experience of being suicidal

In seeking to reveal the experience of being suicidal, the final part of the literature review explores autobiographical accounts. This aspect of the review therefore offers further opportunity to connect with the written and spoken words of those who have lived or died through suicide; to encounter their raw unaltered voice. To, therefore, glimpse the experience leading up to, and following, suicidal behaviour and perhaps highlight aspects of how individuals in hospital may also feel following suicidal behaviour.

4.6.1 Search strategy

Identifying such material required searching beyond academic databases traditionally used within literature reviews. One rich source identified was the autobiography section of the local County Library in Preston, along with the town's Waterstones bookshop and the library of the University of Central Lancashire. Staff were asked for their advice and five autobiographies were identified which described the experience of being suicidal in some detail (Benjamin, 2018; Blauner, 2002; Haig, 2015; Styron, 1990; McGregor, 2018). Within the poetry section of the bookshop, a further source was identified that also shared the experience of being suicidal within this medium (Benjamin, 2012; 2014). The BBC iPlayer was also searched, and a powerful series of documentaries entitled 'Students on the Edge' was located (BBC iPlayer, 2018). Within this series, which recalls the life of students within higher education, episode six, entitled 'Breakdowns on Campus', documents the experience of students, who via a video recording on their mobile phone, share their suicidal thoughts. The recording is short, but perhaps of all the sources identified, offers the most powerful glimpse into an individual's feelings moments before deliberately seeking to end their life. Grashoff's (2007) work was also studied in detail, an anthology of forty-five anonymous suicide letters that witness to the final hours, and sometimes final moments, of peoples' lives who died by suicide. Importantly, they are reproduced by Grashoff (2007, p.9), as they were written: '… they themselves are doing the talking; and they are talking for the last time.'

4.6.2 Emotional pain

All the differing lived accounts reviewed connected the experience of being suicidal, with a deep, raw, emotional pain; a pain that the sufferer was seeking to escape. Indeed, many of the individuals used powerful images to seek to express this pain: a mind on fire (Benjamin, 2018), a hand placed on a hot stove burning (Haig, 2015), a feeling of drowning or suffocation (Styron, 1990), a sense of being imprisoned in a 'fiercely overheated room' (Styron, 1990, p.49). Other individuals used single words to seek to express the insufferable nature of their pain: 'Lost' (Grashoff, 2007), 'torture' (Blauner, 2002, Grashoff, 2007), 'broken' (BBC, iPlayer, 2018). It was a pain they desperately wanted to cease: 'I yearn for an end, an end to this torture' (Grashoff, 2007, p.84). Furthermore, the pain was often described as constant, omnipresent: 'One does not abandon, even briefly, one's bed of nails, but is attached to it wherever one is' (Styron, 1990, p.61). For many of the individuals, the presence of this pain also made time appear to pass slowly, each moment being agony, and exhausting: 'People say "take it one day at a time". But I used to think to myself, that is all right for them to say. Days were mountains' (Haigh, 2015, p.84). 'Pain lengthens time' (Haig, 2015, p.229), the human mind 'registering, minute by minute, varying degrees of its own suffering (Styron, 1990, p.58).

4.6.3 Hopelessness, suicide is the only option

Importantly, for the suicidal person, there was also the belief, or indeed absolute certainty, that the *only* way to escape this agony was 'oblivion' (Styron, 1990, p.50). Suicide was the solitary means to end their pain, the only way to be freed from the suffering: 'What I remember most is the overwhelming, desperate need to find peace and my conviction that the bridge was the only way out' (Benjamin, 2018, p.2). Suicide becomes 'the only water in a barren desert' (Blauner, 2002, p.10), 'I don't know any other way' (Grashoff, 2007, p.61). Life and existence were frequently described as hopeless: 'The pain is unrelenting, and what makes the condition intolerable is the foreknowledge that no remedy will come – not in a day, an hour, a month or a minute' (Styron, 1990, p.51). In fact, there was often the belief that the pain would only intensify into the future: 'I've just seen tomorrow. It's even worse' (Haigh, 2015, p.52). Indeed, it is this 'hopelessness even more than the pain, that crushes the soul' (Styron, 1990, p.61).

Many sufferers had looked for other ways, they had 'tried fighting but in the end just couldn't fight any more.' (McGregor, 2018, p.58). 'I have literally been there so many times about how bad I have been struggling and no one has done shit' (BBC iPlayer, 2018, 03:40). There was no other way out, no other exit (Haigh, 2015). Suicide was portrayed as the solitary means to take control of life's awful existence, albeit perhaps offering a somewhat 'twisted sense of control' (Blauner, 2002, p.42). Significantly, suicide was frequently portrayed as a choice that always remained, even if they were no other choices to be had (McGregor, 2018).

The opportunity to be freed from this agony through suicide was also repeatedly portrayed as deeply tempting, Haigh (2015) writing of how as he was standing on the edge of the cliff he thought, just one more step, one simple step forward and he would be free of pain. In one sense the answer was so 'preposterously easy – a single step – versus the pain of being alive' (Haigh, 2015, p.17). The opportunity was all around, the buckets of ice that would stop the burning so readily available (Haig, 2015). Within almost every situation was the means to be free, every busy road, bridge, chemist shop, was a way out, a way to be liberated from the pain. 'It's so tempting, it feels so alluring. Death' (Benjamin, 2018, p.109).

4.6.4 A rational choice not understood

The choice to end life was often therefore depicted as a deeply rational choice. 'Why would I stay alive? Wouldn't it be better to feel nothing than to feel such pain? Isn't zero worth more than minus one thousand?' (Haig, 2015, p.109). Suicide was the logical choice that must at some point be inevitably made: 'When the pain descended once more, or tomorrow after that – certainly on some not-too-distant tomorrow – I would be forced to judge that life was not worth living' (Styron, 1990, p.26). Indeed, Haig (2015, p.19) believed that if other people could sense the pain, they would understand the reasons why:

> Maybe if they were actually in my head for ten minutes they'd be like, 'oh okay, yes actually. You should jump. There is no way you should feel this amount of pain. Run and jump and close your eyes and just do it'.

Repeatedly, however, for the authors reviewed, other people did not seem to understand their pain and their struggle, and this simply served to intensify the agony and increased feelings of isolation. 'Professionals do not seem to be able to comprehend the nature and depth of the anguish their patients are undergoing' (Styron, 1990, p.68). Likewise, family and friends were often portrayed similarly:

> "Why do you keep doing this to yourself? … I don't see why you can't move on?" These statements were effective, yes, but only in

> reinforcing my experience of abandonment and despair (Blauner, 2002, p.18).

The sufferers spoke of how they felt their pain was dismissed, rejected, denied, resulting in feelings of loneliness and the belief that no one really cared.

4.6.5 Hidden pain through fear of judgement

Many of the writers also spoke of being ashamed of their pain, partly through stigma; fearful of how people would react if they shared their true selves (Benjamin, 2018). 'I've wanted to talk to you, but I didn't dare because I was afraid of what your answer would be' (Grashoff, 2007, p.123). Other authors wrote of not wanting to burden their loved ones with their feelings due to their love for them: 'At times I spoke to mum, but I always felt like I didn't want to burden her with everything' (McGregor, 2018, p.46). As a result, sufferers described how they were called to leave their feelings at the door and 'fix a smile in its place' (Benjamin, 2012, p.17). 'All my shame, guilt, and pain were safely hidden behind masks I wore for work, friends and family' (McGregor, 2018, p.52). Individuals faked happiness (McGregor, 2018), further compounding feelings of 'loneliness [that] would tear me apart' (McGregor 2018, p.68), 'an immense and aching solitude' (Styron, 1990, p.45). Benjamin (2018, 00:37) through a poem speaks passionately of a longing for the ability to be able to share the pain he felt and for people to acknowledge its presence:

> I wish I could tell you, I am longing to explain, because the day to day would be easier if I could share a little of this pain. It's not the words I am looking for, I have them all right here, it's the courage I need to say them which is buried deep within my fears. The fear of what you will think…

Some of the authors even spoke of how suicide would at least be a means for their pain to finally be acknowledged: 'If I hang from this tree, if I drown in this lake, then perhaps you will see …' (Benjamin, 2012, p.11); the final act of suicide therefore, perhaps witnessing to the truth and authenticity of their pain, their death a proclamation of their agony.

4.6.6 Freeing loved ones from their presence

For several writers, taking their own life was perceived as a means of freeing their loved ones from the pain that they themselves were causing, the 'real burden' (Grashoff, 2007, p.72) of their presence; suicide being an act of perceived love for family and friends. 'I don't want to cause you any more worries' (Grashoff, 2007, p.101), 'I've caused you enough unhappiness' (Grashoff, 2007, p.105).

4.6.7 Human contact and love

Despite such feelings of being a burden, many individuals within the accounts reviewed seem to long for human contact and love: 'What I really craved was relief, love, understanding and connection' (Blauner, 2002, p.42f). Likewise, Styron (1990, p.77) recalls the untiring and priceless support of a friend: 'I still look back on his concern with immense gratitude'; human qualities offered from human to human, being deeply valued. Elsewhere, Benjamin (2018, p.35) also writes of longing for simple human understanding and contact:

> I don't want to see another doctor, I can't bear to swallow another pill, I don't want to cut my arms anymore, I need someone to understand, somebody to tell me it will be ok. I need a friend to hold my hand.

For those authors who had strong loving families, that love seem to almost force them to continue their struggle, rather than to end their suffering through suicide: 'I couldn't inflict more pain on Mum, or Steve, on the people around me.' (McGregor, 2018, p.53). Love kept people alive:

> I had a mother and father and a sister and a girlfriend. That was four people right there who loved me. I wished liked mad, in that moment that I had no one at all. Not a single soul. Love was trapping me here (Haig, 2015, p.19).

'Somewhere through the thick fog of my despair, I remember thinking that I didn't want my family to feel guilty' (Benjamin, 2018, p.2).

4.6.8 A fear of death

For some authors, another factor that kept them alive was their fear of death, perhaps highlighting again that suicide was about the ending of emotional pain, rather than the desire for death itself: 'I didn't want to be dead, I just didn't want to be alive' (Haigh, 2015, p.11). 'I wish I could just fuck off for a *while* [my italics] and just, just not do it…' (BBC iPlayer, 2018, 04:43). This fear of death seemed to offer some of the authors a last-minute lifeline, an impulsive and reactive feeling of fear, causing them to step back from taking the final fatal action. For example, Blauner (2002, p.42) writes that after taking an overdose, the fear seemed to kick in and almost compel her to call for help: 'Upon facing death, I always ran back to life'. As noted by Haig (2015) however, although for him the fear of death remained the same, the pain of life increased and at times the fear of living became stronger than the fear of death. 'The best way to beat a monster is to find a scarier one' (Haig, 2015, p.141). Frequently, fear appeared to be a battle that must be overcome to die:

> The gas just keeps hissing! I feel as sick as anything. A roaring in my ears. I've felt the fear of death, but I know that I've got to

> overcome it. My skull is buzzing, I still can't hear anything. I'm really scared now. Or at least I imagine I am. And yet it has to be … (Grashoff, 2007, p.39).

4.6.9 Limitations

Except for Grashoff's (2007) anthology of suicide letters and the BBC iPlayer (2018) documentary *Students on the Edge*, it should be noted that one of the limitations of autobiographical accounts is that they record the experience of being suicidal after the phenomenon had occurred, frequently many years later. Accordingly, the account will inevitably consist of a recollection of this experience, which may differ from the experience as first perceived; the author's present, and their perception of the period following their suicidal behaviour, influencing their account.

4.6.10 Summary

In summary therefore, these very personal accounts of the experience of being suicidal highlight how suicide appears to relate to emotional pain. A raw, deep, and agonising emotional pain that people can see no other way of escaping from, apart from by ending their life. Amid such pain, suicide seems tempting and available, but also a logical and a rational choice. For some authors dying was incredibly terrifying, but the thought of having to continue living could also be felt as even more frightening. Furthermore, suicide seemed intrinsically bound up with relationships and the love of others. For some people, their death felt more valuable than their life, by contrast, for others, it was the love of their family, and the perceived negative impact their death would have on them, that caused them to continue to struggle to live. For many writers however, it was also out of love that they kept their feelings to themselves, love silencing their pain. Furthermore, many sufferers did not feel that their pain was understood or accepted; the fear of the criticism and the judgement of others frequently causing them to impose a smile on their face in the presence of others which increased the sense of loneliness and isolation for the individual. The authors appeared to crave and value human kindness and compassion, human qualities seemed to be treasured and remembered. Overall, however, for many of the individuals whose words form part of this review, suicide seemed a choice: A choice between 'a terrible end' or 'terror without end' (Grashoff, 2007, p.138).

4.7 Conclusion of the literature review

In summary, the literature review identified only five academic papers and two governmental reports that sought to explore, at least in part, the experience of individuals within emergency care following suicidal behaviour. Common experiences noted were the experience of shame, anxiety, vulnerability, exposure, poor standards of care, and negative judgment from staff. Indeed, CQC (2015) evidenced that the highest levels of negative care for individuals in crisis were reported in relation to A&E departments. Conversely, positive experiences were frequently associated with the experience of genuine kindness and positive relationships with staff. Individuals also valued staff keeping them informed about their care, offering them reassurance, and treating them the same as other patients. None of the papers or reports however, explored such experiences in depth, or distinguished between self-harming and suicidal behaviour, or captured the experience at the time the phenomena were occurring.

Wider research into the lived experience of being suicidal within academic papers, suicide letters, documentaries, and autobiographies, suggests that the experience of being suicidal is frequently associated with the following perceptions: A fear of judgement from others, escape from emotional pain, feelings of isolation and loneliness, thoughts of loved ones, a rational choice not understood, a fear of death, hopelessness, and a longing for human contact. Accordingly, it would be interesting to explore if such perceptions were present for individuals following suicidal behaviour within acute hospitals. In contrast, the studies identified above, in connection with acute hospitals, focus mainly on the experience of care, rather than the whole lived experience. Furthermore, none explored the experience of being on a hospital admission ward.

The literature review has also highlighted several methodological considerations. Many sources frequently failed to recognise the important distinction between self-harming and suicidal behaviour. Furthermore, the views of family and friends were often included within the papers and reports identified, without distinction. The use of on-line forums also raised questions of authenticity and offered little depth in terms of lived experience recorded, especially compared to the use of phenomenological interviews. Additionally, the period between data collection and the experience of suicidal behaviour was frequently unspecified or significant, therefore resulting in the possibility of individuals reflecting *on* their experience rather than *revealing* their perception of the phenomena at that time.

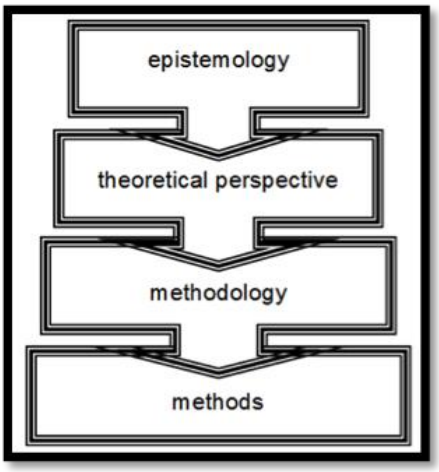
In conclusion, no study was identified within the literature review that sought to reveal in depth the whole of the experience of being in emergency care following suicidal behaviour within the NHS. This study seeks to uniquely achieve this, including to reveal the experience upon admission wards. Furthermore, unlike many of the studies included within this review, this study seeks to uphold the important distinction between self-harming and suicidal behaviour, recognising that they are connected but different forms of behaviour (see Chapter 2). The review has also highlighted how, to capture that experience as authentically perceived by individuals at that moment, such data should be collected as closely as possible to the experience itself, ideally while it is still being lived. This however triggers significant ethical considerations, which will be discussed (see Chapter 5.8).

Following the literature review, I also became mindful that many of the papers reviewed about the experience of acute care were negative; I reflected on this in my journal and the need to seek to ensure that this did not impede *my* listening within *my* research. Such concerns were enhanced due to my awareness that as a counsellor, as discussed in Chapter 11, I tend to focus on distress more than contentment and joy, when listening. I wanted to avoid this and believed the best way to do so, was to seek to be very aware of it. The autobiographical aspect of the literature review also helped me be more aware of the wholeness of the lived experience that I sought to capture within this research. I now felt a passion to reveal not just the experience of care, but as much as possible of the whole of the experience, a desire that certainly guided my choice of methodology, as discussed in the next section of the thesis, the research approach.

5. The Research approach

This chapter will discuss the research approach for this study and the rationale for the choices made.

5.1 Introduction



Crotty (1998, p.4) offers a clear and helpful framework to express the research approach in any given study, outlining four interconnected elements that inform each other, namely: epistemology, theoretical perspective, methodology and methods. Accordingly, each of these elements will be discussed in detail to facilitate an understanding and justification of the 'scaffolding' that underpins this study and upon which its stability depends (Crotty, 1998). Furthermore, within this section, I highlight how my own beliefs and values as a person have impacted on the research approach adopted, which, as noted by Creswell and Creswell (2018), should be made explicit in any such discussion.

5.2 'Epistemology – the theory of knowledge' (Crotty, 1998, p.3)

Epistemology is concerned with the theory of knowledge, how we know what we know; the researcher's epistemological approach guiding the entire research project, even determining what is initially considered to be legitimate research (Bazeley, 2013). One such prominent epistemological approach is objectivism, which argues that the 'truth' is out there, and our role as researchers is to discover that 'truth'. As Crotty (1998, p.8) notes: 'That tree in the forest is a tree, regardless of whether anyone is aware of its existence or not.' Here, the objective truth is waiting to be discovered, often through careful scientific measurement and observation by the researcher. The truth exists independently of our experience or consciousness; the truth and its meaning to be found within itself as an object (Crotty, 1998).

In many ways, the positivist approach reflects the hopes and the beliefs of the Enlightenment period which asserted that it was through the sciences that we can obtain the truth about the world. Indeed, positivism is intrinsically linked with empirical science which is seen by positivists as both accurate and certain (Crotty, 1998). It is through science that we can know what the truth is and discover that objective meaning which is waiting to be found. Such an understanding of knowledge has led to great discoveries, including in medicine. One of the criticisms of positivism however, as noted by Crotty (1998, p.29), is the exclusivity of its claims: 'Articulating scientific knowledge is one thing; claiming that scientific knowledge is utterly objective and that only scientific knowledge is valid, certainly is another.'

Within the current field of suicidology however, such boldness and strong adherence to positivism remains strong (Webb, 2010). For example, Maris (2019, p.42) in his work entitled *Suicidology. A Comprehensive Biopsychosocial,* states:

> We need to strive to have evidence-based psychiatry and suicidology … To be concerned with facts and systematic observation implies quantification, paying attention to numbers, data, counting, sampling, measurement, statistical analysis, appropriate methods and research design. … Any bona fide science attempts to be objective, universal, impartial, and cultural free ….

Such an approach, however, has deeply limited the breadth of suicidology. Indeed, most research on suicide has focused on what can be counted, measured, and quantified, resulting in limited understanding in terms of lived experience (Webb, 2010). Indeed, as noted by Hjelmeland (2016, p.32):

> We now have thousands of risk factor studies, yet we still understand very little about when, where, how (if at all), and for whom the found risk factors are related to suicide and why it is that the vast majority displaying one or more of them do not kill themselves.

One of the general criticisms of positivism, as stated by Crotty (1998, p.28), is that 'this scientific world is not, of course, the everyday world that people experience.' This is certainly true for the suicidal person, with their subjective world driving their suicidal behaviour. Therefore, as Webb (2010, p.25) argues, the scientific approach is 'fine for testing new drugs but is simply inappropriate for understanding the dark invisible interiors of the lived experience.'

The positivist approach to suicide research fails to recognise the complexity of the phenomenon of suicide. Ironically, this is perhaps best evidenced by the vast number of risk factors produced by 'scientific' research which has only achieved in capturing almost every living human being as a suicide risk (Webb, 2010). Indeed, as Hjelmeland (2016, p.40) notes, 'suicide is as complicated as life'; there is not one objective truth or meaning or indeed one model that can explain all forms of suicide. Any approach that therefore seeks to do this will inevitably fail. Suicidal behaviour is rather embedded in the individual's experience of the social, political, ethical, within their own personal story (White *et al.*

2016). Subsequently, there can never be one ‘truth’ in terms of suicide; instead, we must recognise that suicidal behaviour is a ‘complex problem that is always “on the move”’ (White *et al.* 2016, p.1) and therefore adopt a research approach that embraces this reality.

Constructivism, or social constructivism, seeks to do just that, recognising that an individual’s reality is constructed through their interactions with, and interpretations of, the world around them. In contrast to positivism, constructivism suggests that there is not one objective meaning, but rather that the meanings people ascribe to things will be dependent on a multitude of factors. For the constructive researcher, the aim is to discover the meaning for that person, often via listening, observation, and acceptance, rather than testing and examination. Such researchers also recognise that their own background will inevitably impact on their interpretations of any ‘data’, therefore ensuring that their own personal, cultural, and historical experiences are made explicit within any study (Creswell & Poth, 2018).

Driven by my original training as a counsellor, based on the person-centred approach by Carl Rogers (1961), in many ways my own epistemology also feels closely aligned to the constructivist worldview. Within my professional work, as I listen to patients, my role is to seek to enter respectfully into their world, to glimpse their pain and anguish, to help them express and explore the roots of that pain safely, and in time, perhaps move to understanding and even to acceptance. Within this approach (Rogers, 1961), there is no place for the ‘expert’ who diagnoses and prescribes a course of action based on a notion of objective truth. Rather, the patient is the expert on their pain, their fears, their anguish, their direction. This is their ‘truth’ which I seek to grasp. In many ways, this epistemology is also reflected in the choice of title for this study; the experience of the *patient* in acute care following an overdose.

To achieve the aims of this study therefore, a constructivist epistemological approach is taken. Such an approach will seek to honour the complexity of the suicidal experience and recognise that ultimately suicide is a deeply personal act, taken because of what that person believes and feels at that moment in time, even if other people believe differently. It is *their* meaning that causes them to seek to end *their* life, which has resulted in *them* attending an acute hospital.

5.3 'Theoretical Perspective, the philosophical stance' (Crotty 1998, p.3) – Phenomenology

5.3.1 Introduction

Crotty (1998) notes how a theoretical perspective closely 'intertwined' with social constructivism, is phenomenology. Phenomenology is primarily a philosophical approach that suggests that human experience is the fundamental source of knowledge, rather than that which can be empirically observed and tested (Holloway & Galvin, 2017). 'Only knowledge from immediate experiential evidence can be accepted' (van Manen, 2014, p.89). Furthermore, phenomenology seeks to express the lived experience of a given phenomenon as accurately and as authentically as possible, to convey its structure and its character as it appears in the person's consciousness, in that moment lived (van Manen, 2014). As Moran (2000, p.4) notes, phenomenology attempts 'to describe *phenomena*, in the broadest sense, as whatever appears in the manner in which it appears, that is as it manifests itself to consciousness, the experiencer.' Importantly, phenomenology seeks to make no judgement about what is real, or not real, but rather focuses on 'content of consciousness' (Stewart & Mickunas, 1990, p.4).

In seeking to answer the question of this thesis, this distinction seemed vital. For example, Webb (2010) notes how one of the main reasons why the individual lived experience has been almost erased from suicidal research, is because of the judgement made by many researchers that such individuals are 'mad' (Webb, 2010, p.170). Their views, because of their condition, are perceived as unreliable and lacking credibility (Webb, 2010). By contrast however, the title of this thesis dictates that what matters here is indeed the participant's truth, their lived experience. Accordingly, within the research approach adopted within this thesis, there must be no place for judgement or evaluation, but rather a seeking for that experience to be revealed as fully as possible.

Furthermore, as highlighted within the literature review of the lived accounts of being suicidal, suicidal behaviour is a deeply complex phenomenon that contains contradictions and ambiguities that fluctuate over time. Therefore, the research approach adopted for this study, must embrace, as phenomenology does, such individuality and diversity, to avoid the risk of simplification and generalisation. As Madjar & Walton (1999, p.7) notes, phenomenology seeks to 'honour the chaos of the narrative stories of confusion, futility, helplessness and lack of coherence', something other approaches such as grounded theory may fail to do.[1]

5.3.2 Husserl

Amongst phenomenologists, there is great diversity, including among two of the greatest thinkers, Husserl and his onetime pupil, Heidegger. Husserl was born in 1859 and as Polt (1999) notes, is arguably the most important continental philosopher of the twentieth century. Originally educated in mathematics, Husserl, influenced by the work of Brentano, came to be the intellectual founder of phenomenology (van Manen, 2014). Husserl believed that human experience was the starting point for all philosophy, defining phenomenology as the description of the pursuit of the essence of pure experiences. Phenomenology sought to capture everyday experiences in their 'primordial origin, or essence, without interpreting, explaining, or theorizing' (van Manen, 2014, p.89). For Husserl (1982), the only knowledge that was acceptable, or indeed trustworthy, was that derived from the evidence of immediate

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[1] Grounded theory was first developed by Glaser and Strauss (1967) and is a very systematic research approach to data collection and analysis which seeks to generate a theory grounded in data that can be applied to similar setting and contexts. In seeking to generate theory, diversity and rawness can however be lost (Holloway & Galvin 2017). Significantly, Grounded Theory also seeks to move beyond the reporting of participants' experience, to provide explanation, which is outside the focus of this thesis.

experiences in consciousness. Therefore, phenomenology does not seek to study the object of our experiences but rather the experiences of an object or event; indeed, anything that appears to a person's pre-reflective consciousness is suitable of phenomenological study. Husserl described this pre-reflective experience as the 'lifeworld', the original, naïve, 'natural' experience, free from prejudice and interpretation. Importantly, Husserl suggested that phenomenology enables us to capture the common, universal essence, or, the essential structures of human experiences, to define a phenomenon in a general sense. For Husserl (1982), essence came to be defined as those themes that, if they were absent from the given, the phenomenon would render incomplete. 'Essence asks for what something is, and without which it would no longer be what it is (van Manen, 1997a, p.xv).

Drawing on the idea of intentionality from Brentano (van Manen, 2014), for Husserl, all our thinking, feelings, and behaviour are inner perceptions of something, all having direction towards an object. When we are conscious, we are always conscious of something in the world. To understand the essence of any phenomena therefore, Husserl (1982) suggested a process called reduction; a process of narrowing our attention to the essential aspects of the phenomenon understudy. To achieve this, Husserl, drawing on his background as a mathematician, proposed a process of bracketing. Here our natural and preconceived thoughts and ideas are set aside to reveal the phenomena as it appears to consciousness, as it is originally experienced, even before it is given names or definition. 'To go from words and opinions back to the things themselves, to consult them in their self-givenness and to set aside all prejudices alien to them' (Husserl, 1983, p.35). As within the method of bracketing one part of a mathematical equation, Husserl suggested that we should not deny that which is bracketed, but rather place it outside the present process of questioning. We seek to suspend our current beliefs and understanding, an approach for which Husserl (1983) used the Greek term, *epohe.*

This approach, as discussed below, was later criticised by Heidegger (2010), along with Husserl's notion that it is possible to capture experience without reference to meaning and interpretation; without connection to the world within which the individual exists. Indeed, as highlighted by the accounts of the lived experience of being suicidal explored within the literature review of this thesis, meaning and interpretation, ascribed to perception, is indeed at the very heart of the suicidal experience. For example, the individual's interpretation of themselves in relation to their loved ones, impacts on suicidal perceptions (Chapter 4.6.7). Indeed, the very definition of the word 'suicide' discussed and employed within this study, has as a defining factor, the word 'intent' (Chapter 2). Meaning matters, and it is therefore to Heidegger we must now turn.

5.3.3 Heidegger

For Heidegger, phenomenology was the means to answer what he considered to be the most important primordial question, the meaning of Being; what it is to Be. Heidegger fundamentally disagreed with Husserl's focus on description within phenomenology, arguing that it is impossible to separate consciousness from the world of human existence. Heidegger argued that as Beings, we experience everything in relation to our Being in the world; not as a subject relating to an object, but as a Being that is inseparable from the world of Being (Rapport, 2005). Consequently, for Heidegger phenomenology is, by necessity, an ontological project rather than an epistemological one. 'As far as content goes, phenomenology is the science of being of beings-ontology' (Heidegger 2010, p.35/37). Heidegger was not concerned with the knowledge of any given phenomena, but rather the meaning of the phenomena; phenomenology therefore being hermeneutical in nature. Indeed, Heidegger (1962, p.297) went on to describe human beings as *Dasein* – being in the world:

‘Self and world belong together in the single entity of *Dasein*. Self and world are not two beings, like subject and object.’

For Heidegger, Being was also fundamentally interlinked with time, life always in a state of flux, nothing ever constant, including our descriptions of things. Furthermore, Heidegger argued that it was impossible to halt experience and describe it, as this would fail to do justice to the nature of being in the world.

> The problem is that epistemological forms of schematization confuse non primordial (conceptual objectifications) for primordial (non-conceptual meanings) dimensions of experiences as they are lived through’ (van Manen, 2014, p.105).

In seeking to fully grasp the experience of being in acute care following an overdose, this distinction between Husserl and Heidegger seems critical. By the term ‘experience’, this study is seeking to reveal what it *means* for that patient to be in acute care following an overdose. How does *that* patient *interpret* waiting within A&E, being in an acute hospital bed, coming close to death? For this study it is the meaning of that experience that I am seeking to be reveal. Furthermore, as highlighted by the literature review, suicidal experiences appear deeply complex and even contradictory; Heidegger embracing and emphasising such uniqueness and diversity within lived experience. Furthermore, Heidegger highlights how the power of the past and the perception of the future impacts on all lived experience; such perception as shown within the literature review impacting significantly on the suicidal experience. Individuals experience of seeking help in the past impacts their experience of the present and their perception of the future – hope (Chapter 4.6.3). Heidegger (2010) expresses this notion, through his writing on temporality, explored later in more detail in Chapter 8.1.5.

In seeking to grasp that individual meaning, Heidegger (1962) adapted a hermeneutical approach taken from his theological studies, to become known as the hermeneutical circle. Within this approach, the present experience is explored in depth, to grasp the fore structures within that experience that were perhaps implicit but can now therefore be made more explicit. This understanding, in return, gives increased insight into the present experience being explored: 'A remarkable relatedness backward or forward' (Heidegger, 1962, p.28). As Crotty (1998, p.92) notes, within this approach, 'understanding turns out to be a development of what is already understood, with the more developed understanding returning to illuminate and enlarge one's starting point.' The interpretive process is therefore, by its very nature, a process of moving back and forth in a circular motion, between the part and the whole, to go beyond the existing, to the preunderstanding, which in turn enlightens the existing in greater depth, which in turn increases our understanding of the whole. Indeed, Polt (1999) suggests that a more accurate description of Heidegger's hermeneutical approach would be a 'spiral' rather than a 'circle'.

Such an approach highlights again the explicit hermeneutical nature of Heidegger's work in contrast to the teachings of Husserl; Heidegger, seeking to understand the meaning, by going behind the text. As Wright (2013, p.82) summarises: 'The voiced experience needs to be heard, but it may need the researcher to expose the essence through interpretation.' In contrast to Husserl, for Heidegger, therefore, instead of seeking to suspend or bracket any preconceptions, our thoughts and ideas are instead made explicit and used to grasp more fully the meaning of the phenomena being studied. Furthermore, for Heidegger, any such attempt to suspend or bracket our preconceptions, as suggested by Husserl, is unattainable. Our involvement in the world, our being-in-the world, is not an optional add-on attitude that we may adopt or suspend at choice. As Heidegger (2010, p.57/57) writes: 'According to what we have said, being-in is not a "property" which Dasien sometimes has and sometimes does not have, *without* which it could *be* just as well as it could with it.'

In some respects, the hermeneutical circle also mirrors aspects of my own person-centred approach. Within my work as a counsellor, through the therapeutic relationship, I explore individual experiences or responses to events, which give insight and illumination to wider, more deep-seated feelings; fore structures being revealed through the exploration of the present. With patients, as within the hermeneutical circle, I often move back and forth, to discover other feelings, which in turn facilitates a greater understanding of the past, present and future. Furthermore, my role as a therapist within this process is an active one, as for the phenomenologist. I may at times sense feelings that are perhaps only at the very edge of that person's awareness, meanings and emotions that perhaps until named are not fully known or recognised by the individual. As Rogers (1961, p.53) notes:

> Can I sense it so accurately that I can catch not only the meanings of his experience which are obvious to him, but those meanings which are only implicit, which he sees only dimly or as confusion?

Such similarities between Heidegger's hermeneutical circle and the Person-Centred approach, inevitably impacted on my attraction to this aspect of his work, along with his recognition of the inseparable place of meaning within all perception. I wanted however to explore the writings of further phenomenologists, turning next to Gadamer.

5.3.4 Gadamer

Gadamer was deeply influenced by Heidegger, studying alongside him at one time. Gadamer sought to develop Heidegger's unfinished work on philosophical hermeneutics, which he came to express through his greatest text, *Truth and Method* (2004), seeking to uncover the nature of human understanding. Following on from Heidegger, Gadamer stressed that all understanding is historically and culturally situated. As Langdridge (2007, p.42) notes, for Gadamer: 'Understanding is not about producing a-historical and a-cultural truths about the world – the project of science - but rather something that is situated in a particular space and place, historically and culturally contingent.'

Furthermore, like Heidegger, Gadamer (2004) argued that it is through language that we gain such understanding of the world, and particularly through speech and conversation. Gadamer claimed that it is through the language of dialogue and shared understanding that the truths of history, society and culture are revealed, rather than through scientific observation (Langdridge, 2007). Indeed, he argued that regardless of rigorous method or rules, science can never be fully independent or objective, as it is based on the conduct of humans. 'There is no method to truth' (van Manen, 2014, p.133).

Accordingly, for Gadamer (2004), central to the endeavour of understanding is the recognition of the importance of self-awareness of our own situation, culturally and historically. For Gadamer (2004), understanding is both enabled, and limited, by our pre-judgements and horizons. It is however, through the fusion of such horizons, between participant and researcher, that understanding can be gained. For Gadamer (2004), it is through genuine conversation that understanding emerges, rather than being revealed by the speaker themselves. As Moran (2000, p.249) notes:

> The dialogical character of his philosophy is such that Gadamer always interprets the matters themselves as the events which occur 'between' people and their tradition – the common understandings which emerge in a dialogue and which go beyond the intentions of the speaker.

Accordingly, the removal of individual prejudice is not only impossible but also unnecessary.

Gadamer (2004) also noted that as the current horizon of both the participant and the researcher is always changing, the interpretation offered is importantly just one understanding at that moment in time (Dowling, 2011).

Such comments seemed to resonate with my study of the historical experience of being suicidal (Chapter 3) which showed that people's experience was closely connected to the culture and context of the time; Gadamer (2004) reminding us therefore, that this study will be an offering of my interpretation, of my encounters with the participants, at one moment in time, a moment that can never be replicated and is therefore unique. Likewise, Gadamer's notion of the fusion of horizons seemed to resonate with me; it was through encounters with the participants and through language that we would glimpse their world. The notion of the common understanding, emerging through dialogue, perhaps because of my Person-Centred approach however, felt uncomfortable. I wanted the focus, at least in terms of the data collection and the findings, to be as fully as possible within the participant's frame of reference. Accordingly, something of Husserl's aim of bracketing through self-awareness still seemed important, as I sought to reveal the lived experience as authentically as possible for the participants. I therefore continued my reading and in time, found the work of van Manen.

5.3.5 van Manen

Within the field of nursing and health care, many researchers have been drawn to the work of van Manen (Heinonen, 2015). Drawing on the work of Heidegger, for van Manen, phenomenology is an interpretive act, which seeks a deeper understanding of the meaning of that experience; to come into contact with that lifeworld as experienced by the individual. Whilst drawing extensively from Heidegger's work, including the notion of the hermeneutical circle, van Manen however is also influenced by Husserl's writing. Interestingly, van Manen (1997a, p.47) embraces Husserl's concept of reduction, suggesting that researchers should seek to be explicitly aware of their biases and hold their presuppositions 'deliberately at bay', to grasp the phenomenon as fully as possible as experienced; the aim of phenomenology being to connect with the lived experience rather than conceptualize or categorize it (Peoples, 2021). Likewise, van Manen also adopts ideas from Gadamer, for example, reinforcing how phenomenology is an active act, understanding occurring through the fusion of horizons and mediated via language. Furthermore, van Manen (2017, p.777), like Gadamer, is deeply sceptical of method, suggesting it is the most 'dangerous assumption of phenomenological research.' van Manen (1997b, p.346) suggests, as outlined below, that 'there is no single method, as there is no uncontested truth' but rather 'principles' to 'guide our injury'.

Along with drawing from the work of previous phenomenological thinkers, van Manen also brings new emphases, particularly in relation to writing. For van Manen (1997a), writing is an essential part of the process of phenomenology, an approach that requires creativity and time. van Manen argues that illumination of the lived experience occurs through writing, creating, or crafting not certainties or finality, but wonder. Indeed, such writing should cause the reader to reflect, to pause, to question preconceived ideas; it is through writing that we glimpse the significance of the experience in a fuller and deeper way of the other; an approach that, however, also reflects the ever-shifting nature of humans, as they move in the lifeworld (Peoples, 2021). Indeed, van Manen rejects clarity and certainty within phenomenology. Accordingly for van Manen, to construct a full interpretative description of a phenomenon, is an impossible task, an endeavour that is never completed, that 'lived life is always more complex than any exploration of meaning can reveal' (van Manen, 1997a, p.18). Rather phenomenology is a 'mindful wondering about the project of life, of living, of what it means to live a life' (van Manen, 1997a, p.12).

Just as Heidegger (2010) spoke of phenomenological reflection as following certain wood paths, towards a clearing, where something could be shown, revealed, or clarified, van Manen (1997a) also offers a pathway for phenomenologists. Importantly, van Manen does not prescribe directives, but an approach based around six interconnected research activities: guidance and direction for the journey ahead. Accordingly, to grasp this approach further, I now explore that pathway, highlighting to the reader why this path was adopted as the methodology for this study.

5.4 'Methodology: the strategy, plan of action, process or design' (Crotty, 1998, p.3)

5.4.1 Turning to the nature of the lived experience

For van Manen (1997a), at the heart of phenomenological research is the commitment to a particular lived experience and the willingness to be given over to the search for the description and meaning of that phenomenon. The research process is about a researcher embarking on a quest, at that moment, in that setting, to offer one possible interpretation of that lived experience through writing. The phenomenological question, van Manen argues, must be driven by a deep personal interest, the researcher living the question with their very being.

When reading van Manen's (1997a) work, this sense of personal passion for the research question deeply resonated with me. As outlined within the introduction of this thesis, my encounters with patients affected by suicidal behaviour through my work serve as a constant motivation to grasp and appreciate more. As van Manen suggests, within any phenomenological study, there must be a sense of determination and a giving of ourselves, we must even become the question, 'to interrogate something from the heart of our existence, from the centre of our being' (van Manen, 1997a, p.43). As van Manen reminds us however, that 'interrogation' must always be a referring back to the lived experience, not to the employment of existing theories of knowledge and pre-understanding. Such an approach therefore mirrors my own person-centred philosophy (Rogers, 1961); the patient is the expert and the authority which we must always return to.

For the researcher however, their interest and passion in the phenomena also presents a significant challenge. 'The problem of phenomenological inquiry is not always that we know too little about the phenomena we wish to investigate, but that we know too much' (van

Manen, 1997a, p.46). Due to my work supporting suicidal patients and teaching staff, I have read widely and attended many courses around suicide, and there is therefore a danger, perhaps even an inevitable consequence, that such pre-understandings, assumptions, and beliefs may prevent me from hearing the lived experience under study, as fully as possible. To address this problem, van Manen refers to Husserl's concept of bracketing discussed above, suggesting that simply trying to forget what we know is impossible, rather, we must seek to make our understanding explicit and be mindful of pre-conceived ideas, so that we may 'hold them deliberately at bay' (van Manen, 1997a, p.47). Throughout this study, and specifically within Chapter 11 of this thesis, I have sought to do this.

In connection with this challenge, I have also found the notion of 'bridling' helpful. Dahlberg and Dahlberg (2004, p.272) suggests that Husserl's concept of 'bracketing' 'carries with it the exactness and finitude of mathematics' which is impossible to achieve. In contrast, the notion of bridling, brings with it a sense of seeking to control or regulate these influences, while also being humble in the face of the ultimate impossibility of this challenge and the power of these influences. As humans we all have values and judgements, some of which are deeply hidden within ourselves, even within our unconsciousness. Self-awareness, reflective practice, and personal therapy can enable us to be mindful of these and to make them explicit, however we must never be arrogant and imagine that such influences can ever be fully known or controlled. As Cozolino (2004, p.xix) writes: 'The unconscious mind is like a wild lion. We can never overpower our unconscious, only learn about it and hope to gain its cooperation.'

5.4.2 Investigating the experience as we live it

For van Manen (1997a), the aim of the phenomenological methodology is to encounter the lived experience as fully and closely as possible, while recognising that ‘the meanings we bring to the surface from the depths of life’s oceans have already lost the natural quiver of their undisturbed existence’ (van Manen, 1997a, p.54). van Manen stresses that any study will fail to fully reflect the lived experience; no description or interpretation will ever be complete. For myself, this acknowledgement feels particularly important in relation to this study. As highlighted within the literature review, suicide is a deeply complex and personal experience, and any claims of being able to fully reveal that lived experience would be misplaced, overconfident and indeed disrespectful.

5.4.3 Reflecting on the essential themes

van Manen (1997a, p.77) suggests that phenomenological research requires a process of ‘reflectively appropriating, of clarifying, and of making explicit the structural meaning of the lived experience.’ van Manen writes that this may be achieved through thematic analysis, a means via which research and writing may be given control and order, offering a framework to convey the experience. Thematic analysis, according to van Manen, also encourages the researcher to ‘mine’ into the meaning of the accounts, offering an opportunity to read over the text and to wonder what is being expressed here; thematic analysis becoming like ‘knots in the web’ that make up the lived experience, or stars in the sky via which we can ‘navigate and explore’ the phenomenon (van Manen, 1997a, p.90).

van Manen’s (1997a) thematic analysis consists of three stages of reading, namely: 1. Holistic reading of the text, through which we locate the overall meaning of the text. 2. Selective reading, through which, after several readings, key statements or phrases are identified. 3. Detailed reading, whereby each sentence is studied, and the question asked, what is this saying about the experience? Through this process, common, recurring themes are identified which are then brought together, using phrases and statements to capture them in as much fullness as possible. It is an approach that requires an immersion in the words of the participant, to keep returning to transcripts, to ponder and reflect.

5.4.4 The art of writing and rewriting

For van Manen (1997a), phenomenology and writing are part of the same thing, to do phenomenology is to write; it is the methodology. Writing is a means through which, (according to van Manen), we can find the ability to see the lived experience more clearly, the means through which we reflect and explore the vehicle by which we may convey, in some inadequate manner, the lived experience of others. Writing, for van Manen is also by its nature hermeneutical, it is through writing that the researcher may grasp the meaning embodied in them. For the phenomenologist, writing takes time and effort and is often frustrating. As we write, we reflect, we read the words typed on the screen and ask, is that it, does that express and convey as fully as possible the meaning that the person was trying to articulate? Furthermore, writing affords us space to reflect, it provokes emotion and wonder and offers us the chance to grasp the aspects of that lived experience as fully as possible. ‘It is the writing that brings forth the meaning, the structures, and the understanding of the phenomenon’ (Nelms, 2015, p.10).

This process of writing and rewriting however, also brings with it the potential for the author, and therefore the reader, to move further away from the raw voice of the participants. Indeed, contrary to the aims of the phenomenological approach, the process of writing and revision can cause the research to become more an expression of the author and less a revealing of the experience of the participant. It is essential therefore, that at the heart of all phenomenological writing are the stories and the anecdotes from those who have lived that experience. These must be the bedrock that draws us into the experience. Indeed, as Munhall (2007, p.163) notes, phenomenology is 'the science of examples.'

As a person, I love writing and as a counsellor, it is through journal writing that I explore and reflect on my work and most importantly on myself as a person, through wrestling with the words, through the process of returning and re-rereading. Undoubtedly therefore, this is a further reason why I was drawn to van Manen's methodology.

5.4.5 Maintaining a strong and orientated relation

van Manen (1997a) sees the journey of the phenomenologist to be one full of temptation, especially in our modern world, to turn away from the philosophical foundations of phenomenology and to fall back on pre-conceived ideas and abstract theories, to seek generalisations and in doing so to abandon the gravity of the voice of the one who has lived that experience. To resist this temptation, phenomenological writing requires depth, because depth resists simple generalisation and understanding (Merleau-Ponty, 1999). Therefore, the phenomenologist must remain strong and focused on their task. For myself this is particularly a challenge, working in a health care system that fully embraces *standard* DSM Medical Diagnostic Codes (American Psychiatric Association, 2013) and Standard Operating Procedures, that homogenizes patients (Madjar & Walton, 1999). Phenomenology instead offers me the opportunity to meet the stranger in the familiar. Phenomenology seeks to honour the chaos of the patient experience, going beyond the labels and symbols to encounter an individual being. It is also a challenge that excites me, a calling to be almost prophetic; 'the voice of one crying out in the wilderness' (Mark 1.3). This methodology, also, perhaps offers me the means to fight against a deep fear I have of working within the NHS, that of losing contact with the individual human person who is before me.

5.4.6 Balancing the research context by considering parts and whole

Finally, within his phenomenological approach, van Manen (1997a) advocates both openness and flexibility, particularly at the start of the journey, as the project is planned. As discussed in the reflective section of this thesis, this research began in a very different place to where it ended, as I gained more understanding of phenomenology, through which I found confidence and courage. I moved from a sense of needing to offer explanation and evidence of an existing suicidal theory, to appreciating the power of phenomenology and the value in honouring chaos, particularly in the suicidal mind (see Chapter 11 Reflexivity).

Within his approach, van Manen (1997a) offers several ways in which to structure the writing of phenomenology, including thematically, analytically, exemplificative, existentially and exegetically. When writing the findings of the thesis a thematic review seemed the natural place to begin, as it enabled me to immerse myself within the transcripts and the experience of the participants. This was rightly a long process, but vital, as it enabled the participants to become more alive for me as persons, listening to the interviews and reading the transcripts numerous times. Following the exploration of the themes however, I also knew that there was more still to discover, and therefore explored the transcripts and themes with the aid of what van Manen (2014, p.324) termed 'insightful cultivators.' Insightful cultivators are found in the reading of related literature, particularly the work of other philosophers and phenomenologists that aid the reflective interpretative process, stimulating creative insight and understanding. As van Manen (2014, p.324f) notes: 'Insight cultivators allow us to see new possibilities as well as limits, or to transcend the limits of our interpretative sensibilities.' Importantly, however, 'we should not assume that we must uncritically accept or integrate those insights into our study' (van Manen 2014, p.324).

Accordingly, to support the exploration of the experience of the participants further, the work of two 'insightful cultivators' was employed within the study, namely, Heidegger's work on death and temporality, and aspects of Rogers' person-centred approach. The reason for the selection of these thinkers is outlined below (Chapter 8).

5.5 The relevance of phenomenological research in health care

A challenge for the phenomenologist working within the health sector is that in terms of policy makers, it has been argued that phenomenological research rarely results in a change of policy or practice. For example, McWilliam (2010, p.235) argues:

> It is extraordinary that phenomenological research survives in investigations of health, health care and health services delivery today. In a predominantly capitalistic world, health care and health services delivery have been increasingly commodified and objectified.

McWilliam (2010) suggests what matters within health care systems today, is the treatment of disease with a focus on treatments that produce proven objectified outcomes, that are cost effective and can be formulated into standardised guidelines.

Events like Mid-Stafford and the Francis enquiry (2013), which recounted the 'terrible and unnecessary suffering of hundreds of people' within an NHS hospital, have however, challenged this approach (Mid Staffordshire NHS Trust, 2013, p.1). Indeed, within the NHS, there has been a renewed focus on person-centred practice in health care (McCormack & McCance, 2016), with the experience of patients becoming central to current hospital inspection procedures. Events within the NHS around patient experience, have also evidenced how the power of patient stories and images can bring about change, perhaps in ways statistics fail to. For example, during the winter of 2017, Blackburn hospital made national headlines, with images of sick children sitting on the floor with their parents in A&E waiting for care. One national headline reading: 'Shocking photos reveal the true scale of Britain's A&E crisis – with mothers and children on floors and pensioners on trolleys being cared for by "corridor nurses"' (Borland & Norton, 2017, para.1). It was such stories that caused the then health secretary, Hunt, to declare that this was, 'completely unacceptable' (Triggle, 2017, para.1). What brought the government ministers onto the media and to the dispatch box, were not quantifiable statistics, but individual images and stories of lived experience. An example of the power of how encountering the lived experience of others, can ‘shake us into opening our eyes’ (van Manen, 2002, p.250).

5.6 Validity, rigour, and trustworthiness

Holloway and Galvin (2017, p.303) argue that: 'Health researchers must consider the "truth value" of their studies and demonstrate that it is credible and valid.' Such a requirement can present significant challenges for researchers employing qualitative methodologies, compared to quantitative studies which have widely agreed criteria for assessing validity (Silverman, 2011). Within qualitative research, there is no single definition of validity, or criteria for its assessment, and indeed some researchers argue that the very term 'validity' is inappropriate to use within qualitative research (Holloway & Galvin, 2017). Certainly, the simple transference of concepts such as reliability and generalisability from quantitative to qualitative methodologies, is both problematic and inappropriate due to their different epistemological foundations. As Dibley *et al.* (2020, p.150) comments, in hermeneutic phenomenological research:

> We are not trying to say, 'this experience means the same thing for all who endure/enjoy it'; instead, we are trying to say, 'this experience told to us in this way at this moment in time, appears to mean this for these participants, and we invite you into that understanding'.

Yardley (2000) argues that the failure of qualitative researchers to establish a clear set of criteria to assess rigour and trustworthiness within their approach, risks the potential of qualitative research being widely ignored within healthcare. Consequently, attempts have been made to develop such criteria, perhaps most noticeably by Lincoln and Guba (1985), and more recently by Yardley (2000). Lincoln and Guba (1985) based their suggestions around the notion of trustworthiness (credibility, dependability, confirmability, and transferability). Likewise, Yardley (2000) seeks to offer a 'flexible' way of assessing qualitative studies based on four broad areas, which are now briefly explored in relation to this thesis.

5.6.1 Sensitivity of context

The first of these areas, sensitivity of context, seeks to express the importance of context within a research study on several different levels. Yardley (2000) argues that the researcher must ensure and demonstrate that they have obtained and expressed an awareness and understanding of the context of the theory behind the research approach taken; the context of the methodology employed. Indeed, as noted by Leonard (1994), one of the main criticisms faced by researchers that purport to employ phenomenological methodology, is that the researchers fail to grasp the philosophical underpinnings of such an approach, leading to confusion. By contrast, Yardley (2000, p.220) suggests a clear understanding of the theoretical context of the methodological approach employed (as I have sought to outline in Chapter 5.3), provides 'the researcher with the scholastic tools to develop a more profound and far-reaching analysis.' Yardley (2000) also argues that as qualitative research recognises the importance of social-cultural influences, all qualitative studies must therefore locate the research within the social and cultural context within which it is conducted. As a result, therefore, within this thesis, the background to this study, including the historical and present context of the care of people affected by suicidal behaviour has been explored in Chapter 3. Furthermore, the context of the participants' experience of the emergency pathway is outlined in Appendix 4.

Within the area of context, Yardley (2000) also argues that within any qualitative study the researcher themselves must be visible, recognising their impact on the research. Accordingly, I have sought to achieve this within this study, not only through the reflexive chapter of the thesis (Chapter 11), but also by seeking to be present as a person throughout its writing, highlighting, for example, how my own beliefs and practices have impacted on the research choices taken.

5.6.2 Commitment, rigour, transparency, and coherence

For Yardley (2000), commitment concerns the demonstration of a clear focus and engagement with the topic studied over a significant period; the researcher immersing him/herself fully within the phenomenon. Importantly, however, Yardley (2000) suggests that this principle is not purely to be understood in terms of the data produced by the study, but more widely, as an engagement with the research topic, through the researcher's life; a living commitment to the subject and the issue being explored. Yardley (2000) also suggests that qualitative studies should be rigorous in terms of the use of a sample and method of analysis that is suitable for the approach adopted, thereby enabling the findings to transcend the superficial and obvious. Furthermore, choices made by the researcher in terms of approach, should be transparent and appropriate for the question being asked, findings being displayed in a clear manner, enabling the reader to fully grasp the whole research process, including the method and influences in data collection, and how conclusions were reached.

Through seeking to be present as the author within this thesis, it is hoped that my commitment and passion to this research is evident. Furthermore, the research approach and rationale for the choices made, have been explored in detail (Chapter 5.1-5.4).

5.6.3 Impact and importance

The final set of criteria offered by Yardley (2000), is perhaps the most controversial, namely, impact and importance. Yardley (2000) argues that the quality of qualitative research, particularly health research, can be assessed by its impact on beliefs and practices; the research contributing to changes in how people think and talk, resulting in creative ideas and new thoughts. Indeed, as Langdridge (2007, p.157) comments: ‘Having an impact on the wider world, in terms of an effect on people’s beliefs or behaviour, for Yardley, is the ultimate way of judging the value of any piece of research.’ Yardley (2000) acknowledges that such an effect may be delayed or indirect, but equally argues that research must have an impact. The inclusion of this criteria has however, been criticised as it supports the argument, often endorsed by funding bodies, particularly in health, that the only valid research is applied research, research that can have an impact (Langdridge, 2007). Such a stance, however, raises significant questions, particularly around the independent value of knowledge and who determines ‘impact’. Increasingly however, within academic institutions, part of the expectation of research students is to share their research widely to contribute to discussion and debate. Indeed, Finn (2005) notes how in some countries, such as the Netherlands, the publication of research papers is a formal requirement for the award of a PhD, recognising the importance of the impact of research. Likewise, Phillips & Pugh (2010, p.188) notes as part of the supervision and examination process, the following questions are often asked: ‘Will the work make a significant contribution to the discipline? Does it have policy implications?’ Accordingly, within Chapter 10, the implications of the research are discussed. Furthermore, within Appendix 10 details of how this research has been used to date, for example in training and teaching, are listed. Future plans are outlined in Appendix 11.

Before moving to our discussion on ethics and research methods, a brief comment is made in respect to Interpretative Phenomenological Analysis (Smith *et al*. 2009).

5.7 Interpretive Phenomenological Analysis

As Holloway and Galvin (2017) note, Interpretive Phenomenological Analysis (IPA) (Smith *et al*. 2009) has become very popular in health and nursing research, although the use of the term 'phenomenology' within its title has been debated (van Manen, 2017; Smith, 2018), Dibley *et al. (*2020, p.27) suggesting instead, that it 'stands as a methodology in its own right.' IPA is a very structured approach that is closely associated with psychology, with a focus on experience and the meaning that the experience has for participants. As Smith *et al*. (2009, p.1) note, 'IPA is a qualitative research approach committed to the examination of how people make sense of their major life experiences'. Within the approach, the participant is asked to recount the experience and then to interpret that experience. The researcher then interprets the participant's interpretation, 'the research trying to make sense of the participant trying to make sense of their world' (Smith & Osborn 2008, p.53). Indeed, Smith and Osborn (2008, p.53) refer to this approach as 'a two-stage interpretation process, or a double hermeneutic', the researcher's own conceptions being required to make sense of the other person's world.

Although there is not space within this thesis to debate the place of IPA within the philosophy of phenomenology, this methodology was rejected for several reasons for the purposes of this study. First: This study sought to purely reveal the experience of the participants as it was lived, rather than asking them to reflect and interpret that experience. Secondly: The study sought to reveal the whole of the experience rather than having a focus on mental processes, as IPA does (Smith *et al.* 2009). Thirdly, undoubtedly influenced by my own person-centred approach, I wanted the participants' lived experience to be the highest authority rather than my 'analytic interpretation' (Smith *et al*. 2009, p.4). I was therefore uncomfortable with an approach where the researcher was the expert who can 'make sense' of the participants' accounts. Indeed, van Manen (2017, p.778) argues, 'the IPA of Smith is really interpretative psychological analysis…’. Fourthly, the structured nature of IPA seemed inappropriate in seeking to reveal the lived experience of a phenomenon as diverse and ambiguous as suicidal behaviour, as highlighted in the literature review.

5.8 Ethics and research methods - 'the techniques or procedures used to gather and analyse data' (Crotty, 1998, p.3)

5.8.1 Thinking ethically

As noted above, within any research project, the practical methods used to collect and analyse 'data' are guided by the student's epistemology, theoretical perspective, and methodology, all governed by the research question itself. In relation to the collection of data and its use however, a further factor must also determine the methods employed by the student, particularly in relation to research that involves living participants, namely, ethics. Indeed, as Kara (2018, p.15) notes: 'Some researchers argue that ethics is method and method is ethics.' Furthermore, as Kara (2018) highlights, it could be argued that it is unethical to discuss research methods, without reference first to ethics.

5.8.2 The Helsinki Declaration

The Helsinki Declaration, issued by the World Medical Association and revised most recently in 2013, is now widely accepted as the international set of rules and principles that must govern all medical research methods involving human participants (Holm, 2018), including within the NHS (HRA, 2018). Within the declaration of Helsinki, four fundamental ethical principles can be identified: First, the interests of society or science can never be considered to outweigh the interests of the individual participants. Secondly, all participants must give voluntary and fully informed consent, unless unable to do so, and then consent must be given by proxy. Thirdly, all participants have an unconditional right to withdraw from research at any time during the study. Fourthly, before taking place, all research must be reviewed and assessed by an independent body. Such principles, therefore, guide the ethical discussions below. Importantly however, in relation to research involving vulnerable participants, the Declaration of Helsinki 2013 (World Medical Association, 2018) places added importance on enhanced ethical consideration in terms of research methods, stating that such participants require 'specifically considered protection'. The ethical issues of research involving those impacted by suicidal behaviour, are therefore considered first.

5.8.3 Participants affected by suicidal behaviour - A vulnerable group

Research that seeks to engage participants with lived experience of suicide, as within this study, clearly involves individuals who may be considered extremely vulnerable (Liamputtong, 2007). Such potential participants, as noted within the literature review, are likely to have experienced intense emotional pain and may also have been diagnosed with mental health conditions (Joiner, 2005). Indeed, as Mishara & Weisstub (2005) forcefully highlight, the risks inherited when undertaking research with participants affected by suicidal feelings could not be higher: 'In suicide research, life and death are potentially at stake.' Furthermore, a research approach that employs a phenomenological methodology, as proposed within this study, could be considered to place participants at particular risk. Phenomenology, by its very nature, seeks to provide the research participant with the opportunity to share very personal experience at depth. The sharing of such experience, however, brings with it the potential of the expressing and experiencing of intense emotions. Indeed, as Smythe (2011, p.39) notes: 'It is very common for tears to be part of the phenomenological interview.' It could be suggested therefore, that inviting vulnerable people to participate in phenomenological research, could place them at an enhanced risk and is therefore unethical. Such concerns are often referred to as the 'Pandora's box' phenomenon (Dickson-Swift *et al.* 2008, p.6). Consequently, as noted by Dazzi *et al.* (2014), gaining ethical approval for research around suicide, particularly qualitative research, is recognised as a major challenge for researchers, leading to fewer research studies being conducted within this area, compared to other, less common forms of death (Mishara & Weisstub, 2005). Before simply accepting such concerns however and avoiding phenomenological research with participants affected by suicide, it is important to consider if such fears are evidenced based. Does talking to individuals affected by suicidal behaviour enhance distress and increase suicidal thoughts?

5.8.4 Does talking to individuals affected by suicidal behaviour cause emotional distress and increase suicidal thoughts?

Evidence suggests that for some professionals, the very notion of any suicidal patient being asked about their feelings and thoughts is both dangerous and increases their risk of death by suicide (Mishara & Weisstub, 2005). This view is reflected by Bajaj *et al.* (2008) who evidenced that among 103 general practitioners in England, 36% believed that talking with patients about their feelings, even briefly, could increase suicidal thoughts and intent. Research by Lakeman and Fitzgerald (2009b, p.15) found that 65% of institutional review board members believed research within this area might be harmful to participants, as 'suicidality might be exacerbated or "reinforced" by bringing attention to suicidal thoughts and feelings, revisiting or bringing up distressing material…' Such an opinion, however, appears to be unsupported by current research, as evidenced by Dazzi *et al.* (2014). Dazzi *et al.* (2014) conducted a review of 13 research papers published between 2001 and 2003 which sought to assess if enquiring about suicidal thoughts enhanced suicidal feelings. Papers were reviewed that studied both adults and adolescent groups and included both general and 'at risk' populations. Dazzi *et al*. (2014, p.3361f) concluded that: 'None found a significant increase in suicidal ideation in participants because of being asked about their suicidal thoughts.' Furthermore, Dazzi *et al.* (2014, p.3362) noted that the papers reviewed indicated that talking about suicidal feelings may in fact 'reduce, rather than increase suicidal ideation, with a suggestion that repeat questioning may benefit long-term mental health.' Likewise, Harris & Goh (2016) conducted a double-blind randomized controlled trial to explore this question, seeking to assess if taking part in a suicide risk assessment, which involves talking about any self-harming thoughts, increased emotional distress for participants. The trial involved 259 participants who were known to have experiences ranging from 'no suicidal thoughts' to 'highly suicidal'. Again, the trial supported the 'null hypothesis that asking people suicide related questions would not lead to a significant increase in emotional distress' (Harris & Goh, 2016, p.7). Indeed, mirroring the findings of Dazzi *et al.* (2014), Harris's and Gosh's (2016, p.9) trial also stated that around 20% of participants reported positive reactions in taking part in suicide assessment and talking about their internal experiences, causing the researchers to conclude that: 'Overall, the present research supports previous studies that suicide research can benefit some participants.'

Furthermore, as Sieber and Stanley (1998) notes, avoiding research in an area that, as noted in Chapter 1.3, is a leading cause of death, could also be considered unethical. Likewise, Liamputtong (2007) argues that avoiding research around vulnerable people due to ethical concerns, perpetuates and enhances their vulnerability; their voices remaining unheard.

Despite such comments however, it is imperative that all ethical issues around the research methods are carefully considered and evaluated, as will now be done.

5.8.5 Data collection methods

In seeking to reveal the lived experience of acute care for individuals following an intentional overdose, a variety of forms of qualitative data collection methods were considered, including social media, focus groups and interviews. These methods are therefore reviewed to highlight the rationale for the final choice that was made and utilised as the data collection method for this study.

5.8.5.1 Social media

As noted by Bell and Waters (2018), social media is an immensely powerful tool for connecting with prospective participants and undertaking data collection. For example, researchers who engage platforms such as Facebook, have the potential to reach incredibly large numbers of young adults quickly, with '87% of online users aged 18-29 years being on Facebook' (Bell & Waters 2018, p.162). Consequently, such forums offer a huge opportunity to connect with participants within an age group that is considered at high risk of suicidal behaviour and therefore may have accessed acute emergency care for this reason. Indeed, as noted in the literature review (Chapter 4.3.4), Owens *et al.* (2016) employed an online discussion forum as a method to obtain data around self-harm and the experience of A&E care.

Employing social media as a method of data collection however, for this study into the lived experience of patients in acute care following an intentional overdose, presents several limitations. First, as highlighted by Beninger *et al.* (2014), evidence suggests that people frequently exaggerate their views when communicating on-line. Within a study that aims to reveal participants' lived experience, this is therefore problematic. Furthermore, Beninger *et al.* (2014) highlights how people often post inaccurate profiles on-line, researchers therefore finding it very difficult, even impossible, to evaluate if individuals taking part in the research meet the inclusion requirements for the study. For any data to be valid within this study, it is important that it is possible to confirm that the lived experience being explored, has been genuinely experienced by the participants. Additionally, while the use of social media as a means of data collection offers the potential to reach and recruit vast numbers of participants, for this study, employing a phenomenological methodology, such numbers offer no benefits. Phenomenology seeks to focus on revealing the individual depth of lived experience, often in a small number of participants, rather than pursuing quantity and generalisation. Furthermore, it could also be argued that such depth of sharing would be difficult to obtain from a social media post; such posts often being characterised by brevity and shorthand. Indeed, such a limitation was noted within Owens *et al.* (2016) study above (Chapter 4.3.4). Finally, as highlighted by Gadamer (Chapter 5.3.4), the richness of the lived experience is brought to light through the interaction between the participant and the researcher, through conversation and a sharing of the journey of exploration together. Such interaction, although perhaps possible, would be potentially problematic via social media posts. For these reasons, this method as a means of data collection was rejected.

5.8.5.2 Focus groups

Another form of data collection which has become increasingly popular, especially within health research, is the use of focus groups (Bell & Waters 2018). Focus groups seek to bring people together who have shared characteristics or a common experience, with the aim of seeking to enable them to interact with each other and discuss in detail the given area of focus for the study. Such interactions are considered to offer valuable data that is then analysed. Within a focus group, the interaction between the various participants is considered to play a crucial role. By the sharing of ideas on the given topic, by agreeing and disagreeing, participants are thought to be stimulated to share thoughts and experiences (Holloway & Galvin 2017). Furthermore, as Farquhar (1999, p.47) notes: 'Focus group research has shown that people may be more, rather than less, likely to self-disclose or share personal experiences in group rather than dyadic settings.'

When considering focus groups as a method of data collection for this study, despite such comments, as a researcher I had several ethical concerns. Bringing together a group of people who have lived experienced of acute care following suicidal behaviour felt perilous, particularly in relation to the interaction that could take place in a setting that is impossible to control. For example, participants may become distressed hearing about other people's lived experience. Furthermore, as Kitzinger (2005, p.63) notes: 'There is often an element of unpredictability to focus group research.' Despite any attempt to keep the interview focused on the experience of being in acute care, participants might also discuss other aspects of their suicidal experience; for example, suicidal methods used, something which could place other participants at increased risk (Joiner, 2005). Furthermore, within a focus group setting, it would be impossible to ensure anonymity for the participants. Additionally, while accepting Farquhar's (1999) comments that the interaction within a focus group can 'encourage' or 'support' people to share their views in a way that they may not do within another setting, this feels uncomfortable, even unethical to me. Finally, within the context of a phenomenological methodology, which does not seek consensus or generalisation but rather the individual lived experience regardless of difference, focus groups as a method, feels incompatible. As highlighted by Holloway and Galvin (2017), focus groups can produce the views of the most dominant person/s in that group, with other members feeling inhibited in speaking out or disagreeing. In contrast, 'a phenomenological approach requires that an individual describes their experiences in a relatively 'uncontaminated way' (Webb & Kevern 2001, p.800). Accordingly, focus groups were discounted as a data collection method for this research project.

5.8.5.3 Interviews

The final form of data collection method considered in detail, was individual interviews. This method is widely used within phenomenological research and is the most common form of data collection within health research (Holloway & Galvin, 2017) and published qualitative research (Silverman, 2011). van Manen (1997a, p.66) suggests that the interview within a phenomenological study has two very specific purposes: First, it is a means for 'exploring and gathering experiential narrative material that may serve as a resource for developing a richer and deeper understanding of a human phenomenon.' Although conversational in style, the phenomenological interview is therefore by its very nature disciplined; throughout the interview process, a clear focus constantly remains on the phenomena under exploration. The question of the study always orientates the interview. Within these boundaries however, the interviewer remains fully open to what the participant is expressing, always curious about what is being said, along with what is not being said. The aim of the research interview is to stay as close to the lived experience, enabling the participant to share that experience in as much detail as possible, including via examples and anecdotes, which have the potential to offer further rich insight. Furthermore, participants are asked to share specific instances, events or encounters, as Brinkmann & Kvale (2015, p.33) note: 'Descriptions of specific situations and actions are elicited, not general opinions.'

Along with the gathering of experiential material, according to van Manen (1997a), the second purpose of the phenomenological interview is to reveal, through conversation between the two parties, the meaning of that experience. Within this approach, 'the interviewee becomes a co-investigator of the study' (van Manen, 1997a, p.99). Both the interviewer and the interviewee reflect on the experiences shared by the participant, 'to determine the deeper meanings or themes' (van Manen, 1997a, p.99). For van Manen, interpretation, therefore, comes through conversation. Above all however, the phenomenological interview seeks to enable a 'listening gaze' (van Manen, 1999, p.v), a 'space to translate knowing into telling' (Rapport, 2005, p.134).

One of the main limitations of phenomenological interviews, however, is the dependency on the participant being willing and able to describe the phenomenon in depth. As Holloway and Galvin (2017, p.99) notes:

> The people in the research are sometimes less articulate than the researcher assumes; it may be hard to bring to words the depth of the experience; they may be in an environment not conducive to interviewing, or they might not be able to concentrate.

Such situations may be mitigated against by careful consideration of the interview setting, the wellbeing of the participants, consideration of how the interview is conducted and the relationship between the two parties. Such factors are therefore considered below. Despite such efforts however, there is always a risk with interviews that sufficient 'data' of depth may not be revealed, a risk the researcher must accept, being prepared to conduct further interviews if required.

Brinkmann and Kvale (2015) offers further discussion of the limitations of interviewers more generally, as a means of data collection. For example, Brinkmann and Kvale (2015, p.332) note that as a method interviews may be criticised as:

> It focuses on the individual … it takes everything an interviewee says at face value, without maintaining a critical attitude …. It focuses on thoughts and experiences at the expense of action … Its published reports are boring collections of interview quotes …

Within a phenomenological study however, it *is* the individual's lived experience that is being revealed, rather than any details of what has 'happened', with their 'truth', being glimpsed. Furthermore, as has been noted above, rather than producing research that are ‘boring collections of interview quotes’, phenomenology, through its writing, seeks to produce research that causes people to wonder (van Manen, 2002). Indeed, within the literature review it was noted how those studies that employed phenomenological interviewing, revealed the greatest depth of the lived experience of being suicidal. Accordingly, for these reasons therefore, this data collection method was chosen for this study.

5.8.6 Sample size

In seeking to determine the number of participants interviewed within a phenomenological study, Coyle (2014, p.119) notes how such a decision should be ‘guided by the number to appropriately illuminate the experience.’ Equally, it is vital that the researcher must be able to ‘seek to honour each participant by working intensively with their data’ (Smythe, 2011, p.41). Indeed, too many interviews may cause the researcher to fail to truly analyse and wrestle with each phrase, sentence, and word, failing to grasp the depth of the lived experience. Accordingly, as noted by Creswell and Poth (2018), the number of participants within some phenomenological studies can be very small, even as low as one. The use of such low numbers of participants however, risks that not enough rich data will be available. Furthermore, material from a very small number of participants may also increase the likelihood that, within the study, participants may be identifiable. Indeed, such ethical concerns are particularly important when conducting research into a sensitive topic, such as suicidal behaviour. Overall, Smythe (2011) suggests that for a doctoral study, 12 to 20 participants should be considered. Accordingly, 16 interviews were completed for this study.

5.8.7 Sampling method

The focus of this study required purposive sampling to be adopted as a method, 'selecting interviewees who are likely to generate appropriate and useful data' (Green & Thorogood, 2014, p.121). To be invited to participate in this study, participants must have been admitted to the hospital following an intentional overdose with any suicidal intent. All individuals meeting this inclusion criteria, during the recruitment period, therefore had equal chance of being invited to participate. Despite no distinction being made as to the substance used within the overdose in terms of recruitment, by chance, all the participants included within this study had taken an overdose with paracetamol.

5.8.8 Recruitment of participants

My position as a chaplain and counsellor in a large acute hospital offered a considerable advantage in gaining access to potential participants. Perhaps the most obvious recruitment method was to invite past patients to participate. For example, this could be achieved by offering invitations by phone, letter, or email, following discharge, asking interested potential participants to contact myself. Indeed, as noted in the literature review, such an approach was adopted by Hughes *et al.* (2005) (Chapter 4.3.3). As discussed above however, the response rate for this study was low, with only 10% of patients contacted agreeing to take part and only half of these (5%) attending the arranged interviews. Such low response rates, while not perhaps an issue within a methodological approach that does not seek to be representative, may present problems in terms of providing enough rich data. My major concern with this method of recruitment, however, was ethical. Inviting patients to offer themselves for interview following discharge, meant that it would be difficult to confirm, with a suitably qualified professional, that such participants, at that moment in time, were emotionally stable enough to participate. Simply because an individual is not in hospital, does not mean that they are suitable to participate safely in research. Furthermore, in terms of phenomenological interviews, as Galvin and Holloway (2015, p.218) notes: 'The richness of the account is often better when it is closer to the experience in time.' As highlighted within the literature review, the further the time between the experience being explored taking place and the interview being conducted, the greater removed the participants' accounts may potentially become from that first experienced (Galvin & Holloway, 2015).

Accordingly, the decision was made to recruit and interview participants while in-patients, to share their experience in acute care as they lived it. This approach had clear ethical benefits. First, it would be possible in every case, to gain the approval of professional staff as to the suitability of inviting any potential participant to take part. Furthermore, following the interviews, along with offering advice as to where to find further support and help, all participants would have direct access to professional staff, who would also continue to monitor their wellbeing.

5.8.9 Informed consent.

As noted in Chapter 5.8.2, one of the four fundamental ethical principles within the declaration of Helsinki, is informed consent. Accordingly, all potential participants were given an information sheet which had been evaluated by members of the public, informing them about the study (see Appendix 3) and given time to consider this. Furthermore, inclusion criteria ensured that participants also had capacity to make an informed choice (Dickson-Swift *et al.* 2008), their mental capacity having been assessed. In accordance with the declaration of Helsinki, participants were also informed that they may withdraw consent at any time and that their data may be removed from the study, within 7 days of the interview taking place (see Appendix 3).

5.8.10 Clinical site and potential impact

As part of Health Research Authority ethical approval, researchers must provide adequate information to ensure that the participating organisation has both the capacity and capability to safely undertake the proposed study within the intended site. This was granted (see Appendix 2.4).

5.8.11 Length of interviews

As part of the clinical site approval, it was noted that the data collection for this research must not impact on the delivery of clinical care. Furthermore, because of the vulnerability of the participants, many still receiving medical treatment, it was recognised that long interviews would not be appropriate. As Holloway and Galvin (2017, p.95f), note:

> Because of the reflective character of interviews, the participants may become tired as they recount their experiences and describe and illustrate with examples; hence researchers may not be able to continue the interview for long.

Accordingly, a focused approach to interviewing was adopted, with the aim of keeping the focus of conversation on the participants' experience in acute care, while also importantly, allowing interviewees space and time to reflect and explore this phenomenon as fully as possible. As a result, the length of the 16 interviews conducted ranged in time from 15 minutes to 51 minutes (see data table in Appendix 5). As Brinkmann and Kvale (2015, p.190) notes: 'If one knows what to ask for, why one is asking, and how to ask, one can conduct short interviews that are rich in meaning.' It could be argued however, that conducting the interviews within a time pressured medical environment, may be a limitation of this study.

5.8.12 Location of interviews

As noted by Green and Thorogood (2014, p.114), the location of the interviews can impact on the nature of the data generated: 'The same person may stress different aspects of their identity in an out-patient clinic, a private room in their home, or in their workplace.' Green and Thorogood (2014) argue therefore, that the most preferable location for interviews is a private comfortable space, free from distractions. Following this advice, the desired location for the interviews were the quiet rooms on the hospital Admission Ward. This was outlined in the participants' information sheet (see Appendix 3). It was also stated however, that if the individual preferred, the interview could be conducted at their bedside. Interestingly, of the 16 interviews conducted, only 3 participants accepted the offer of the interview being conducted in the ward's quiet room. 6 interviews were conducted at the patient's bedside, in a private side room. 7 interviews were conducted at the bedside of participants situated on four bedded bays. Although this may be considered as impacting on the data, as individuals may be less likely to speak openly within a setting that was not private, it is important to respect the wishes of the participants. Furthermore, it is vital that the interviews were conducted in a location of their choice, where the participants were comfortable.

5.8.13 Recording

As Green and Thorogood (2014) note, the most reliable means of capturing the data shared within an interview is via audio recording. This method also enables the interviewer to focus on the participant, maintaining eye contact, actively listening to what is being said and asking supplementary questions where further clarification or deeper understanding is possible. Furthermore, the use of an audio recording device also frees the researcher to make notes of any emotions and actions that are expressed by the participants. Such notes can play a vital role in bringing to light lived experience. It was also an ethical requirement of the HRA ethical committee however, that participants were given a clear alternative to the method of recording, in the form of note taking. In accordance with this requirement, this alternative was explained on the participant information sheet and the choice given on the participant consent form (see Appendix 3). Of the 16 interviews completed, 6 participants agreed to have the interview recorded and 10 participants requested notes to be taken. In seeking to capture the interviewees' lived experience as fully as possible, it could be argued that the use of note taking within this study, rather than audio recording, is a limitation. Despite such comments however, as Holloway and Galvin (2017, p.96) note: 'The principle of respect for autonomy includes choice and free decision and must be considered first in terms of consent.' Furthermore, as Bell and Waters (2018, p.216): 'Audio … recording can sometimes inhibit honest responses.' Likewise, Oliver (2010, p.47) notes, with reference to research around sensitive matters, participants may be 'extremely nervous' about having the interview recorded.

5.8.14 Interview questions

Due to the conversational style of the phenomenological interview, van Manen (1997a) suggests it is impossible to have ready-made questions that are strictly adhered to within this process, but rather the interviewer should have comments or questions to guide and facilitate the exploration of the lived experience under study. 'The interviewer leads the subject towards certain themes but not to specific opinions about these themes' (Brinkmann & Kvale, 2015, p.34). Accordingly, the participants were asked to comment on the following areas, with responses explored:

1. What was your experience in the Accident and Emergency department?
2. What was/is your experience in the Assessment Ward?
3. What was/is your experience of the staff?
4. What was/is your experience of the physical environment?
5. What was/is your experience of the physical/medical care?

5.8.15 Confidentiality, anonymity, data storage and use

Within this study, potential participants were informed via the participant information sheet that confidentiality would be maintained, except in certain circumstances due to safeguarding reasons (see Appendix 3). Details were also outlined within the participant information sheet, about how anonymized data would be stored, protected, and used (Appendix 3). All participants within the study were given a pseudonym. This was selected at random from a list of top twenty names based on the gender of the participants as determined first, by the gender of the hospital bay in which they were situated, or in the case of side rooms, by the gender of their actual name.

5.8.16 Transcribing

As Cope (2014, p.322) notes: 'Transcribing interviews gives the researcher the opportunity to become immersed in the richness of the data.' Accordingly, the decision was made to transcribe verbatim all audio files myself, rather than using transcription software. Likewise, where interviews were not recorded, notes were typed up immediately after the interview had been completed, to seek to record it as accurately as possible. To aid these processes further, Silverman's (2011) transcription symbols were employed to capture any nuances, intonations, silences, emotions, actions, or other aspects of the interview that may convey information or meaning that would otherwise not be recorded within the transcript (see Appendix 6).

5.8.17 Computer-Assisted Qualitative Data Analysis Software

Computer Assisted Qualitative Data Analysis Software (CAQDAS) was used in the form of NVivo; NVivo being chosen as the university provided a licence for this software along with extensive training which was attended. Therefore, within NVivo, transcripts were uploaded and coded, reflected notes were stored within the memo section, mind maps were produced of emerging themes and data charts were produced to record information, such as location and length of interviews. As Banner and Albarrran (2009, p.27) notes: 'CAQDAS affords the researcher the opportunity to organize, manage and store data effectively while supporting a rigorous research process.'

5.8.18 Analysis

As outlined within Chapter 5.4.3 of the thesis, a thematic analysis of the interviews was conducted based on van Manen's (1997a) three stage approach of holistic, selective, and detailed reading, with the aim of conveying the participants' lived experience. As suggested by van Manen, this process was undertaken over a long period of time, to promote opportunity for reflection, questioning and wonder. Themes and headings were wrestled with, through a process of constantly returning to the transcripts, with the aim of expressing the participant's lived experience as authentically as possible. The transcripts were also studied in conjunction with the field notes made during the interview process.

5.8.19 Patient and public involvement

As noted by Gray-Burrows *et al.* (2018, p.858) Patient and Public Involvement (PPI) in research 'prioritisation, design, conduct and dissemination' is widely recognised as best ethical practice. Involving members of the public and patients in the research process seeks to produce higher quality research by drawing on their experience and understanding in its planning, delivery, and use (Gray-Burrows *et al*. 2018). Therefore, in connection with this study, five adults who had previously been affected by suicidal thoughts and had received treatment at another hospital, were contacted via a local charity to advise on the value of the study, the 'participant information sheet' and the 'consent form'. Following this PPI exercise, two additions were made to the information sheet. First, information was added in connection with why patients affected by suicidal behaviour were being asked to participate. Secondly, a sentence was included to state that any comments made would not impact negatively on participant's care. All members of the PPI group recognised the value and the importance of this research.

5.8.20 Approval of the study

As noted above (Chapter 5.8.2), the Helsinki Declaration states that research involving human participants must be reviewed and assessed by an independent body. In accordance with this requirement, favourable ethical approval was received from the following bodies (see Appendix 2):

- The University of Central Lancashire ethics committee, 17th April 2019 (STEMH 1002).
- Research Ethics Committee (REC), London Surrey Borders, 21st May 2019. REC reference: 19/LO/0844, IRAS project ID: 257193.
- Health Research Authority 24 May 2019, REC reference: 19/LO/0844, IRAS project ID: 257193.
- Confirmation of capacity and capability to deliver the study within the chosen NHS Trust, 31st May 2019.

5.9 Summary

In summary, based on the title of this thesis, this study has adopted a constructivist epistemology, based within the theoretical perspective of phenomenology, the methodological approach of van Manen being employed. The research method of interviewing was adopted, with 16 participants being interviewed while inpatients in acute care following an intentional overdose. Full ethical approval from the HRA was received for this study. Further details of the participants' medical pathway and a summary of the interviews in table form is in Appendix 4 and 5.

6. Findings

6.1 Introduction

Within this chapter, the principal findings of the interviews for each participant are now summarised. These are explored in further detail, within Chapter 7 of the thesis, 'the emerging themes', before moving to analysis and discussion. It is hoped that this section will also enable the participants to be more than simply names for the reader, serving to remind us that they are/were beings in the world. As Munhall (2007, p.148) notes, phenomenology recognises that there is always 'a situated context and it is embedded in time, space, embodiment and relationships.'

6.2 Alex

Alex indicated that she had attended the hospital on multiple occasions due to suicidal behaviour. She was familiar with the ward where she was now a patient, the ward staff knew her well. During the interview she described how she had suffered with 'low mood' for many years, which resulted in her living with intense feelings of 'anger and pain.' During the interview she explained how she was angry about coming into A&E. Indeed, her anger was also evident through the tone of her voice and her body language during the interview. Alex said she was angry that she had 'failed' to end her life 'again', and she was angry with the staff in A&E who had given her the medication to 'keep me alive'. She also described however, a 'sudden fear' that had caused her to call for help after taking the overdose; she expressed this as a weakness. Indeed, when asked further about this 'sudden fear', Alex said she did not want to talk about it, as it is 'horrible', saying it had been 'very frightening'. Instead, Alex spoke about needing to be stronger to overcome this fear to end her life. Indeed, she described with real determination that she could not keep coming back here. She had to end her life.

Paradoxically, during the interview, Alex also spoke of wanting to be safe and wanting help from the Mental Health Team to be 'well'. Indeed, she pleaded, 'I will accept any help, anything.' Alex said she had been referred to various mental health services over the 'years'. They had made 'promises', but all that happens is that she gets passed from 'pillar to post'. 'No one wanted me'. The past had taught her that it would be the same this time. Alex described how she would not be getting any help from the Mental Health Team when they came to see her. Indeed, she described their forthcoming visit as 'pointless.' She knew what would happen, they would come and just say, 'safe for discharge'. That would be it, 'back to square one'. Once again, Alex said she would just be sent back to that 'dangerous place' and then she must start again, trying to find that strength to end her life. She stated that suicide was the only way, but the ‘problem’ was that she feared death.

Alex described how she deeply valued the safety offered by the presence of the hospital staff. She valued that they checked on her and looked after her. For example, she spoke about some of the staff by name and how they were ‘kind’ to her and kept her ‘safe’. Alex also mentioned her family and friends and how it frightened her that she might ‘leave them.’ For her, there seemed a real contrast between wanting to find the strength to end her life, therefore breaking the cycle of admissions and discharges to the hospital, and a longing for help and support so she could be safe and well.

6.3 Charlotte

Charlotte described how she suffered with ‘crippling anxiety’. This resulted in panic attacks meaning that she rarely left the perceived safety of her own home to go outside. She was on medication for her anxiety and attended her local GP regularly, although found that despite her medication she still felt very unsafe ‘outside’. Prior to the current admission, Charlotte had tried to end her life before, for which she had attended A&E and been admitted to the same Admission Ward.

During the interview Charlotte could recall little of her arrival in hospital, via ambulance, following her overdose. The only recollection of A&E she had, was that it was noisy and busy, and contrasted this with the environment of the Admission Ward, where she was transferred to. The Admission Ward was experienced as a safe place, where she was looked after and was able to escape from the pressures outside, describing it as a ‘nice break’.

Charlotte described the hospital staff as ‘lovely’, ‘friendly’, ‘very helpful’, and when this was explored further Charlotte said the staff made her feel ‘looked after’ and ‘like I am worthy’. Indeed, during the interview Charlotte became very tearful when describing how the hospital staff made her feel ‘safe’ and ‘special’. Furthermore, Charlotte seemed genuinely surprised at the ‘kindness’ that she received from the staff. Simple acts like the staff making her a hot drink or remembering her name seemed significant to her, making her feel ‘valued’. Within the hospital Charlotte felt like she ‘mattered’, staff caring about her. Indeed, Charlotte said she was not ‘really bothered about going home’. In hospital she perceived that people recognised her struggles and importantly the staff listened, something which she said her GP did not do. Charlotte also described how she valued the safety of the hospital as a place. In hospital she was ‘looked after’.

At times however, Charlotte also seemed to have little hope of overcoming her fears of the future, of struggling with her anxiety. She wanted to be ‘well’ and she wanted help. She described \,however, how she had little hope of finding the support she perceived she needed, from the Mental Health Team. For Charlotte, only the Mental Health Team could help her long term, and she had tried so many times in the past to get that help and failed. Consequently, this made her feel like suicide was likely soon, the ‘only means to escape her anxiety’. Indeed, she described how being in hospital had given her time to think about the future and decide, although she was unwilling to share that decision within the interview; the hospital offering her a safe space to make choices about her future.

6.4 Elizabeth

Elizabeth described being very reluctant to attend A&E following her overdose; her friend had called the ambulance, but she wanted to die. Elizabeth stated that she had suffered with anxiety for a long time, which had caused her to seek to end her life previously 'many times'. During the interview she spoke of being upset and angry that once more 'it hadn't worked'. In A&E she 'didn't want to be better' but 'the staff were trying to make better'. Elizabeth recalled with passion, how she was also angry in A&E with herself for taking the overdose, there was lots of 'mixed emotions'. For example, Elizabeth described how in A&E she was 'scared' and 'frightened' about the overdose working and herself dying, saying she knew she needed help and 'part of me wants to get better.' Elizabeth also expressed however, that she wanted to die, but was 'scared of dying' when she was in A&E. Coming into the physical space of A&E seemed to have initiated this fear, however these feelings frequently seemed confusing for her, as she articulated them during the interview.

Elizabeth also described how she valued the kindness and compassion of the staff and linked this to her fear of dying, valuing how the staff made her feel safe through 'checking' on her and through being 'kind'. Their presence was described as 'comforting' and Elizabeth felt she could 'rely' on them. Knowing that the staff were there, just behind the curtain, made her feel safe. Indeed, Elizabeth became very emotional when speaking about how she felt safe in hospital, with the staff around, talking to her and checking up on her. She spoke emotionally about how this is what she wanted, and what she needed, 'someone to talk to'. Elizabeth said that outside of the hospital, without the staff around, she was not safe, especially when she was on her own. Elizabeth describing twice, how outside, she desperately needed someone to talk to and wanted to be safe.

6.5 Ellie

Ellie lived with one of her parents and explained that she suffered with anxiety and depression for which she was prescribed diazepam, and which she stated she was addicted to. Ellie was particularly communicative and animated about her mental health problems, some of which were not recorded as they described personal details. From her descriptions overall however, Ellie suffered with very serious mental health problems and at times was very poorly. For example, she described how she had tried to end her life before on several occasions and had spent time at various inpatient mental health units. She was very familiar with how the 'system worked' following an overdose. Ellie described herself as 'having been here before' and was familiar with A&E and the Admission Ward, including some of the staff.

Her anxiety meant that Ellie did not like 'busy busy busy', finding it difficult being in places where there were many people. Consequently, Ellie stated that being in A&E had made her feel more anxious because it was full of people. Being on the Admission Ward however, felt much 'calmer' for her, Ellie describing how there were 'less beds' around her, which helped.

Overall, Ellie recalled how she had experienced the staff as 'kind', which she said was 'a good thing', staff talking to her 'about normal stuff, telling you about themselves a bit'. Indeed, such interactions with the staff made her feel 'more positive about the future'. Ellie also described how when members of staff brought 'their own experience into it' around mental health, it made her feel like someone understood and was on 'her level'. For example, Ellie describing how one staff member had said that her daughter also struggled with mental health problems, and this was helpful.

In contrast however, Ellie recalled how a member of staff in A&E had been 'patronising', which made her feel 'horrible' and 'agitated', and angry, Ellie wanting to 'punch her'; Ellie stating that the nurse in A&E

said, ‘something about’ the reason for her admission being her ‘fault’. Ellie also believed that she was not trusted when it came to her medication due to her mental health problems. Although she was an adult, her mum had to bring in proof of her prescription of diazepam, which made her ‘annoyed’.

Ellie spoke of how she will be returning to hospital, in some point in the future, or she will be dead. Indeed, Ellie seemed to have little hope for the future, saying, ‘I know I won’t get the help’. Ellie thought that nothing ‘had really changed’ following her overdose and admission, her ‘mental health crisis’ was ‘still the same’, describing how the future felt ‘dreadful’. Ellie seemed to equate getting help, with being given a ‘mental health bed’, but she explained that she was aware that there was such a high demand for such beds and therefore, this was very unlikely to happen. This made her feel hopeless. It seemed that experience had taught her this.

Finally, Ellie described how in hospital, on the Admission Ward, she felt ‘safe’, however, she was not safe ‘outside’. The night before the interview, Ellie had also seen another patient die on the ward, and this had made her want to be safe and get help even more. Hearing this patient dying in her bay and being aware that the staff were ‘laying her out’, had made Ellie think about her own death. She expressed how she was fearful of dying herself, having witnessed the death of another patient just hours before the interview.

6.6 Harriett

Harriett's interview was conducted as she was waiting for her discharge letter from her nurse. She had been admitted the previous day via A&E, following an overdose, which during the interview she stated was the first time she had tried to end her life. Harriet described being very 'shocked' about what had happened over the past two days in hospital, saying it had 'made me think'. Seeing how upset her father was when he had visited her in hospital following her admission to the ward, seemed to have caused Harriet to question some of her previous thoughts. For example, Harriet was shocked that her father cared about her; Harriet being impacted by his tears and his emotion for her when he visited her. Indeed, she explained how she was genuinely surprised that he wanted her to get better and live. Previously, she had thought that she was 'a pain and a burden' to her family. Harriet described movingly how her dad was so pleased that she was alive, and consequently this had changed her perception of herself, and therefore she was going to accept the help that 'she needed' now. Being in hospital had given Harriet time to think; the realisation of her dad's care for her, becoming a motivation for her to 'sort this out'. Furthermore, Harriet was very positive and hopeful about accessing suitable help and support from the Mental Health Team.

Harriet was also positive and grateful about the care she had received in the hospital from the staff, being particularly moved by the actions of one nurse, who took the time to make an appointment for her with her local GP. She described how the nurse 'was on the phone ages and arranged it all.' The nurse also gave her some information about charities who could help her, which she said she would be in touch with. Harriet seemed very positive about the future, almost excited about accessing help. Indeed, Harriet explained that one day she would like to come back to the hospital to work as a Health Care Assistant, to 'show you that I have done it.'

During her stay in hospital, Harriet had also seen another patient die on the ward, which she described as 'horrible', especially seeing how upset their family were. She reflected how this had caused her to consider how her family would feel if she had died, how 'it would hurt people, they would be upset.' Furthermore, she now knew, having spoken with her family, that they would have been 'upset' if she had died. Not wanting to cause them this 'hurt', had become a reason and a motivation for Harriet to now accept help and support.

Harriet also described her mental health problems in detail and how they were connected to a recent sudden and tragic bereavement, although to ensure anonymity, these details are omitted from the study.

6.7 Jasmine

Jasmine described being ‘basically dragged in’ by a friend who had phoned for an ambulance, following her overdose, which during the interview she indicated that she had ‘done before’. Jasmine said that coming into A&E had been ‘embarrassing’; Jasmine perceiving that ‘it was my fault’ and describing how she felt ‘kind of silly’. Indeed, she described how when coming into hospital she felt she was wasting people’s time and that she was not coming in for a ‘good enough reason’. Jasmine, also however, valued the reassurance of being in hospital and the care offered by the staff. She described how she wanted to ‘get checked out’ as she was ‘scared’ of the ‘effects’ of the overdose, ‘in case I was going to die.’ On the Admission Ward Jasmine continued to feel ‘embarrassed’ and ‘exposed’, describing how she was not allowed to have the curtain closed around her bed. Jasmine understood why this was the case, but perceived that people were ‘watching’ and ‘judging’ her. This feeling was enhanced by the actions of the doctors, speaking loudly during the ward round so that other people ‘would have heard’ about what had happened. This made her angry.

Jasmine experienced the nursing staff as ‘lovely’ however, ‘chatting and making conversation’. She valued them talking to her, making ‘general conversation’ and spending time with her like a ‘normal person’, saying this helps ‘put you at ease’. Jasmine particularly mentioned how one of the nurses had made her a hot chocolate, which made her feel ‘like you are worth something.’ For Jasmine, the ‘little things’ ‘make you feel better’, someone ‘smiling’. She also valued that the staff continued to ‘check-up’ on her, as that made her feel safe.

Being in hospital had given Jasmine time to think, ‘a bit of reality check’, although she was uncertain about being able to access help for her mental health problems in the future. Indeed, Jasmine spoke of how she finds it hard to access support and accept help, instead she just carries on, ‘thinking that I can do this on my own’. Jasmine described however, how over time things ‘just build up’, and she struggles to cope with her busy home life, which she described as ‘very full on’. Jasmine explained how being in hospital however, had ‘just given me some space to think.’ She was going to ‘take the help that I will get offered’.

Jasmine also spoke at length about her children and their lives, although these comments were removed from the transcript, as they were considered personal details. She was however very proud of them and wanted to live to see them grow up.

6.8 Katie

Katie described how coming into hospital was embarrassing, 'like everyone knows and they are looking at you.' Katie felt that people were thinking 'what has she done' and judging her which made her feel 'crap, worse.' These feelings of being judged made Katie want to 'escape'. Katie however, declined to explain further about what she meant by the word 'escape'. Katie continued however, to recall how she felt 'stupid' for taking the overdose.

Katie also described how as soon as she had come into hospital, she 'regretted it', describing how coming into hospital 'makes it real.' Katie explained that as she began to feel physically sick in A&E, she experienced herself getting 'really worried' and started 'panicking', as I 'thought I was going to die'. Katie spoke of how this feeling of panic was experienced as shock; it was something that just 'hit' her; 'I was really panicked that I was going to die.' During that time, Katie explained how she started thinking about her children and feeling 'stupid' and 'ashamed' again, for what she had done. Katie describing also how she found herself specifically thinking about her children's future. 'What are they going to do without me?' Consequently, Katie perceived, in A&E, that she really wanted to 'live for them'.

As time passed, and Katie stopped feeling sick, she explained that she slowly started to feel safe. Katie continued however, to value the nurse and the doctor being 'kind' and 'reassuring' her, especially about the sickness and how she would be okay. Katie also described how she valued that the staff kept coming to check on her, just to ensure she was okay and not going to die. The staff's presence making her feel 'less scared.' Indeed, Katie spoke about how she wanted to have the staff around, their presence making her feel 'at ease'. Furthermore, Katie also mentioned how when the staff smiled, that made her also feel 'at ease'. Katie described how she found it less embarrassing on the Admission

Ward, as there were ‘not as many people’ and it was ‘quiet’. On the ward therefore, she did not feel as ‘exposed’ compared to being on A&E.

Finally, Katie discussed how the fear that she experienced when she thought that she was going to die, had made her not want to ‘go that far down again’. She explained that looking after her children had been hard, but she was proud of them and ‘I don’t want to put my kids through that’. Katie explained how being in hospital had ‘given me time to think’ and she did not want to die and leave her children. She also did not want her children to experience this again, especially her oldest son who was with her in A&E. Katie wanted to get some help from the Mental Health Services and especially some support for her depression and anxiety. She seemed hopeful of obtaining this support and positive about this. Indeed, towards the end of the interview Katie was very determined that despite the challenges she faced in her life, ‘this’ would never happen again, ‘this was the first time and there won’t be another.’

6.9 Lauren

Lauren worked for the NHS in another hospital and had suffered with significant mental health problems following an incident at work, which resulted in many distressing symptoms, including disturbing flashbacks. Lauren stated that she could recall little of her experience of being in A&E, apart from that it was 'really loud' which made her anxious when she was 'very poorly'. Lauren did however, recount how at one point in A&E, she was struggling to breathe. She tried to explain this to the nurse looking after her, however felt that she was not listened to 'because of my mental health problems.' Although as a nurse herself, she recognised that 'it is hard to take everything in', this still made her 'cross'. As her condition deteriorated in A&E, Lauren explained that she was moved to Resus, where the nurse there was 'snappy' with her and lied to her about her medication. The nurse, Lauren said, informed her that she was being give an antibiotic, when later she was told that the medication administered was diazepam, to calm her down. This made Lauren 'angry' that she was 'lied' to by the nurse, she would have rather been told the truth.

In contrast to being in A&E, Lauren found it 'all right' on the Admission Ward, although she said she wished that the staff would talk to her a little more. Lauren reflected however, that they were 'busy people aren't they' and that they have 'not got time for me at all'. If she did try to talk to them, Lauren felt like she was 'bothering' them, saying that it was her 'fault' that she was in hospital. Lauren however, felt it would have been 'much easier' if they had got to know her, and reassuring, when she was having flashbacks. Indeed, the night before the interview she said she had suffered several flashbacks of the incident at work that had caused her problems, feeling 'abandoned' as she had no one to talk to on the ward.

Lauren also spoke positively about the staff on the Admission Ward. In other hospitals she had felt 'judged and blamed', but she did not perceive that here, saying the staff were ‘nice’. She also found the ‘peaceful’ ward helpful.

The future for Lauren however, felt hopeless. Indeed, she said, that there was ‘no hope’. She described how nothing was going to get better; the staff in the hospital could do ‘nothing’ about her mental health, Lauren believing that the Mental Health Team would come and say: ‘Discharge you!’ She believed that the Mental Health Team ‘don’t want you.’ Lauren felt ‘let down’ by the NHS as there was ‘no help for people like me.’ Lauren was certain that ‘it will happen again’, referring to her suicidal behaviour. Lauren explained that part of her wanted to be safe, but also part of her had ‘just had enough’.

6.10 Mark

Mark described how he had suffered with 'massive' mental health problems and suicidal thoughts for many years. During this period, he had had frequent contact with the Mental Health Crisis Team and several admissions on to Mental Health Assessment and Treatment Units. Mark stated he had also been in this hospital several times due to his mental health problems and suicidal behaviour. Mark described how his mood could change very suddenly which could then cause him to become suicidal; the awareness of this making him feel very vulnerable and anxious.

Mark recalled how he arrived at hospital by ambulance, and 'knew' he needed help. In A&E Mark described how the staff were understanding and he did not have to keep repeating himself, as he had done on previous admissions. Even though A&E was busy, he felt like he was being 'looked after' by the staff, the staff 'keeping an eye on me', which he valued and found reassuring. For a short time, Mark was placed on the corridor in the A&E department but felt 'better' when he was moved to one of the side rooms. Here he could have some 'privacy' and Mark described how he did not feel like he was 'being watched.' When he was on the corridor, people 'walking past' made him feel in 'danger' and more 'anxious'.

Overall, Mark was very positive about the staff who looked after him, especially a nurse who shared with him how she had been through similar things. This made him feel less 'alone and someone cared.' Mark also described how the doctor was 'really respectful', which made him feel more 'relaxed and contented and peaceful.' Mark also said the paramedic who brought him into hospital was 'really kind', wishing him 'good luck'. Mark did however describe how he felt 'bad' taking up the staff's time. He also mentioned that it was his 'fault' that he was not receiving his mental health medication during his time in hospital. Mark described how this was causing difficult withdrawal symptoms but reiterated that this was his 'fault' for taking the overdose.

On the Admission Ward, Mark had also witnessed another patient dying, which he said was 'horrible and 'frightening'. This had made him want to find help for his mental health problems; 'to feel better'. Mark also valued the hospital as a place of safety; indeed he said, 'that's why I wanted to come here'. Having the staff around was reassuring for Mark, the staff offering him a 'safety net', a place of safety.

6.11 Mollie

Mollie stated that she had taken an overdose before with the intent to end her life, explaining that this time she had been 'really down and really sad' following a recent tragic event. She also spoke of how she suffered with 'anxiety' and 'excessive drinking'. When she woke up in A&E she was very 'scared' however, about what was going to happen and if she was 'going to die', describing how she thought she was going to die in A&E.

Overall, Mollie experienced the staff as 'nice and friendly and helpful' and spoke of how they had been 'kind'. Furthermore, this seemed to surprise Mollie, that she was not being 'treated differently or anything.' Mollie described how she thought she would not be treated like other patients, due to her overdose. Accordingly, although Mollie valued the presence of staff, she also wanted to be left alone, she wanted to be 'isolated' because of 'what has happened.' She worried about people 'judging' her, and she felt 'embarrassed'. Such feelings were enhanced due to the actions of the doctors during a ward round. Mollie emotionally described how the doctors had spoken 'really loudly about what had happened and everything', which meant that 'everyone knows now what happened'. They had spoken about the overdose and her excessive drinking. Although the curtains had been closed, Mollie perceived that 'everyone' had heard, and were therefore judging her. Indeed, this had caused Mollie significant distress, 'it made me feel worse, much worse.' During the interview, Mollie was still clearly distressed by this incident and angry. Linked to this experience of embarrassment, Mollie had said to the nurse that she wanted to go home, but the nurse had explained that if she did this, the police would be contacted, and they would go to her home and bring her back to hospital. Accordingly, Mollie felt 'trapped'. Overall, however, Mollie described the nurses as a 'bit kinder' than the doctors and more respectful of her privacy. 'The nurses think about me.'

Mollie contrasting the nurses with the doctors she had encountered on the ward round.

During the interview Mollie also described how she had ‘instantly’ regretted taking the overdose when she woke up in hospital. In A&E she had been ‘scared of what might happen and if I was going to be OK’. This fear of dying also seemed to be compounded for Mollie by being in hospital, surrounded by ‘sick people’; the presence of other sick patients enhancing her fear of death.

6.12 Noah

During the interview Noah mentioned that he had tried to end his life numerous times in the past and made references to previous admissions at this and other hospitals. Indeed, Noah seemed to know the hospital well, talking about several different wards he had been on following past suicide attempts. Noah stated that he suffered with severe mental health conditions caused by a traumatic event that occurred when he was in the military, resulting in frequent distressing flashbacks. Noah did not use the term PTSD (Post Traumatic Stress Disorder) within the description of his mental health problems, rather describing his recent overdose occurring because of 'being in a bad place'.

Noah could not recall anything of his time in A&E, his first recollection of coming into hospital was 'waking up on this ward'. Noah was very positive about the staff on the ward, describing them as 'fantastic and supportive'. Noah described how they were 'easy enough to approach and talk to', something which he clearly valued. Indeed, he noted how they even talked to him and 'interacted' when they were busy, making him feel more 'positive' and 'at ease really'. Indeed, during his time in hospital Noah experienced how talking made him feel 'a lot more positive.' Specifically, Noah commented how it was helpful that the staff were 'open and honest', rather than being 'fobbed off and getting lied to'. Noah commented and reflected on this in relation to a previous hospital admission when he was much younger, when he had experienced the nurses as not being honest with him.

Noah also described how a nurse from another ward had purposely come to visit him. This member of staff had met him during a previous admission and wanted to see how he was feeling, something which made Noah feel 'really good'. Noah perceived that this nurse was not just doing their job, but 'genuinely cared'. Indeed, the action of this nurse, gave Noah hope 'that there are people out there that do care'. Furthermore, when staff shared something of their personal lived experience of mental health problems, Noah described how this made him feel more ‘hopeful’ and ‘positive’ about the future. Interestingly, Noah explained that the staff were helpful when they were ‘individual’. Specifically, Noah seemed to relate this to staff expressing aspects of themselves outside their clinical role and ‘especially ones who have been through similar stuff’. Noah also explained how other staff had also gone ‘that extra mile’, doing things ‘off their own back’, for example, making phone calls for him to deal with practical things. Indeed, Noah used the word ‘genuine care’ to describe such staff, saying you can tell who is ‘faking it’. Furthermore, simple comments from staff like, ‘if anything gets any worse to let them know’, Noah perceived as genuine care. Noah valued such comments a great deal, becoming emotional when describing such encounters, suggesting that the nurses he had met were a ‘fantastic example’. Finally, Noah also valued the hospital as a place of safety, he said through the presence of staff he felt safe here ‘without a shadow of a doubt’; Noah believing that outside of the hospital he could quickly again become a suicide risk.

6.13 Naomi

Naomi had suffered with self-harm for many years and had lots of scars from cutting herself, which were visible. She also said that she had sought to end her life before, however this current experience of taking an overdose had shocked her. In A&E, as she felt the overdose 'kicking in' Naomi described how she 'regretted it' and 'felt scared about what might happen', experiencing 'panic'. This feeling shocked her and surprised her. It was not something she had experienced before. Naomi was very scared that she might die when she was in A&E, but this fear also continued when she was on the Admission Ward. Indeed, during the interview, Naomi repeatedly said that she was 'scared' that she was going to die. This fear was closely connected to her belief that if she died, she would not see her family again.

For Naomi, the thought of not seeing her family again was now for her a reason to get better, it gave her 'a purpose to keep going', to 'keep fighting for a better life.' Naomi also wanted to get better for them. Before this overdose, she had thought that her family would not be 'really bothered' if she ended her life. Seeing how upset they were in A&E however, had challenged this view. Naomi never wanted to witness their distress caused by her taking an overdose again.

Within the hospital, Naomi expected to be judged by staff for her suicidal behaviour; in the past staff had been judgemental towards her. On this occasion however, the 'polite' nature of the staff and their 'soft voices' had surprised her and made her feel that it was safe to talk to them. She enjoyed talking to the staff. Indeed, Naomi was surprised that the staff seem to care about her. This made her feel that 'you are going to be all right.' Likewise, when the staff were treating her, Naomi was surprised that they were gentle and did not hurt her when putting the needles in. In the past, staff had not been so gentle. Naomi also described how she valued the staff checking on her, taking her blood pressure regularly, reassuring her. This made her feel safe and helped to reduce her fear of dying.

In A&E Naomi was placed on the corridor, which she found ‘uncomfortable’ and made her feel ‘really anxious’. She felt people were looking at her and wondering what she had done and why was she there? Naomi thought people might know that she had taken an overdose and judge her negatively. Likewise, on the Admission Ward, Naomi found it difficult being in view of other people, perceiving that they were judging her. Naomi preferred the curtains closed around her bed and said it was ‘even better’ when she was moved to a side room. Being in sight of other people made her anxious. Even though Naomi had experienced kindness during this time in hospital, she still expected judgement.

6.14 Olivia

Olivia described how she had been brought into A&E and Resus following her overdose and was critically poorly, at risk of dying. Olivia recalled how the staff had told her that she was going to die, describing how the staff explained that she would go into 'a deep sleep' before she died. Olivia recalled how this was a frightening experience. 'I just thought I was going to die to be honest, I didn't think I was going to be waking up'. Indeed, when Olivia did wake up, she described how she was 'confused' because she thought 'I should be dead'. Olivia also explained that she had 'mixed feelings about it all'. When she was at home, she wanted to die and that was her decision and indeed, she was angry that people had interfered with this wish. In contrast, however, Olivia described how the experience of coming close to death in A&E had been very frightening, consequently stating that: 'I just think no one should try to take their life'. Indeed, she described the experience as 'horrible', of seeing 'just blackness'. Consequently, Olivia described how she valued the medical care that she had received, perceiving that it had saved her life: 'This place couldn't have done things better, it's been brilliant.'

When interviewed, Olivia expressed a real determination to be well now for her mother who was suffering with COPD (Chronic Obstructive Pulmonary Disease) and who was also in the same hospital. Indeed, while in hospital, Olivia had gone to visit her mother on another ward. She described how she wanted to now live for her mother and to be able to care for her. Indeed, coming close to death in A&E had caused Olivia to think more about her mother; Olivia describing how as she could 'feel the tablets working', she was thinking about her family, especially her mother and her children. Accordingly, Olivia now wanted to be 'free from whatever is in my mind and live with my mum'. Olivia was determined that she would not experience dying again, although she expressed little hope of getting help and support from the Mental Health Services, to 'free her mind'. The fear of dying and her desire to live for her mother, was, however, her motivation, although she seemed unclear about how she would get ‘her mind well’. This caused her at times, during the interview, to be less hopeful about her future.

6.15 Simon

Simon lived with one of his parents and had suffered with mental health problems for many years. He indicated that he had sought to end his life many times in the past, his family, on each occasion, 'making me' attend hospital, rather than die. Simon spoke of being very impulsive, of getting waves of wanting to self-harm or end his life; however, he also described these occasions as moments when he was very much in control. Interestingly, Simon perceived self-harm and suicidal behaviour as different, self-harm being a way to 'cope with life'. Simon explained that he was on medication for his mental health, but still struggled. Indeed, his mother had sought his admission to a mental health ward several times before. He had, however, always been turned down for a bed. Simon described how even with the help of his family, he had struggled to get the help and support that he perceived he needed from mental health services for his illness.

Simon had found the experience of being in A&E to be something that increased his anxiety, due to the busyness and the level of noise within the department. Indeed, he described it made him feel 'frantic', and contrasted this with the Admission Ward where he said he could 'chill' and felt more 'relaxed'; the latter being more peaceful and less busy. Simon however, experienced staff both in A&E and on the Admission Ward as 'very nice', commenting about how it helped that they were 'chatty'. This made him feel more relaxed. Indeed, he described how if you had a problem you could talk to them. One nurse had been really 'kind' to him when he was having difficulties with his cannula; Simon being genuinely surprised by such kindness. Simon commented that the staff do not judge you or look at you like you are the 'devil', unlike 'outside'. Simon explained that he also gained reassurance from just having the staff 'around', as their presence made him feel safe. If he started to worry or get anxious that he was going to harm himself, he knew that the staff were available. He described how in hospital he could not physically end his life and seemed to find this reassuring, despite his earlier comments about being made to come into hospital by his family.

Simon was very relieved that he had been admitted to hospital and this also brought him hope for the future. He described how, 'before I have never been one of those people who do it severe enough'. Now however, Simon believed he knew how many tablets to take to gain admission; this bringing him a sense of reassurance. 'Being in here is good, I am safe in here'.

Simon also described his struggles to get the help and support that he perceived he needed from Mental Health Services, explaining how he had been 'sent to' different treatment teams but 'passed from pillar to post'; Simon commenting how he wanted to see a psychiatrist or have some form of treatment. Interestingly, for Simon, the help he sought was in the form of support from the Mental Health Team, rather than, as his mother's wish, for him to be admitted onto a mental health unit. Sadly, Simon believed, based on his previous experience, that he would not get any help however, from the Mental Health Team. Consequently, he seemed certain that he would be in this hospital again for the same reason, although now reassured that he knew the number of tablets he needed to take to gain admission.

6.16 Sophia

Sophia said that she could remember very little of her experience of being in A&E as she was 'struggling to stay awake', although she did describe how she was very reluctant to come into hospital as she 'didn't want help'. Sophia also said she was terrified, because she did not 'know what they were going to do' or what 'they were going to ask her'. She described how she feared people 'asking questions' about what she had done, fearing judgement and expecting people to be 'nasty' because of her overdose.

On the Admission Ward however, Sophia described how she 'felt a bit better about being here', indeed Sophia said later during the interview, 'I don't mind being here'. Sophia spoke about how she kept apologising to the staff, and she was surprised that they were 'fine', 'pleasantly surprised'. This made her feel 'a lot better, a lot more welcome, a lot more comfortable to actually be here'. Indeed, Sophia described how she was prepared to stay 'as long as she needed to'. Sophia explained that 'outside' she struggled with her 'impulsive moods' but in hospital she felt 'safer'.

At times Sophia did find the noise 'scary', people 'shouting' and 'people trying to shush them, but this calmed down', Sophia describing that it had been 'really nice on here'. Sophia expressed how the nurses had been 'really friendly', 'kind and helpful', although she experienced this as a bit awkward at times, saying she was 'not used to it'. Sophia described herself as an 'awkward' person on several occasions. She said it was hard to talk to the staff as she was fearful that if she expressed her feelings 'it will just look completely bonkers, completely stupid'. Sophia also explained that she had tried to talk to the staff and commented that: 'I do need to speak to them a little bit more.'

Sophia also indicated that the presence of the staff made her feel safe. She explained that her suicidal behaviour was very impulsive. 'In that moment everything gets too much, and you lose control', however having someone with you can 'guide you through it'. Sophia also explained how following her recent overdose, once she arrived at A&E, she realised that she was going to die, and it was the 'most terrifying thing ever'. Indeed, having suffered with mental health problems for years she was surprised by this fear, believing previously that she would not be afraid to die. Furthermore, during the interview, she explained that she was still scared of dying, describing this fear as 'very real'.

Sophia also recalled a sense of guilt for the panic she had caused her friend who had come into hospital with her, her friend crying and fearful that she was going to die. Sophia also explained that during her time in hospital she had felt guilty for seeking to end her life, as she would have 'abandoned' her cat that she had rescued. Indeed, she recalled how while in hospital, she had been thinking about how she missed her cat: 'I miss him so much. And I am glad that I can still be alive for him. It is a weird thing that wanting to die, it is something that comes and goes.' Being in hospital had given her time to 'sit and think a lot more'.

Sophia was very frustrated by the Mental Health Services, and recalled her struggles to access help, being 'pushed to different persons'. Sophia recalled being told that she needed therapy but her appointments being stopped. During the interview however, she said that she was going to try and 'pursue' it, 'see what I can do about it' to get therapy, along with seeking a review of her medication. Sophia said: 'I just want to be stable.'

At the end of the interview Sophia was keen to stress that she was very grateful to the staff for their 'kindness', stating that: 'kindness helps a lot'.

6.17 Trevor

Trevor described how he suffered with depression and linked this to problems with his back that prevented him from working, he was often ‘stuck in bed’. He perceived that this affected his status in his community where, previously, he was well respected.

Trevor described being in A&E following his overdose as ‘terrible’. He was first ‘stuck’ in a room and then the ‘hallway’, waiting for a bed to become available on the Admission Ward, for six hours. Trevor recalled how he was crying and screaming in pain, with people looking at him, people ‘walking past and looking’. He also perceived that ‘people were making fun of me’, other people ‘thinking look at what he has done’. Furthermore, Trevor recalled how nobody came to explain what was happening, no one was ‘bothered’, ‘I was just alone’. Trevor described how he is ‘not someone who complains’ and therefore he was ‘stuck in that state’. Over time, his anxiety kept increasing and he wanted to escape, Trevor saying it felt ‘very depressing’, ‘all sorts go through you’. Consequently, while in A&E in the ‘hallway’, Trevor took a further overdose. Trevor did not wish to describe what happened then. Instead, he explained that on the Admission Ward he continued to feel ‘alone’, perceiving that the staff spent ages ‘with everyone else’.

Trevor described how he felt ignored, no one asking ‘how I am feeling’, no one ‘caring’ about him; Trevor perceiving that he was being treated differently because ‘what I have done’, because ‘it is my fault that I am in here’. Trevor explained that this made him ‘feel bad’, he valued talking to people, people asking how he was, Trevor linking this to being well known in the community and having many contacts. Trevor described that talking was ‘better than tablets’. Trevor longed for the staff to talk to him, to ‘just say hello when they start the shifts that would be kind’. Trevor said he wanted the staff to be ‘kind’ to him. Instead, the lack of contact with staff was making him feel ‘depressed’. Indeed, he explained that now he felt like an ‘animal’, just being fed and watered by hospital staff. ‘I would rather die’, than return to hospital. Trevor indicated that ‘next time’ he would stay at home and die.

Accordingly, having outlined the main findings from each interview conducted, these findings are now explored in greater detail through the thematic analysis, to enable us to glimpse the participant’s lived experience at depth. In doing so, in accordance with van Manen’s (1997a) approach, direct quotations are presented from the interviews.

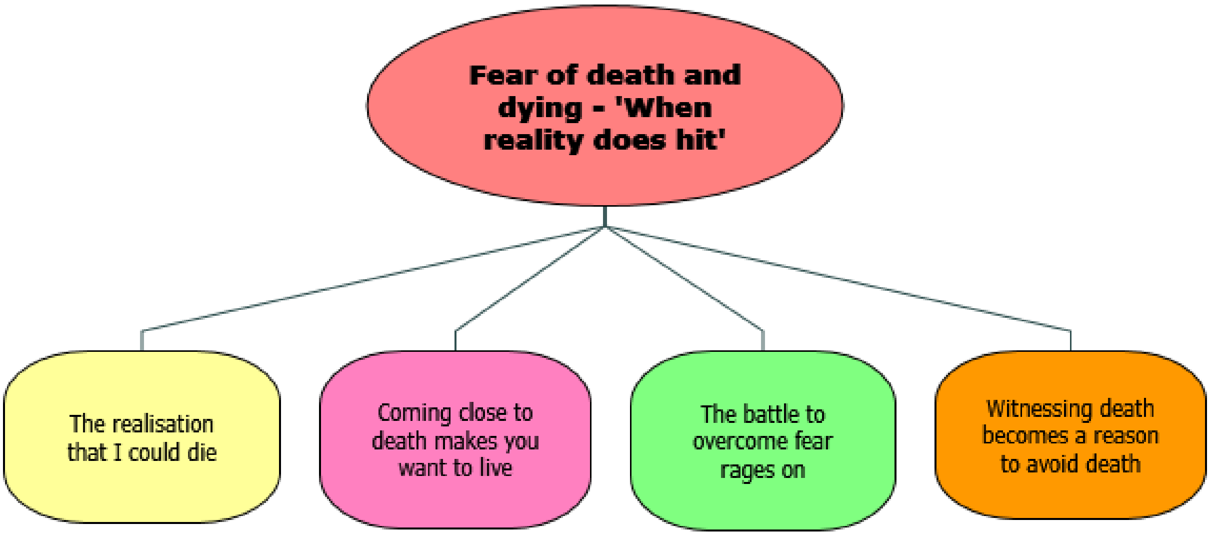
7. Constructed themes

7.1 Introduction

A summary of the overall themes is outlined over the page, in the form of a mind map. This is followed by a detailed discussion of the six main themes and subsequent subthemes. The titles of the themes were chosen by me, to try to express both the content and the emotion of the participants' lived experience. Numbers enclosed within brackets, located within participants' quotations, indicate pauses in seconds (see Appendix 6, Transcription Symbols).

7.2 Mind Map of main themes and subthemes

7.3 The fear of death and dying – 'When reality does hit'.



7.3.1 Introduction

An overarching experience that all the participants described to some degree, was a fear of death and dying. As Mollie recounted: 'I was really scared, scared about what had happened, what was going to happen, scared that I was not going to be ok.' This experience of fear seemed to be driven by the participant's perception that they could actually be close to death, that they could be about to die. For these patients, although they had only recently taken an overdose, now in A&E or on the Admission Ward, the thought of death and dying seemed to engulf them in fear. Indeed, this experience of the fear of death and dying seemed surprising and confusing to the participants. For example, Katie did not want to 'go on', she was a burden to others, and yet, when the 'reality of death does hit', she was scared:

> 'It is confusing, I think it is confusing for the patient as well, like it is confusing to me, at the time you are in a place where you know you think you don't want to go on, you think everybody is better off without you, that you are just making a mess of things, so when reality of death does hit. You know it is scary…'

Within this section, the theme of the fear of death and dying will therefore be explored in detail, presented through four subthemes: The realisation that I could die, coming close makes you want to live, the battle rages on, and witnessing death.

7.3.2 The realisation that I could die

For many individuals, their acute medical symptoms, experienced within A&E, particularly their violent vomiting, seemed to enhance and even initiate a fear that they might indeed be dying. For example, as Jasmine said: 'I was scared of the effects because as I don't really know much about what the effects were, I think I was scared that way in case I was going to die. I was throwing up everywhere.' Likewise, for Katie it was vomiting in hospital that made her panic for her life:

> 'At one point I was being sick a lot after they put the thing up ((drip)) and it was making me really sick, and I got really worried then.
>
> It was just like, (2) panic, I panicked, I thought I was going to die. (4) I panicked; you know. It surprised me really, yeah it did, reality hit me, definitely. … I was scared that I wasn't going to be okay.'

Katie's realisation that she could indeed be about to die seemed to strike her suddenly, as if being hit by a powerful unexpected force, and the consequence was panic and fear: 'You know it is scary, scary ((said louder)), everyone is scared of dying really, and when you hit that reality, that's the scary part. So, yea.' Indeed, the word 'hit' was also used by Lauren and Olivia to express the suddenness and power of this 'gripping' fear that got hold of them, and from which they could not escape.

For other individuals however, while this experience of the fear of death was still sudden and intense, rather than being connected with their symptoms of vomiting, it appeared to be initiated by coming into the physical space of the hospital itself. For example, Naomi describes experiencing fear as she arrived in A&E and was taken straight into Resus: 'I was scared, scared about what was going to happen and why was I in here ((Resus)) if I was going to be alright … scared that I would not be okay. Scared!' Naomi seemed to perceive that if she was in Resus, she must be dangerously ill, it must be serious, she could indeed be about to die; something that truly frightened her. The physical space of Resus, perhaps with all its machines, monitors, alarms, along with the high numbers of staff, perhaps enhanced this fear of her own impending death. On the Admission Ward however, that fear of dying also continued for Naomi and even seemed present during the interview: 'To be honest, I am still scared.' For Naomi, the experience of the fear of dying was both intense and long lasting. She described how it began when she arrived in the hospital building and continued during her admission.

Another participant, Sophia, powerfully described her experience of the fear of dying as the 'most terrifying thing ever'. Like other participants, Sophia also spoke of how it was a fear that suddenly struck her, and like some other participants, this feeling seemed to be initiated by being in the physical space of the hospital, by being 'in here':

> 'I was fine, it has always been like a weird thing, I have suffered with mental health for years and I always thought that because of that I am just not afraid to die, but as soon as I was in here, there is just a thought that will come into your head that this is actually it, you are actually going to die and it is the most terrifying thing ever, like some of the first things that goes through your mind, is there an afterlife, like so many thoughts go through your head and I turned to my friend and I said oh if there is a God, like I am fucked and I am so scared right now.'

Her fear led Sophia to think about what is after death, the possibility of judgement and this scared her, she perceived that she was 'fucked', that she would die, and nothing could be done to save her life.

Another participant, Olivia, described coming very close to death, speaking of her perceived experience of dying in A&E Resus, as 'horrible':

> 'You know like you see a white light, they say you are in heaven don't they, or that is heaven, it's not like that, I will never do it again, never ever. That is all shit. I saw no white light, just blackness. I woke up and I thought I was gone and that was it. Don't believe that white light bullshit! It's horrible.'

Indeed, Olivia's use of the word 'blackness' seemed to powerfully express her dreadful experience of dying. There was no white light, just horrible blackness.

In response to this fear of dying, many participants described how they searched for and valued any reassurance that the staff offered, that they were indeed going to survive. For example, Alex spoke of how it brought her 'reassurance' when staff were 'constantly checking' on her, and Katie pleading: 'I just want them to reassure me that I can go home, and everything is going to be fine.' The fear of death seemed to cause many participants to yearn for the certainty that they would indeed survive this moment, that death was not about to consume them.

7.3.3 Coming close to death makes you want to live

During her interview, Olivia also spoke about how her experience of dying had resulted in a feeling that she now wanted to live. Prior to the overdose, she had believed that dying would be a peaceful, comforting experience, however now, she had witnessed to its 'blackness' while lying on a hospital trolley, and she feared experiencing it again. The experience of dying for Olivia had given her a strong yearning to now live. Likewise, for Katie, the shock of coming close to death and experiencing the fear of it, seemed to have given her a determination not to undergo that experience again:

> 'I feel um, (5) umm I am not sure (2) I think it has been a scary enough experience to make sure I don't go that far down again, do you know what I mean? (6) I definitely won't be here again, no, this was the first time and there won't be another, it shocked me.'

For a few participants, coming close to death and the resulting fear and shock, seemed to have given them a desire to now live. The awfulness of this experience made participants like Katie never want to experience dying again. Coming close to their perceived death, became a reason to seek to live at that moment.

7.3.4 The battle to overcome the fear rages on

For some participants like Alex however, an inner conflict to overcome this fear of death seemed to continue to rage inside her. Alex described how as she laid on the A&E hospital trolley, a battle was taking place, a battle to overcome her fear of dying, a battle that also implicated the staff.

> ‘I didn't want to be better, and the staff were trying to make better, but I knew also that I wanted help, or I wasn't going to get better. Part of me wanted, wanted to get better, and part of me was upset that it didn't work. I was also angry with myself for what I had done, angry that I had done it and also scared that it might still work. Part of me wants to kill myself and part of me doesn't, part of me wants to feel safe. (3) It does scare me ending my life ((looks to the floor)).’

For Alex, I could sense that battle taking place even during the interview; it was still being played out. There were so many thoughts connected with wanting to die in her lived experience, anger towards the staff for seeking to save her life in A&E and sadness that the overdose ‘didn’t work’. Paradoxically however, Alex also described in the same breath how she wanted to get better, indeed how she was angry with herself for doing what she had done, and at moments she seemed to desperately want to live. Amongst all these paradoxical feelings however, the fear of dying seemed directly or indirectly present as a powerful force: I am ‘scared that it might still work’. Indeed, Alex said several times during the interview, using exactly the same words: ‘it does scare me ending my life.’ Alex appeared to long for death to end her distress, but death was also what she seemed instinctively frightened of:

> ‘I came in here to get help, but I just want to die, but something scares me about dying … but then I want to escape the anger and the pain that is all inside me.’

Alex had taken so many overdoses during her relatively short life, but this fear of dying each time appeared to have caused her to reach out for help on every occasion, not because she wanted to, but because she almost *had* to. It felt like she was fighting a battle with this fear of death which kept saving her. It seemed like an instinctive force that existed within her, that would not give up on life, at least not without a fight. By contrast however, it was a battle she desperately wanted to overcome, a battle where death would be the victory, the prize, the ending of her emotional pain and torment. At times during the interview Alex sounded so determined to end her life, determined to triumph, but then after a moment’s reflection, the feeling of fear returned, to almost force her to recalibrate her thinking: ‘I will do, I have got to, I can’t just keep coming back in here again and again. (2) But it does scare me, (1) ending my life ((Alex now very emotional and looks away)).

For Elizabeth, it seemed that a similar battle was also taking place inside her as she describes regaining consciousness in A&E following her overdose. In A&E Elizabeth described feeling angry at the doctors and nurses who were trying to save her, angry at herself for taking the overdose, feeling upset that the overdose had not worked, but also knowing that she needed help to get better, frightened, and scared that she could die.

> ‘When I came in it was a bit blurry, I felt ill and upset because I had taken the overdose, upset because it hadn't worked, I wanted it to work, lots of mixed emotions because it hadn't worked, angry and upset. I didn't want to be better, and the staff were trying to make better, but I knew also that I needed help, or I wasn't going to get better. Part of me wanted, wanted to get better because I was so frightened that I would actually die, and then part of me

> was upset that it didn't work. I was also angry with myself for what I had done, angry that I had done it as I was scared and also angry that it didn't work.'

At the same time as it seemed that Elizabeth wanted to die following her overdose, she also seemed to want help to get better, because she was terrified that she could die. Within her perceptions there were direct contradictions, between wanting life and wanting death. Importantly, it appeared that the closer she came to death, the more intense that fear seemed to become. Almost like coming close to a hot burring fire, the closer she came to death itself, the more her human instinct seemed to repel her back, away from this danger. This battle however, to overcome the fear of death, continued to rage on for Alex, even as we spoke.

7.3.5 Witnessing death becomes a reason to avoid death

Interestingly however, for two participants, it was not only drawing close to their own death that resulted in an increased fear of death and dying, but also the witnessing of the death of another patient that heightened their fear. The experience of another person's death seemed to become a motivating factor for these participants to want to avoid their own death. For example, as Mark said: 'Seeing other people on the ward a lot worse than you, I saw someone dying, makes you think, it was horrible and frightening. It gives you the determination to try and sort your life out.' Likewise, Ellie had a similar experience: 'The other thing that made me think about getting the help, is that someone else died in the bay I was in last night. It was horrible looking at it.' Seeing another patient die appeared to have caused Mark and Ellie to look death in the face, and see the harsh reality of what it means, perhaps removing some of the romanticism that could be related to it. Like Olivia, the white light had gone, and the darkness of death was exposed in the mortality of another patient. On the ward, in a bay opposite her, Ellie saw death in all its unadorned form. Indeed, during the interview, Ellie spoke of hearing the ‘rattle’ of the dying person ‘fighting for breath’. As Ellie laid in her hospital bed, she also listened as the corpse was being ‘laid out’ by the staff and she saw the body being ‘taken away to the morgue’ by the porters. Witnessing this, just a few meters away, caused her, like Mark, to fear it, to want to turn away from it, to fight to live. Witnessing the rawness of death in another patient, caused Mark and Ellie to want to avoid death for themselves.

7.3.6 Summary

In summary therefore, for all the participants interviewed, coming close to their own death following their suicidal behaviour, resulted in an experience of the fear of death. This experience came suddenly and was a shock to them, being initiated by the participants physical symptoms of vomiting in hospital, or through being in the physical space of the hospital. For a few participants, this experience of fear also continued during their time on the Admission Ward. Furthermore, one of the consequences of this experience of fear, for a few participants, was an increased desire to live. For other interviewees however, it seemed that the fear of death was something that had to be battled against, even overcome, if they were to win the victory of death, as they perceived it. For two participants however, it was not only the close encounter with their own death that kindled within them a fear of dying, it was also witnessing the death of another patient on the ward, that made them fearful of their own death. Overall, however, coming close to death, either the perception of their own death due to their vomiting or their presence in the hospital, or through witnessing the death of another, the result was the same, an experience of terrifying fear. In many respects, as will be highlighted below, this experience of the fear of death and dying seemed to permeate many aspects of the lived experience of being in hospital following suicidal behaviour, including the perception of the hospital as a place of safety.

7.4 The hospital – a place of safety: 'Your hand is not on the trigger of the gun.'

7.4.1 Introduction

Many of the participants interviewed described the hospital as being prized, in a very tangible sense, as a place of safety. Indeed, the way in which the participants used the word 'outside' made the external world feel a dangerous, volatile, unpredictable and a lethal place to exist in. By contrast, the hospital was often perceived and depicted by participants as a place where they would be protected and sheltered, even from death. Indeed, as Ellie said: 'In here I feel safe from myself, but not outside'. Similarly, Alex explained what she meant when she described the hospital as being a place of safety: 'Safe means I won't hurt myself anymore.' Likewise, for Charlotte the need to be in hospital because it was safe compared to being outside felt very important, perhaps expressed most powerfully by her irrepressible tears. Here, in hospital, she was safe compared to being at home:

> ‘I am not really bothered about going home ((nervous laughter)), no I am only joking. Err, (2) it’s just safe here, it is not safe at home. Err (4) it’s safe here ((Charlotte cries uncontrollably))’.

Within this section, this theme of safety will therefore be explored in detail, with reference to four sub-themes: A place to be saved, the ward a place of calm, a place to be protected from yourself and, a safe place to think and to decide.

7.4.2 A place to be saved by medical intervention

For Mark, the hospital was experienced as a place of safety in a very medical sense, as here his life could be saved by the medical intervention provided by the hospital staff. It was only in hospital that Mark believed he could receive the lifesaving drugs that would counteract the effects of the overdose that he had taken. Mark, fearing death, therefore felt he had to be in hospital: ‘When you take the tablets you know you have made a massive mistake, that you shouldn’t have done it, it’s scary, you know you need to be somewhere safe to be helped.’ Likewise, Naomi perceived the medical care she received as the means of ensuring that she was safe, which she also experienced as reassuring: ‘They have been really good ... regularly coming to take my blood pressure, that made me feel safe. It reassures you that you will get out of where you are now.’ It was the medical monitoring that was delivered by the staff, that made Naomi feel safe, in contrast to the administration of drugs for Mark. For both however, it was physical interventions offered by staff that produced a sense of safety.

7.4.3 A place to be safe from yourself

For some participants interviewed, their perception of the hospital as a place of safety also seemed to relate to their fears and concerns that they were still at risk of completing suicide. They felt vulnerable and needed to be protected from their own actions, particularly impulsive ones. As a result, several participants experienced the hospital in a very physical sense, as a place where they would be safe from this danger, as Simon describes:

> 'In here, it is not as if I can harm myself, I can't exactly take an overdose in here, I get waves of feeling down in the day and I can be very impulsive, I just go into my room, put my music on, and take the tablets to kill myself. But if I get that in hospital I can't just get up and go, especially if I have one of these attached to me ((Simon points at his drip stand)). (2) In here I am safe.'

Simon perceived himself to be very vulnerable, his mood could quickly change resulting in a desire to end his life, something, that at the point of the interview, he did not want to happen. Here in hospital, Simon believed he would be physically protected from acting on any such impulses, and therefore, he was safe; the hospital staff therefore providing an external control of his suicidal behaviour. Likewise, Mark described the hospital staff as offering him that 'safety net' that removed his capacity to end his own life:

> 'When you are in hospital you feel safe, (3) when you are on your own your mood can change at any time, but here there is that safety net. It is hard for people to understand, but the best way I can put it is that in here your hand is not on the trigger of the gun, that is how I would describe it.'

The hospital for Mark, like Simon, protected him from acting on his sudden mood changes and ending his life. In hospital his finger was no longer 'on the trigger'. For Mark, this experience of being safe in hospital also seemed closely aligned to the presence of staff. Mark experienced their presence and availability as the 'safety net', there to catch him if he falls: 'You can tell that the nurses were willing to speak to you if you wanted to talk, and that makes you feel safe in a way, knowing that you have always got that safety net, that they are around. That means a lot.' For Mark, having staff around him, even if not interacting with him directly, made him feel out of danger. The importance was their availability. For example, Mark spoke of how even with the curtains closed around his bed, simply hearing the noise of the staff talking, made him feel reassured: 'I don't trust myself outside, so being in here is safe. Just knowing that they are there and that makes me feel safe. (3) Knowing they are the other side of the curtain is reassuring.' Mark also spoke of how, compared to being in a side room, where he was when first admitted, he found being on an open bay more comforting: 'It is really hard to explain to people, but here there are other people and other voices around.' The physical presence of other people mattered, making Mark feel safer. Similarly, Alex experienced the staff as 'making sure I am alright', as a positive thing. This kept her safe, keeping her away from that dangerous place of suicide: 'I feel safe here, here I have got people around me, making sure I am all right, because here I am away from all that is, that dangerous place, my dangerous thoughts.' Interestingly, her suicidal thoughts did not seem to have the same power when Alex was in hospital and the staff were present.

Likewise, for Elizabeth, the accessibility and interaction with the staff also made her feel safe:

> 'It's been really good, they keep checking up on you, telling you what happens next, and that makes you more comfortable and cared for. Also makes you feel more safe, they are always around if you need anything, I feel more safe in here than outside, out there I am not safe, I will hurt myself again, but I want to be safe.'

For Elizabeth, having staff check on her, therefore, seemed to bring her both comfort and the reassurance that a least, while she was in hospital, she was safe. Being kept informed about her care made her feel in control. Furthermore, having the staff available and talking to her about ‘normal stuff’, interacting with her as a person, caused Elizabeth to feel that she was not alone. This reassured her that, at least for the present time, she was safe, something which she desperately wanted, as expressed by her tears:

> ‘I feel safe here as I am not alone and talking to the staff about normal stuff, it helps you know they will keep me safe. (3) It’s what I want. (2) It’s what I really want. (4) It’s what I really want (3) ((Tears form in Elizabeth's eyes)).’

Elizabeth spoke about how when she was at work and with her friends, then she was okay, she would not act on her suicidal thoughts. However, ‘when I am on my own, I don’t feel safe’, she described how it was during such moments, when she was alone, that she felt in mortal danger. Being in hospital however, having staff around her, in contact with her, checking on her 24/7, gave her that sense of safety, a deeply comforting experience and something she longed for. Like Alex, for Elizabeth, her suicidal thoughts seemed to have less power in the presence of staff.

Interestingly however, two participants seemed to highlight the importance of staff being available but not being intrusive, in connection to perceptions of safety. As Katie described: ‘Yea kind of having people around, but not being nosey, not asking to many questions if you know what I mean’.

7.4.4 The ward, a place of calm

Although the presence of the staff in the A&E department and on the Admission Ward, helped many participants to feel safe, several participants also described how perceptions of safety were also linked to the level of noise and busyness of their surroundings. Many participants contrasted the relative peace and quiet of the Admission Ward to the busy A&E department, as Simon described:

> ‘A&E is busy, there are a lot of people and noise, and that makes you feel frantic and more agitated, makes me feel more anxious, yea it compounds the agitation being in there. … Here ((admission ward)) it is chill, it is ok in here, not many people and everyone is ok. A&E staff look really busy and rushed off their feet. Here it is quiet, steady, makes me feel more relaxed here, less anxious it is not so bad staying in here.’

Indeed, several participants found being in A&E confusing as Sophia described:

> ‘It got a bit scary sometimes because of that, like I know, I woke up and there was noise and I had forgot that I was in hospital, there were people shouting at one point, and people trying to shush them at one point, and I thought what was going on and when that was going on, I was scared then, but I calmed down, woke up and got moved.’

In contrast, Sophia later commented: ‘Definitely prefer being here ((Admission Ward)) than the major one ((A&E majors)). It is just a lot more peaceful.’ A&E was often perceived as confusing, loud, and frightening. In contrast, the ward was experienced as a place of peace and calm which reduced feelings of anxiety and enhanced the perception of safety.

7.4.5 A safe place to think and decide

Other patients spoke of how being in hospital made them feel safe because it gave them some time-out from the pressures that they experienced outside the hospital setting; pressures that had contributed to or caused their suicide attempt. Here they escaped from the dangers ‘outside’ that contributed to their suicidal feelings. For example, Simon spoke of how he could relax in hospital and not be concerned about behaving a certain way and being subjected to criticism: ‘Outside you have to be a certain way, you have to look this way or that way or you get judged, in here staff don't look at you like you are the devil. Here you can chill.' This reference by Simon, to how outside people look at him like he is the 'devil', perhaps as evil, dangerous, someone to be frightened of, offers us a glimpse of his life perceived beyond the safety of the hospital ward and the pressure and difficulties he faces. By contrast, being in the hospital felt very different for Simon, it gave him a space where he could relax, feel safe and 'escape'. An important factor for Simon was that in hospital he did not perceive the staff as judging him, in contrast to some other participants like Trevor and Lauren who perceived that they were ignored and lied to (see Chapter 7.7). Indeed, for Simon the removal of this pressure seems to have resulted in a reduction of his need to self-harm or to end his life:

> 'Being in here is good, I am safe in here ((Simon showed me his arms with a large number of raw red cuts on)). That was what I did last night before I took the overdose. I have the blade in here ((Simon nods to his bedside locker)), but I will never use it in hospital, feel like in hospital I have escaped, totally escaped. I can chill.'

Indeed, it was because the hospital provided this sanctuary from the pressures outside that Simon felt that he would seek to return to the hospital again soon, being aware of the only other alternative: 'I feel I will be here again, not next week, but next month or just after, or dead. Here it is safe; I don't have to do certain things or worry about what people think.'

Likewise, Jasmine experienced the hospital as a safe place, where she could be away from the daily pressures of home life that contributed to her suicidal feelings. The secure space of the hospital seemed to have given her the opportunity to reflect and to decide to accept help.

> 'I think life at home is very full on and I don't get a chance to think, and this is when it all builds up and yes, and goes how it did. I think it has just given me some space to think, yeah (2) in a good way kind of thing. … It has given me the safe space that I needed

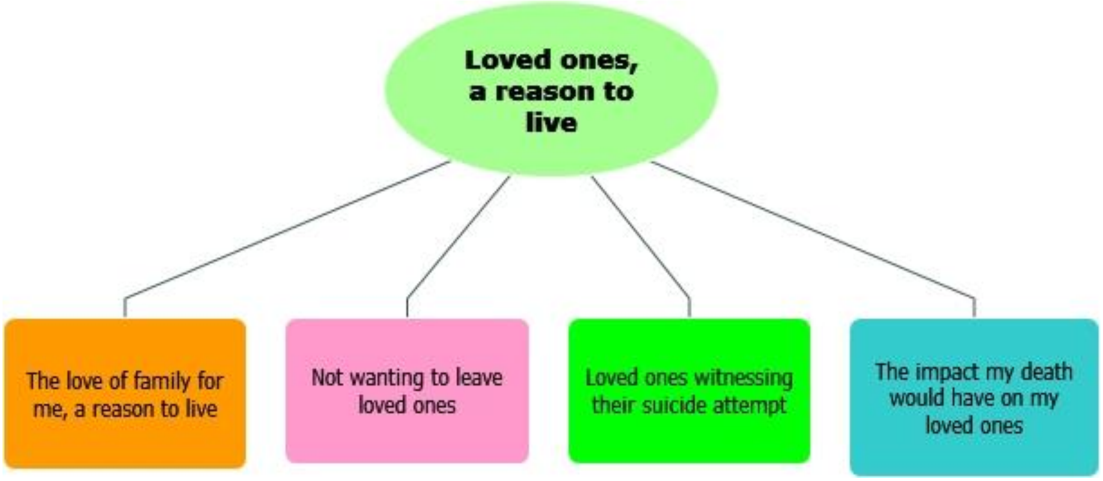
> for the better and I am just going to take the help that they offer me.'

Likewise, Mark experienced the hospital as giving him space to reflect, enabling 'the mist to clear a bit more.' Similarly, for Sophia, it had enabled her to make decisions about the future direction of her life: 'It has made me sit and think about it a lot more. There are certain things in my life that I want to end, but not my life.' Finally, Charlotte also experienced the hospital as providing the space to reflect and make choices, although chillingly, she chose not to share the content of her conclusion: 'It also gives you a chance to think, give you a moment if you see what I mean, (2) but I am not saying what I have decided.' (This felt uncomfortable to hear; however, it is always the patient's choice what to share of their experience. As researchers, we are there by invitation only and must not invade, see Chapter 11 Reflexivity).

7.4.6 Summary

For many of the participants interviewed therefore, the hospital offered them a place of refuge, a place where they could be safe from the dangers and the risks of ending their own lives by suicide. This was a place where their lives could be saved through medical care. It was also however, a physical space where they would be secure and protected from further suicidal attempts. Within this space they were safe from physical harm that would, outside, be conducted by themselves on themselves. Furthermore, they were safe from emotional harm that would otherwise be inflicted on them by people outside. Both the presence and the availability of staff were vital in offering that sense of safety, combined with the staff's non-judgemental attitude towards them. For many of these participants the hospital was experienced as a harbour from the storms of life raging outside, a space where they could take sanctuary and reflect and even make choices about their future. There seemed a deep longing among the participants to feel safe due to their fear of death. The hospital and its staff, for many participants, became that refuge, for that moment in time.

7.5 Loved ones, a reason to live: 'When it started kicking in, I started thinking about my family.'



7.5.1 Introduction

Within the interviews, many participants described how their experience of being in hospital following suicidal behaviour had caused them to think more about their loved ones. This aspect of their experience, as will now be explored, seemed closely connected with dying. Indeed, such experiences appeared to be significant for many interviewees, causing them to reconsider their past choices, with perceptions being accompanied by powerful emotions. Many of the participants revealed how their experience in hospital had brought about changes in their thoughts about their loved ones and their relationship to them. Furthermore, for some participants, this also caused an alteration in their perception of their future.

7.5.2 The love of family, a reason to live.

Several participants spoke of how the experience of being in hospital, during which they had come close to death, had caused them to realise, to their surprise, that their loved ones would indeed be incredibly upset if they died. Several participants interviewed were genuinely shocked that their loved ones truly did care about them and wanted them to be alive and well. Prior to this, participants like Naomi believed that they did not really matter to their loved ones, that they would not be missed if they died. In hospital however, as Naomi describes, she witnessed powerfully the love from her family, including from her children:

> 'I had always had it in my head that no one would be really bothered if I went, but seeing them and the way they were, made me realise that they cared about me more than I thought.'

For Naomi, this realisation that she did indeed matter, that her family did care about her, now became a reason to live, 'a purpose to keep going'.

Likewise, for Harriet, following this her first suicide attempt, the tears of her father, expressing his immense love for her, became the reason that she agreed to stay in hospital and to seek help:

> 'We talked about it for ages and in the end, I agreed to stay, but when I said that my dad started crying, it really shocked me. He said he was crying because he was so pleased that I was going to try and get the help that I needed.'

Seeing her father cry at her bedside on the hospital ward appears to have become a defining moment for Harriet, so much so that within the interview she kept returning to that moment: 'I keep thinking of him crying because he was so happy that I was going to get help. It really made me think.' The experience of her father's tears now seemed a powerful and shocking image that was engrained on her mind; the reason for her present desire to live and access help. At the time of her overdose, Harriet had not perceived the extent that her father wanted her to be well, or indeed his love for her; his tears had however expressed that love.

Simon also described how his mum wanted him to live, furthermore, it was her love for him, that made him keep trying to find help: 'To be quite blunt, my mum is the only reason I am still alive, honest to God, but I will keep trying for her.' For Simon however, in contrast with some other participants, this experience of being in hospital following his recent overdose, had not caused him to realise this. Indeed, it felt as if he had known for a while that his mum was the only reason he continued to come for treatment and to seek help: 'I didn't want to come into A&E, I never wanted to come but my mum made me, I wanted to kill myself. (2.5) I always just want to go home, but it is my family that make me wait.' For Simon, it felt that for him, it was out of duty, obedience, or love, or perhaps all three, that he was still living. If it were fully his choice, his suicide would now be fully complete. For both Simon and Harriet, their acceptance of help seemed to be driven by their awareness that their loved ones cared about them and did not want them to die. For several participants, like Harriet and Naomi, this awareness was experienced as a powerful revelation during their time in the hospital. For Simon however, perhaps due to his significant number of previous suicide attempts, he was fully aware that the love of his family for him was the only reason he was still in hospital, indeed, still alive.

7.5.3 Not wanting to leave loved ones.

Many participants also spoke of how during their time in hospital following their recent suicidal behaviour, they had experienced their loved ones occupying their thoughts in a more powerful way. For some participants this had also caused them to reflect on the importance and value they placed on having contact with their family and friends, and therefore also to question their wish to end their life by suicide. For example, Olivia spoke of how as she slipped into unconsciousness in A&E, thoughts of her family, and especially of her mother, flooded her mind. Furthermore, this experience seemed to have caused her to reflect in A&E on the importance of her mum to her:

> ‘And then a part of me was thinking about my mum and the children and my dad, I haven’t seen my dad in like four years so that’s fine. So, then I put him in the back of my brain and mind, but mother was in my mind, and I was like, I was just closing my eyes and thinking of her, and I blanked out. I just blanked out. It made me think about my mum more now and what she means.’

Likewise, Katie had experienced thinking about her family while she was in hospital. Being a mother of five children had been a struggle for her, but she now realised that she did not want to leave them. Furthermore, she recognised that her children were the most important thing to her.

> ‘So yeah, they are my world, my world, I have got [omitted to preserve anonymity], you know its hasn’t been easy, (3) it had been very hard sometimes, bring them up, but it is worth it. I am proud, proud that I did that. I look at them and I feel proud. But so yea, they are the most important people in the world for me. (3) I don't want to die and leave them.’

It seemed that being in hospital had caused her to think about her children and provided her with a reason to live, something that she was not aware of previously, due to the busyness of caring for her family and feeling desperately low. ‘I’ve been thinking of my children, but I also think at the time you are just so low, you just don’t think about those things, things just don’t come into your head.’ Being in hospital and coming close to death, had caused Katie, like other participants, to recognise that she no longer wanted to leave her loved ones.

7.5.4 Loved ones witnessing their suicide attempt

For several participants, a further reason for now seeking life, rather than suicide, seemed closely connected to the experience of having loved ones visit them at their bedside when they were very poorly, particularly when they were close to death. Witnessing family or friends standing around their bedside, seeing the pain and fear etched into their loved one's face as the effect of the suicide behaviour impacted, now appears to have become a motivating factor for some participants wanting to live. Many of the interviewees spoke of never wanting to have to witness that fear and distress in the faces of their loved ones again. For example, for Naomi, the image of the pain and anguish on her parents' face as they stood around her bed in A&E, seemed to almost haunt her. She returned to this image three times during the interview and clearly never wanted to have to witness this again.

> 'Being in hospital has given me a purpose to keep fighting for a better life. I don't want them to see me in this way again. It has given me a purpose to keep going and to keep fighting for a better life and to get the help that I need for the sake of myself but also for the sake of my family.'

Naomi's family became a motivation to live, having perceived their pain stemming from their love for her:

> 'Been thinking a lot about my family. Seeing my family upset when they saw me in hospital, the way they were looking at me and they did not know I was feeling the way I was. I don't want them to see me in this way again.'

Likewise, Katie described how she did not want her son to see her in A&E so poorly again, and indeed revealed how she felt responsible for what he had seen and the pain which she perceived she had caused him:

> 'He is like 19 but it was unfair of me to make him go through seeing me like that, it's not right. … I didn't want him to see that, I want him, what if I had of died? He would have been looking, he would have been watching, you know, (1) that's not fair, so yeah.'

Similarly, for Sophia it was seeing love, expressed as panic and fear, in her friend's face and his tears as she was in A&E, that caused her to feel distressed about what she had done:

> 'He was there, like not knowing what to do and it was the panic on his face, as well like, what am I doing like, seeing the pain in my friends like, if I had died, I know, I just wouldn't be able to, it didn't sit right with me. One of my friends was yea, and it was like really bad.'

Indeed, Sophia seems to suggest at one point that she wished her friend had not found her, such was her wish not to hurt or upset him by letting him see her dying:

> 'Seeing him like that was really bad, like I wish he didn't have to see, (2) and on the other hand if my friend had not had come to me, I wouldn't even be here so.'

As Sophia spoke these words, it chillingly felt as if she might be suggesting that if she was to seek to end her life again, she would ensure that it was impossible for her friend to witness it; sophie saying after some time to reflect: 'Perhaps that would have been better.'

7.5.5 The impact my death would have on my loved ones

For some of the patients, how their death would impact in the future on their loved ones, also seemed to have been brought powerfully into sharp focus while they were in hospital. Again, this realisation of the pain their death would cause their loved ones distressed them, and during their time in hospital, became a reason to question their desire to end their life by suicide. As Alex revealed: 'In my own head I just want to die, but something worries me about leaving my family and friends now and how it would impact on their lives.' Likewise, Naomi describes how in A&E, as she started to feel increasingly poorly, her thoughts turned to the impact her overdose would have on her family:

> ‘When I came into the hospital, I was very low because of what I had done, and I also felt scared about what might happen. When I did it, I regretted it, when I did it, I was not thinking about anyone else but after, when I felt it kicking in, I started to think about my family and everything else, what I was putting them through and how this would affect them.’

Likewise, on the Admission Ward, Harriet’s experience of the death of another patient, an elderly lady opposite, also caused her to reflect on how her own death would impact on her family. Witnessing the harsh reality of the death and the grief of another family mourning a loved one, shocked her and became a reason for Harriet not to give up:

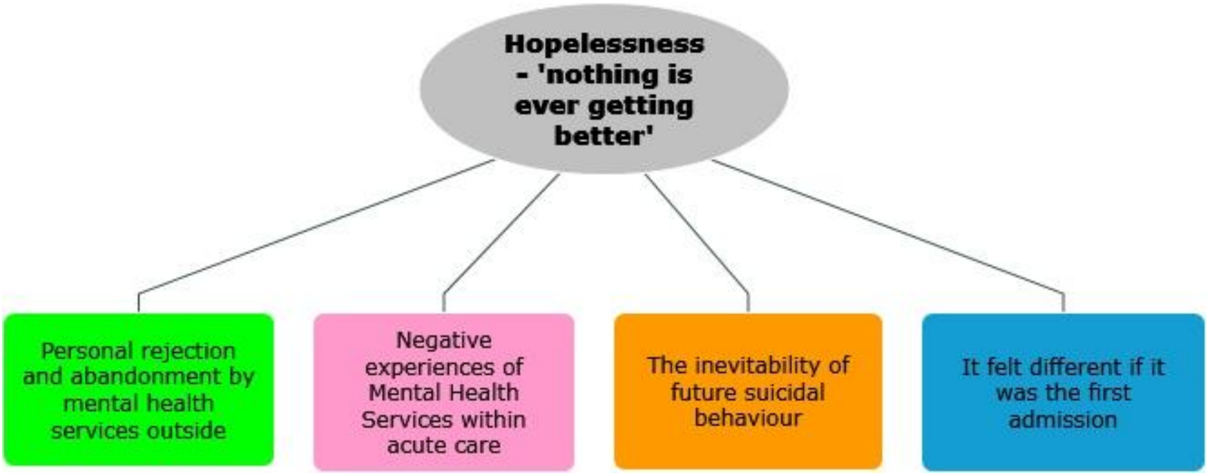
> ‘The other thing that made me think about getting the help, is that someone else died in the bay I was in last night. They were old yes, but it was horrible, and the family were really upset. They were all crying, I think it was unexpected, but that made me think too. If I died, it would hurt people, they would be upset, especially my dad and my sisters, this is really hard, but I need to try it for them, I know inside now if I had of died, they would have been upset.’

7.5.6 Summary

In summary therefore, for many participants, the experience of acute care, following suicidal behaviour, caused them to discover, or re-discover the belief that loved ones are a reason to live. Several individuals were surprised and shocked that their family and friends did indeed care about them and wanted them to live. Through being physically unwell, some participants realised, and witnessed, that their family and friends did not want them to die. Participants also perceived, within themselves in hospital, the extent to which their loved ones mattered to them; coming close to death seemed to cause them to realise what they would lose by dying. Furthermore, seeing the distress and pain on the faces of their loved ones as the effects of their overdose were experienced, also became a motivation to live. They did not want their loved ones to have to witness this again. Likewise, the experience of being physically unwell, had caused some participants to perceive the negative impact their own death would have on their loved ones.

Importantly however, although many of the participants wanted to be well and wished to escape future suicidal thoughts, many individuals also had little hope that they would get the help and support they perceived they needed to achieve this. The theme of hope and hopelessness is now explored.

7.6 Hopelessness – ‘Nothing is ever getting better.’



7.6.1. Introduction

Although the hospital was experienced as a safe place by the participants, most interviewees perceived no hope for the future in terms of their safety and wellbeing. As Lauren said: ‘I don’t feel like I have got a future as nothing is ever getting better, there is no hope.’ As will be explored within this section, participants felt rejected and abandoned by the mental health service, outside the hospital. Experience had taught the participants that there would be little or no help upon discharge. Furthermore, they believed that the standard visit from the Mental Health Team, while they were still in hospital, would be pointless. The consequence, therefore, would be that they will inevitably seek to end their life again through suicide; that was their destiny. A very powerless and hopeless position. Overall, the outlook was experienced as incredibly bleak for thirteen of the sixteen participants interviewed. Only two participants, for whom this was their first hospital admission due to suicidal behaviour, seemed hopeful about their future.

7.6.2 Personal rejection and abandonment by mental health services outside

The participants' experience of hopelessness appeared closely connected to the belief that upon leaving the safety of the hospital, there would be no further effective mental health support for them. Several participants described how their family hoped that they would get the help they needed, but this hope was rarely shared by the participants themselves. Their past experiences had taught them this 'truth', and they were living witnesses of it. They had tried to seek help on numerous occasions, following previous suicide attempts, but to no avail, resulting in them now feeling totally despondent. As Simon said: 'My mum wants me to get help, but that won't happen.' Indeed, Simon spoke at length about how he had tried to get help and support, but had just been passed around between different services, constantly being rejected. Indeed, such experiences had resulted in him feeling that no one wanted him:

> 'I have been sent to one treatment team who said I was not severe enough for their team and then to another who said that I am not mild enough for their team, the same stuff. … I have been in and out of services since 2015, I get passed from pillar to post, people saying that I need more help than they can give me, and then you go somewhere else, and they say you are not severe enough. No one really wants me.'

For Simon, it felt like he didn't belong anywhere and for the past four years professionals were just looking for excuses not to help him; how to be able to cross him off their list and pass him on to someone else. As a result, he felt abandoned. Likewise, Alex described similar feelings around seeking help, trying repeatedly, but always failing:

> 'Many many many times I have tried to get help but, in the end, you just come back to stage one, and you end up going through it all over again, over and over and over and over again. The mental health help is not as it should be, they just move you from pillar to post and then they just discharge you and you are back at square one again.'

As Alex used those words, ‘over and over and over and over again’, she sounded so weary and disillusioned. It really did feel hopeless for her. It felt like she had tried so hard, so many times, that she had now given up all hope of finding help and support. Similarly, Lauren spoke powerfully of her struggles to find the help she needed. Lauren perceived that she had been discharged from a Mental Health ward because she was too much of a ‘risk’; they did not want someone who might kill themselves on the ward. Again, she felt rejected and abandoned by mental health services, and this rejection felt deeply personal, they did not want her:

> ‘If you tell them how you feel, even on a mental health ward, they just say that they will discharge you if you are at risk to yourself, as it is not their responsibility. But you wouldn’t be in [a mental health] hospital if you didn’t need to be in. They don’t want the responsibility when you do it in there. They don’t want you.’

For Lauren, this sense of rejection in the mental health hospital, was felt in contrast to being on the Admission Ward: ‘It has been all right on here … in other hospitals people treat you different because of Mental Health, but not felt that here.’

Likewise, Simon described many broken promises in terms of accessing mental health support, for example: ‘They have promised for years that they will give me a psychiatrist, but I have never seen one’. For Simon, this experience had resulted in a familiar cycle of suicidal behaviour and readmissions into acute medical hospitals, with only one other possible alternative - death: ‘I feel I will be here again, not next week, but next month or just after, or dead.’ Simon wanted to have appointments, to see people, to access help, but there was no means within his control of achieving this goal. Therefore, the only other option for him, the only choice he had, was suicidal behaviour, the completion of which would mean death. That was the only way to end his suffering.

Sophia had a similar perception of being passed around different services, rejected, and abandoned:

> ‘I kept like being pushed to different persons and that was it. … They told me that there was nothing they could do for me except therapy and then they didn’t give me therapy, they just stopped giving me appointments.’

For Sophia, she had been told what she needed, she needed therapy, this would help her, however she could not have it. It was not available to her and therefore her appointments were stopped. The road to feeling better, was blocked. The route to ending her pain, mapped out, but access denied. Reflecting the experience of other participants, Sophia felt abandoned by the Mental Health Services and consequently the future was perceived as hopeless. Furthermore, as for other participants, this abandonment and rejection felt deeply personal, ‘they could not help me.’ It was a rejection of her.

7.6.3 Negative experiences of mental health services within acute medical care

Participants also described negative perceptions of the Mental Health Team that visited them on the Admission Ward, to undertake their ‘psychological assessments’. For example, Charlotte spoke of how the mental health staff simply ‘never listen’ to her. Indeed, for Charlotte, the whole encounter was simply a ‘tick box exercise’. They ‘read the usual list of questions’, announce the word ‘safe for discharge’ and leave. As Charlotte perceived it, there was no empathy from the Mental Health Team and no encountering her as a person. Furthermore, this also made her feel abandoned. Likewise, for Lauren there seemed little point to the Mental Health Team coming to assess her at all, ‘mental health don’t do anything they just say right, discharge you!’ For Lauren as for Charlotte, the word ‘discharge’ felt like she was simply being dismissed, her need for help and her suffering being disregarded, perhaps even snubbed. Similarly, Alex said: ‘They come and just discharge me and send me home when I know I need more help.’ Likewise, Simon said: ‘I think it will be the same outcome again, the same thing, I will just get discharged, it's the same stuff every time.' For many participants, that word 'discharge' felt like a deep personal rejection. The sound of this word seemed to destroy any sense of hope that they were clinging to, that they may be offered help - a mental health bed, an appointment, some therapy, someone to take their suffering seriously, some help, any help. It also felt as if the Mental Health Team had all the power, the participants lying in bed waiting for the judgement to be given. The participants seemed helpless in terms of accessing the support that they felt that they needed, whether it was therapy, medication review, or a mental health bed. The power rested totally in the words of the professionals.

7.6.4 The inevitability of future suicidal behaviour

The consequence of the perceived lack of care from the visiting Mental Health Team in hospital and the lack of mental health support available to the participants outside was powerfully stated by Ellie:

> 'My mental health crisis is still the same as I won't be getting the help I need; I will be back in here at some point soon (3) ((Ellie looks down and speaks quietly)) or dead. I know I won't get the help; everyone is not happy about me going home. The future, feels, (3) dreadful, like (1) I dread it.'

Ellie's use of the word 'dread' felt dark, heavy, and threatening, with a sense of inescapability about it. Indeed, the inescapability of future suicidal attempts and even death, was echoed by other patients, due to the perceived lack of mental health support. For example, Lauren said:

> 'I do feel let down, massively, my future is not hopeful at all because there is no help for people like me. I am a massive danger to myself. (3) Yes, ((Lauren looks at me straight in the eye)) it will happen again.'

Lauren’s use of the phrase, ‘no help for people like me’, powerfully expressed the feeling that there is nothing, and no one, who will help people like her struggling with mental health problems and suicidal thoughts. Lauren desperately wanted to be well enough to get back to the nursing that she loved, but hope had been replaced with abandonment:

> ‘There just isn’t any mental health, I don’t want to be in a hospital bed, I want to be back at work doing my job, looking after other people as a nurse, but I can’t do that without help and I can’t get any mental health help. You spend your life looking after other people and no one is there to help you.’

Lauren felt massively let down by the NHS which she worked for. It was so painful and frustrating for her as she perceived that if she could only get some help and support, she could be better, she could get back to work, doing the job which she loved so much. Furthermore, for Lauren, this experience of being let down by the NHS, felt especially raw as it was an experience at work, that had caused her to suffer. ‘If you get a physical problem caused by work you get so much more help, like physio, but not if it is mental health.’ She felt abandoned by the NHS that she loved and worked for.

For many of the participants therefore, it felt that they were desperate for help, but knew from experience none would come. As Alex described: ‘I will accept help, any help! The future is a dangerous place for me. I can’t get the help and support that I need when I am out there.’ Alex was so desperate that she would just accept anything, anything that would offer her just the smallest ray of hope in her darkness. She also knew however, that she could not access that support. Future suicidal behaviour was therefore inevitable, or death.

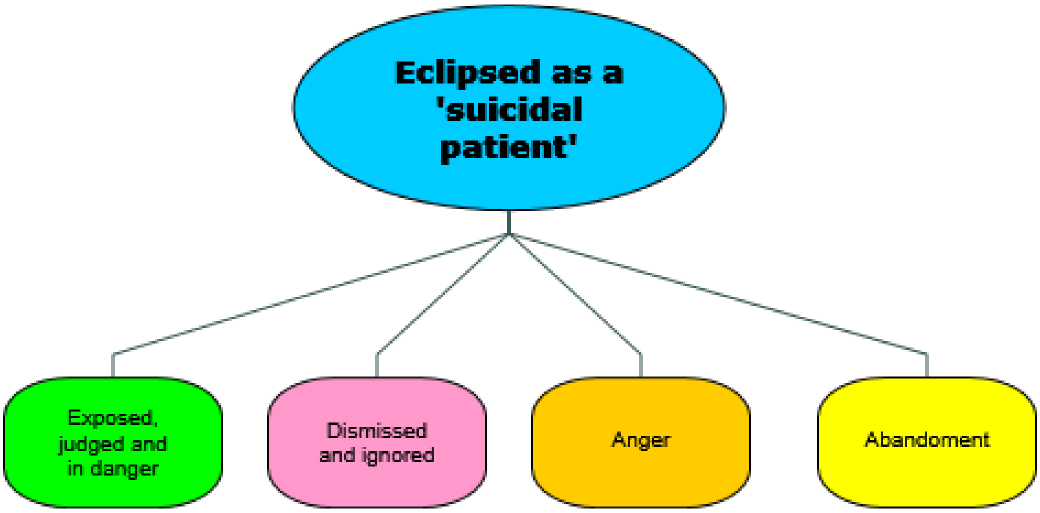
7.6.5 It felt different if it was the first admission

Among the two participants however, for whom this was their first admission to hospital following a suicide attempt, there was a significant difference in their perception of the future. For example, during the interview Harriet seemed confident that she would receive help and support and therefore be able to overcome her mental health problems. Indeed, Harriet appeared to perceive that it was purely the case of agreeing to 'stay to get some help' and this would enable her to become well. Furthermore, such a perception was endorsed by her father, who began crying when she agreed to do this, 'he was so happy that I was going to get help.' During the interview Harriet spoke about her plans for her future, of her 'need to move forward and sort this out' and how she wanted to come back to see the staff to say thank you for what they had done. For Harriet, her time in hospital felt a turning point, a moment of change, where she would accept and receive help to transform her life. Likewise, for Katie, the only other participant for whom this was their first admission due to suicidal behaviour, there was also a clear belief that this was an experience that would not be repeated for her: 'I definitely won't be here again, no, this was the first time and there won't be another.' Like Harriet, Katie seemed confident that she would be able to access support from mental health services: 'I am just waiting to see mental health and then I can get some help and get better.' Indeed, the different perception of the future, between these two participants and the other interviewees, was profound. Katie and Harriet had hope in terms of accessing support that would help them, while for all the other participants, their experience had destroyed that hope.

7.6.6 Summary

Except for Harriet and Katie, every other participant seemed to perceive the future and the present, based on their past, as offering no hope in terms of accessing help and support. The participants interviewed desired, even craved help, as Alex said: ‘any help’. They reported that past experiences of mental health services both within and outside the acute medical hospital, were wholly negative. Their lived experience of the past had diminished any hope that they would obtain any effective support and help. As a result, these participants felt rejected, and abandoned, furthermore, these feelings were experienced as deeply personal. For fourteen of the sixteen participants, the future was partly perceived as one of either returning to acute medical care, following further suicidal behaviour, or death itself. For some, suicide appeared to be the only option after a long, exhausting, and impossible battle to get help.

7.7 Eclipsed as a 'suicidal patient'



7.7.1 Introduction

Six of the sixteen participants included within the study perceived that they were treated differently due to their recent suicidal behaviour. As will be explored in detail within this section, such perceptions seemed to be connected to a belief that staff and other patients held negative opinions towards them, due to their recent overdose. These participants felt exposed and judged, particularly within the A&E department, which resulted in a feeling of being in danger. One of the participants also perceived that her views were dismissed and ignored because of her recent suicidal behaviour, which seriously impacted on her medical treatment. Overall, such experiences caused two participants to feel angry and others to feel abandoned. As will be discussed, being perceived as a 'suicidal patient', for these participants, seemed to eclipse who they were within the hospital in a negative manner.

7.7.2 Exposed, feeling judged and in danger

Jasmine described one of the strongest emotions when entering the A&E department following her suicide attempt, was a feeling of embarrassment. Indeed, Jasmine describes such feelings as obvious, suggesting perhaps that for her, this feeling should indeed be clear for everyone to imagine and understand, such was its strength:

> 'Obviously, I was feeling embarrassed when I came in and things like that because my friend was the one who rang up and like basically dragged me to hospital, um so I was like feeling quite embarrassed ... I kind of felt silly.'

Jasmine did not want to come into hospital and such feelings seemed closely connected with the sense of people looking at her and judging her for what she had done. She felt 'silly', perhaps because she perceived that people judged the reason for her attendance as foolish, even childlike. 'I just felt like everyone was watching me and I couldn't relax, felt like people were judging me and sort of thing.' She would have much preferred to hide away at home, embarrassed of her actions. When asked how this made her feel, Jasmine simply, but powerfully replied: 'It made me feel rubbish, (4) rubbish'. Indeed, Jasmine's use of the word 'rubbish' perhaps expressed how she felt worthless or useless following the 'silly' action of taking the overdose. A perception perhaps also influenced, by her belief that the overdose, and therefore the reason for her attendance at A&E, was 'my fault'.

Katie also described similar experiences of being looked at and judged by those around her:

> 'You feel like everyone is looking at you, like everyone knows. … Like oh my God, they would be thinking what has she done, look at her, like they were judging me.'

As Katie talked about this experience there was a great deal of anxiety within her voice as she seemed to re-live being in A&E, and the feelings connected with people looking at her. Katie looked physically anxious, clawing at her hands as she spoke. She seemed to be aware, that upon reflection, other people probably were not all staring at her or commenting about her, but that is how it felt at that moment and in the retelling of that experience. Indeed, Katie used the word 'paranoid', a word that suggests a feeling that you are under persecution, but also a feeling that is exaggerated (Allen, 1987). As Katie later reflected in the interview: 'Umm, (4) it made me feel crap, worse, they probably weren't looking at me, it was probably just me, (3) paranoid.' For Katie, the thoughts of being judged and paranoid were most strongly linked with the physical A&E environment, due to its busyness and the proximity of other patients and staff around her. For example, Katie described how in A&E she felt 'exposed', with people in the department 'walking up and down … looking at you.' Katie's use of the word 'exposed', perhaps suggesting a feeling of being left 'without shelter or defence … to lay open to danger or ridicule' (Onions, 1973, p.707). Indeed, such a word seemed to powerfully express Katie's experience of being open to criticism or even attack, as other people could see her within the Emergency Department. Her exposed presence evoked judgement, and criticism, 'look at her', which resulted in feelings of danger. She was frightened by her exposure to other people's opinions and judgment. Indeed, Katie spoke of being immensely relieved that she had not been placed on the corridor in A&E, as other patients were: 'I was in a room, I wasn't on the corridor, so thankfully (3) that would have been awful, wouldn't it?' Katie seemed very relieved when she was interviewed that she was no longer in A&E but in the Assessment Ward: 'No it has been fine here, it is a lot better here ((said with relief in voice followed by laughter)).'

By contrast however, other participants were placed on the corridors in A&E while undergoing treatment and waiting for an admission bed, an experience that seemed to increase perceptions of being exposed and judged. For example, although Naomi was first placed in a side room on A&E, she was then moved onto the corridor where she described feeling that people were watching her, talking about her, and judging her, this causing her to feel anxious:

> ‘It was so busy, that made me feel anxious, people were watching you, made me really anxious. I was in a room on my own originally but then they moved me out onto the corridor, and I felt that everyone was looking at me, thinking why is she here, what has she done, why has she got that drip attached to her.’

Indeed, on the corridor Naomi seemed to almost think that people ‘knew why I was there’. Perhaps Naomi believed that having a drip attached to her gave the reason for her presence in A&E away, hence her reference to it. She seemed to believe that people were looking at her, wondering why she was there. They would guess, and then negative judgment would inevitably follow.

Mark also perceived being ‘watched by other people’ when he was on the corridor in A&E, having people ‘at the side of you and walking past you’ and ‘judging you’, again increased for Mark his feelings of being in danger. When he was moved to a side room, Mark felt ‘safer’. Like Katie noted above, Mark seemed to link being judged with danger, being unsafe; on the corridor he was exposed and therefore at risk. Likewise, Trevor experienced similar feelings when he too was placed on the A&E corridor waiting for an admission bed, a place he termed, the ‘hallway.’ On the ‘hallway’ Trevor perceived that people were ‘making fun at me and looking at me’, which caused him to feel ‘terrible’. For Trevor, the judgement he experienced also seemed slightly different from other participants. Along with judgement and being looked at, Trevor sensed people mocking him, laughing at him, deriding him. ‘Everyone was looking at me and walking past and looking ... making fun.’ Trevor describes how he could feel ‘the pressure and anger building up in me as I was stuck in the hall in a bed.’ These were intense feelings, from which he needed to escape, Trevor describing how he took another overdose while on the ‘hallway’, seeking to end his life and therefore to escape that ‘terrible’ experience. Such was the anxiety and terror caused by being on the 'hallway', suicide seemed the only way out for Trevor at that moment: '[I] was stuck in that state, it was very depressing, and all sorts goes through you. I tried to take an overdose, I did it at home, but I tried again in the hall.' Trevor was seeking to hide away permanently from the exposure and judgement of others.

On the Medical Ward, participants seemed to feel less 'exposed', Lauren describing the ward as 'really peaceful'. Safeguarding regulations, however, were perceived by some participants as preventing them from having the same level of privacy permitted to other, non-mental health patients, as Jasmine described:

> 'I asked one of the ladies if she could like close the curtain a bit so I could get some sleep, and she said 'um, no'. So, I am guessing that is just a safety thing so they can keep an eye on me, so I understand that, but I didn't feel the most comfortable…'

The reason for her admission affected Jasmine's physical experience of being a patient within the hospital. She had to be in view of others, and although rationally she seemed to understand that this was for her 'safety', it made her feel uncomfortable and different. As other participants had described being exposed in A&E, on the ward Jasmine used the same word: 'I was like in the middle bay and all the curtains were open, so I just felt like, I don't know, a bit exposed sort of thing.'

For two participants, their feelings of embarrassment where also significantly enhanced by staff talking openly and loudly about their suicide attempt on the ward, within hearing distance of other patients. For example, as Jasmine described:

> 'When they were passing the notes over, they were talking about me quite loudly and I could hear everything they were saying about my situation, and I am sure people around could, and so I was just a little like, so I think that is why I was more aware of everyone around me.'

Jasmine described how, as the staff talked, they kept 'repeating what I had overdosed on … other patients could hear it.' Interestingly, although

Jasmine seemed to find this uncomfortable, she also seemed to simply accept that this is what happens. Indeed, she spoke about how the doctors did the same with other patients, but because of the reason for her admission, this was particularly uncomfortable for her. The experience also had a lasting effect long after the doctors had left Jasmine, causing her to be 'more aware of everyone around' her. People in the bay knew about her suicide attempt and she perceived judgement. Furthermore, Jasmine also experienced staff talking about her differently, frequently using the word 'strange' in conversations that other patients could hear. For Jasmine, such experiences made her feel 'uncomfortable' and that she was 'different', perhaps also increasing a feeling of not belonging in the hospital. These were medical doctors, and she was in a medical hospital, and she sensed she did not fit in, and they did not understand. Rather than talking about medical conditions, as with other patients, the doctors had spoken about her personal life and personal difficulties. She perceived that she was different to all the other patients.

On the Assessment Ward, Mollie, also described a similar experience during the morning doctors' round:

> 'He was talking really loudly about what had happened and everything, talking loudly and everyone could hear him, and it is embarrassing, everyone knows now what happened. … He did not try to disguise his voice or anything and the curtains don't stop it. I know what happened anyway I didn't need him telling me and everyone else what happened. … He was talking about personal stuff and everything, telling everyone what had happened. Because you have done this and taken these tablets, but I already knew what had happened without him telling me and everyone else ((participant looks upset)). He did not have to say all that did he, obviously I knew all that, but he did not have to say it. Now everyone knows and it is embarrassing. '

For Mollie, having the events of her recent suicide attempt shared in earshot of other patients, including the sharing of 'personal stuff', was clearly distressing for her. Like other participants, because of the doctors talking 'really loudly about what had happened and everything', she now felt embarrassed. Furthermore, Mollie believed that this was unnecessary, she was fully aware of why she had been admitted into hospital and believed these conversations could have been done much more discreetly. The impact on Mollie of this experience and feeling exposed was significant, she described how she 'wanted to hide away', 'I don't want to see people', she just wanted to be 'isolated'. It seemed that such feeling came from a profound sense of shame, following her exposure, caused by the loud voices of the doctors. For Mollie, lying in the bed, amongst other patients who knew about her recent suicidal attempt was now incredibly hard and she did not want to be there. Like Trevor, she also felt trapped, unable to escape the judgment of others, as she perceived it. Indeed, Mollie spoke about wanting to leave: 'I don't want to be on here, it's all overwhelming, and confusing, I have strangers in my face, people I don't know, I don't like being trapped, but I feel trapped, I just want to get out of here.' For Mollie, it felt like there was no escape from the judgment that she perceived had being poured upon her by the doctor and those around her. She had to continue to lie there, with no way to escape, now fully exposed and powerless.

7.7.3 Dismissed and ignored

One participant perceived that it was because of their recent suicidal behaviour that their views were dismissed and ignored, even in matters concerning their own medical care. For example, Lauren spoke of how although initially attending A&E due to an overdose, while within the department she experienced a severe asthma attack, a chronic condition that she described as suffering with most of her life. Despite her desperate attempts to inform staff of this, her condition was repeatedly put down to her mental health problems and her anxiety:

> 'I was trying to tell her that I couldn't breathe! I felt like she was not listening to me, like all my problems were mental health, all

> she could see was that label, not that I have asthma as well. I felt like she was not listening because of my mental health problems.'

Lauren described how, alarmingly, her condition continued to deteriorate, to the extent that she was moved into the Resus area in the Emergency Department. Within Resus however, even with different staff members, Lauren believed that her status as a 'suicidal patient' continued to impact detrimentally on her medical care, and, that she was lied to about her treatment. Lauren described being told that she was being given an antibiotic, when she was being given diazepam:

> 'I was agitated because I could not breathe because of my asthma, but they thought it was my mental health when it was my asthma and just kept telling me to calm down. If I needed diazepam and if she told me that she was going to give it me, I would have taken it. She said she was giving me an antibiotic.'

7.7.4 Anger

Within the above quotation, the way in which Lauren used the phrase 'she' to describe the nurse who was assigned to her, expresses the anger she felt towards this nurse. She had dismissed her views, ignored her, and lied to her, and she was angry. This was a feeling that she later openly and powerfully voiced in the interview as she returned to this incident:

> 'I was so angry; I would rather people tell me what they were doing to me. I was cross, she definitely said she was giving me an antibiotic, but later told me that she had given me diazepam. It just made me angry that she lied to me ((Lauren clenched her fist and hit her bedside locker hard)).'

Anger was still very much present for Lauren, even though she had moved out of Resus and was on the Assessment Ward; the past, powerfully impacting on her present feelings.

Ellie also described how she felt angry due to her experience of being judged by staff due to her recent suicidal behaviour. For example, Ellie described how she wanted to ‘punch’ one of the nurses in the emergency department:

> ‘One nurse was so patronising to me, she had attitude with me, said “I have a degree”. She was horrible, it made me feel horrible, agitated, wanted to punch her, she said something else, but I can’t remember it. She was horrible.’

It seems that for both Lauren and Ellie, the result of being judged and dismissed due to their suicidal behaviour, was an experience of physical anger.

7.7.5 Abandonment

Along with feelings of anger, patients also described feelings of abandonment by staff. Within his interview, Trevor constantly kept returning to this theme, believing that staff were spending more time with other patients and avoiding him, because of his recent overdose. First, on A&E Trevor recalled being placed on the corridor: ‘Nobody came back to tell you what was happening, I was just alone, no one was with me, I was just crying and screaming but nobody was bothered, I was 6 hours in that way.’ Trevor seemed to perceive that the staff were just not interested in his pain. He was abandoned to his suffering. Later in the A&E department, Trever was moved to a cubicle, but again: ‘When I was in the room in A&E, they shut the door and just left me for hours, no one came to check on me.’ Furthermore, on the Admission Ward, Trevor shared a similar experience:

> Feel like everyone else is noticed more than me, perhaps they have too much work, no one had been down to talk to me, they seem to talk to everyone else, they just give you the medicine and then they walk away. I think I get treated differently because what I have done. They don't like it.

Trevor desperately wanted the staff to come and talk to him, to have a 'laugh and a joke' or even to just 'say hello when they start shift, that would be good'. Indeed, Trevor even believed that such interaction 'would help make you better than tablets', instead however he felt like he was being treated like an animal: 'I feel like an animal in here or a caged bird, they give you the food to keep you alive and the water and that's it.' Only his most basic physical needs were being looked after, no one was concerned about anything else, including how he was feeling. He was just being kept alive within a situation from which he could not escape. Indeed, Trevor described how staff would approach his bed and just ask a 'single question', never enquiring about how he was feeling. Such feelings of rejection were compounded by his belief that during his time on the Admission Ward, staff were willing and able to spend time with the other patients but 'avoided' and 'ignored' him. Trevor noticed the difference, and he yearned to be like any other patient on the Admission Ward, for staff to talk to him like they spoke to the other patients, 'that would just make me feel happy if they did that.' Instead, he felt deliberately abandoned by the staff, which resulted in increased feelings of being invisible:

> 'I have not found one person who wants to talk to me and that just makes me more depressed, I have been on this ward for 2 days and no one has come to talk to me. It makes you feel bad, like I am not here.'

Furthermore, the experience impacted on Trevor's perception of the future. Trevor now determined that he would not be returning to hospital again, even if it meant that next time he would die: 'The way I have been treated here, next time I will stay at home, (3) we all have to die.'

Similarly, Lauren longed for staff to get to know her, not as a 'mental health patient', but as a person, to see beyond the reason for her admission to hospital. 'I feel like if they got to know me ((Lauren points at herself)), it would make life much easier as they would understand stuff.' She believed that this would improve her experience of care:

> 'I have flashbacks, lots of flash backs, I get agitated and upset but when it is happening, I can't tell them. So, when it happened last night, they just left me to it. I felt sort of annoyed, abandoned.'

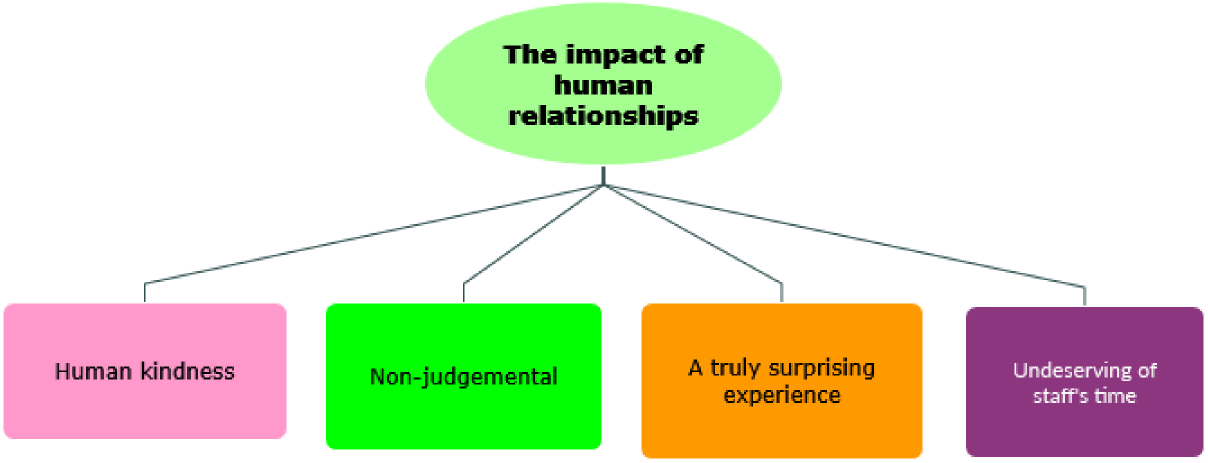
The word abandoned is a strong word, that the Oxford dictionary (Allen 1987) suggests means forsaken and deprived, but perhaps that is how participants like Lauren and Trevor felt. Forsaken by staff and deprived of simple human contact and support; their suicidal behaviour eclipsing their being.

7.7.6 Summary

In summary therefore, six participants perceived that their experience of care within the acute hospital had been negatively affected due to their recent suicidal behaviour. Participants felt exposed and judged by staff and other patients, resulting in a feeling of being in danger. Participants were embarrassed and ashamed of their actions and wanted to hide away, not to be seen, to be invisible. That was the only way to feel safe. Such experiences seemed especially connected with being in the busy A&E department, enhanced for some participants by being placed on the A&E corridor or 'hallway'. Here people were very close to them, people could see that they were on drips, the other patients were wondering why they were there and guessing; the negative judgements would inevitably follow. Being on the corridor therefore heightened the feelings of being in danger. Such feelings of exposure were further enhanced for two participants who experienced staff talking openly about their condition and the reason for their admission, within the hearing of other patients on the ward. For Lauren, her suicidal behaviour also caused her to believe that staff dismissed her views. Being treated differently because of their intentional overdose, caused two participants to feel very angry, however others felt abandoned, forsaken by the staff. For Trevor this experience resulted in a belief that he would rather die than return to hospital.

Strikingly, interviewees, although being ashamed and wanting to hide away, also seemed to want staff to talk to them, to listen to them and to engage with them as people beyond the medical label. Something which when it did happen, as will now be explored, had a profound positive impact on the participant’s experience of being in hospital.

7.8 The impact of human relationships: 'Better than all the counsellors.'



7.8.1 Introduction

A theme that many participants appeared to connect high levels of emotion to during the interviews, was the experiencing of kindness from hospital staff. Indeed, when such moments of kindness were described, it frequently caused the interviewee to shed tears. Furthermore, such expressions of kindness from staff were often recalled by the participants as only lasting for brief moments but were experienced as significant.

7.8.2 Human kindness

Perceptions of kindness appeared particularly related to encounters with staff who seemed to understand or appreciate their feelings; the member of staff communicating this to them, often via a few words or a simple human action. For example, Mark described one such encounter in A&E:

> 'The doctor and the nurse that looked after me were really nice, the nurse especially. She said that she had been through similar things

> and if I ever needed to talk, to ask as she was around. That one thing that she said was better than all the counsellors that have been to the house, it made me feel like I was not alone, and someone cared.'

For Mark, the sense that the nurse appeared to understand because she had also suffered with similar things, and that she offered to spend time with him and to talk with him, had a profound impact. It made him feel as if one person did actually care about him; this brief human encounter becoming an experience that Mark clearly treasured. Within his interview, Mark suggested that he had suffered with mental health problems for many years and subsequently had received countless visits from professionals to his home. This encounter in A&E however, with a nurse who seemed to know how he felt, he described as much more valuable than all those visits. Indeed, during the interview, Mark became very emotional when sharing this encounter; the feeling that he was not alone and that someone understood, impacted on him enormously. He seemed to feel a connection with this nurse through their shared lived experience. Interestingly however, Mark never did call that nurse back and have a conversation with her, but that did not seem to matter. What appeared to be of importance for Mark and what made this encounter meaningful and unique, was that this nurse seemed genuine. Likewise, Mark recalled an encounter with an A&E doctor as he was about to leave the department and move onto the Assessment Ward, which again brought him great comfort and peace: 'The doctor was really respectful as well, he took the time to say that he hoped that I got better, and you could tell that he meant it. It made me feel more relaxed and content and peaceful.' Simple words of kindness clearly therefore impacted on Mark deeply. Again, it seemed significant that the doctor's words were experienced as genuine.

Similarly, Noah revealed two positive encounters with staff on the Assessment Ward, both linked to nurses expressing what he perceived as genuine kindness. First Noah, who had attended hospital following an intentional overdose on several occasions before, described how a member of staff from the 'other side' of the unit, came to visit him when she recognised his name on the inpatient list. 'She came to see me and asked me how I was doing and stuff … Yea, it's good, yea it does make you feel good, really good.' Significantly, the impact of this visit seemed to change Noah's thoughts about the future, giving him hope:

> 'Obviously, it makes you feel like they care and stuff and (2) it is not just their job for them, they are doing it because they are passionate about what they do, and they care. (3) Yea it makes you feel positive, a lot more positive than I was feeling. Like there are people out there that do care, they are not, they are not just out for themselves. … They made me feel a lot more positive and stuff and you know that it is not just down to medication that can heal you. Maybe talking or other things.'

What seemed significant for Noah, was that this member of staff was not just doing their job, but rather that they genuinely cared. The member of staff had made the effort to come and see him when she did not have to; he mattered to someone. Furthermore, this encounter seemed to change Noah's experience, it caused him to feel positive. For example, to feel that not everyone in the world was 'just out for themselves'. To even wonder if there could be other things that could help him apart from medication. Indeed, to consider that talking about his feelings and experiences might help. Perhaps even that there might be other options to suicide.

Secondly, Noah recalled another encounter with a member of staff who was perceived as offering something of his personal experiences and struggles with mental health, following his own active service in the military. Once more, the impact on Noah was significant and made him feel more hopeful about the future and to consider possible alternative forms of treatment:

> 'Its, it's just like one of the staff who also served out in [omitted to protect anonymity] like me, um, and he explained he has had counselling and stuff, he was in a similar situation to me, and he

> has come out the other side. He told me what happened to him. It is positive to hear stories like that. (3) Because there is not many stories that I have heard of like that you know. So, when you hear it is positive. (3) Yea it makes you feel a lot more positive and makes you think about talking and stuff, (2) this is not the only way.'

It seemed that this encounter with a member of staff who had a connection with him, having also served in the same region as Noah within the military, and having experienced similar mental health problems, made Noah identify other options apart from suicide. This seemed a profound encounter. Noah seemed to perceive that these encounters were not just with a member of staff, but with individuals who really cared and offered something of themselves to him. They were individuals who wanted to help him, and that made a difference, giving him hope.

Of course, not all staff have personal experience of being suicidal, however, for Elizabeth, what she perceived as important was that staff tried to understand, even if they had not been affected by mental health problems themselves. Indeed, that willingness to listen and understand made Elizabeth feel less alone and comforted:

> 'Here ((Assessment Ward)) they have been really welcoming and understanding and include you in all the conversations, so you are not on your own, it does feel like they try to understand it even if they have not been through it themselves, they go out of their way to try to understand. It gives you a bit of comfort.'

For Harriet, the kindness of a member of staff also impacted on her significantly, and indeed made her determined to keep living that day. Within Harriet's experience, it was partly the action of a member of staff who was determined to find help for her before she was discharged, that moved Harriet emotionally.

> 'The other thing that has made a big difference is my nurse, she has been really kind, really helpful, like she wanted me to get better as well. She has got onto my GP and booked an appointment for me tomorrow afternoon, so when I go home, I can

> go and see him and he is really good but normally you can't get to see him, but she was on the phone ages and arranged it all! She also gave me a leaflet with some numbers on for charities which I am going to get in touch with. I just really hope I can do this, but I need to do it for my dad and the staff here.'

The time spent by her nurse trying to access help and support for Harriet upon leaving the hospital, seemed to give Harriet the motivation to get better, partly for her dad, but also out of recognition for what the staff had done for her. The nurse's action and persistence were experienced by Harriet as an expression of care for her.

Likewise, Jasmine appeared to equate kindness with the action of staff talking to her, not particularly about her mental health, but rather staff simply being interested in her and taking the time to listen. Furthermore, Jasmine experienced such moments as times when she could forget about her overdose and the problems she faced outside:

> 'I had a conversation with one ((member of staff)), they were asking about my children and things like and er, and yea. I think it just puts you at ease and makes you forget why you are here if that makes sense, it just takes your mind off it …'

Likewise, Simon described a similar experience: 'The A&E staff were very nice, very chatty which makes you forget about why you are there and makes you feel better, it makes you feel all right, they kind of distract you from your thoughts and your mood.'

7.8.3 Non-judgemental

Participants also appeared to value staff who were non-judgemental; interviewees being fearful of being criticised due to their recent suicidal behaviour. For example, as Sophia commented: 'I was scared of being judged, definitely, but it wasn't as bad as I expected. I expected it to be all cold and harsh, and just mean, I just expected everyone to be nasty.' Likewise, Naomi seemed to expect judgement, but experienced understanding which enabled her to feel supported and gave her hope for the future:

> ‘They have been really nice in here, no one that I met was judgemental or anything like that, made me feel better, like no one is judging me why I am here. Makes you feel like someone is there for you and you are going to be alright.’

For Naomi, this expectation of being judged seem to come from her own personal experience: ‘In the past when I have spoken to people about things, they have been so judgemental.’ Indeed, Mollie said that it was because of the fear of being judged due to her overdose, that had caused her to ‘worry … when I came in here’. By contrast however, rather than experiencing judgement, she experienced understanding and warmth: ‘The staff are friendly and helpful and made it better, more welcoming … they have been kind and the things they have said are kind.’

Participants seemed to value being treated the same as other patients, as Katie explained: ‘The most important thing is just to be treated like everybody else, not judged, don’t treat me differently, they haven’t, um, smile, be happy!’

7.8.4 A truly surprising experience

Many of the participants however, when experiencing kindness, were genuinely surprised. This was not what they expected to encounter within the hospital and furthermore, it seemed that this was not what they were used to experiencing more generally within their lives. Indeed, the uniqueness of this experience appeared to make some participants feel uncomfortable at times. For example, Sophia talked about how the staff would come and ask if she needed anything and how that felt awkward; Sophia always choosing to say ‘no thank you’ in reply, regardless of her needs. Kindness, especially from strangers, was not something Sophia was used too, but, upon reflection, she seemed to value it and indeed draw hope from it:

> ‘The nurses are really friendly here as well, they were nice, said like to ask if I need anything, even when I constantly say, no thank you, they still ask! It makes me feel a bit awkward, just because I am an awkward person. I would say no thank you, I’m fine, when they were being kind! Just the kind of person I am. (2) I would say I am not used to it; I know. Like people being kind to you, and it’s nice, really nice, it gives you hope …’

Indeed, Sophia described the way a member of staff was understanding and kind to her when she was being sick as a shock:

> ‘I remember like, when I was first put on a drip, I just ended up throwing up and I was crying and apologising and one of the nurses were there, and I was saying I am so sorry, and she just it was fine, and I just sat there, and I was like (1) thank you!’

At times Sophia seemed amazed that staff were being kind to her. Indeed, it seemed to confuse her: ‘I still feel awkward about it, I just sit here and think when they are nice and stuff, oh God, what do I do. I am just sad.’

Likewise, for Simon, what many people would perhaps consider routine nursing care Simon perceived as acts of immense kindness; again, he appeared surprised. For example, Simon described how simple routine acts like reinserting his venous cannula and offering him food, impacted on him; Simon recalling such moments within the interview as if they were very significant events in his experience of being in hospital.

> ‘I needed to get changed and then as I was getting changed, I pulled this thing out of my hand ((pointing to his venous cannula)) and she came back and put it back in no problem! ((Simon seemed surprised)). Then, later, she came over and offered me something to eat! She came over here two or three times, coming over to my bed to help me! ((Simon again seemed surprised)).’

Simon did not expect such kindness from the staff, and it brought him great comfort, saying it made him feel relaxed, 'just like I have got no worries.'

For Charlotte, the kindness of the staff also seemed to make her feel special, in a way that was clearly moving for her. It felt like the kindness she received from the health care assistants and the nurses kindled a surprise longing, or awakened an aching need, deep within her:

> 'It makes me feel, (4), like (2) what's the word (2) just (5) looked after? I can't think of the word. (3) like I am worthy ((Charlotte laughs nervously)). Er (2) Yea (4), Yea (4) Yea. Just by explaining everything, making me feel safe (3) and asking if I needed anything, you know ((Charlotte became very emotional, cries and hides her face in her hands)). It makes you feel so special.'

Charlotte also seemed moved by the occasion when she was returning to the ward and one of the staff noticed that she was lost and simply called out her name. Charlotte was shocked that despite the number of other patients on the ward and the change of staff due to the shift patterns, a member of staff knew her name.

> 'They have remembered my name, I got lost this morning when I went for a cigarette ((smile)), they shouted my name and so they remembered my name even though they don't know my name. ((smile and laughter, Charlotte becomes emotional)).'
>
> *How did that make you feel?*
>
> 'Made me feel good, good about myself, yea. Plus, I got back to where I was meant to be ((laughter)). I were surprised really that they remembered my name. There are that many people and they are busy, and they swapped shifts this morning so and I had only seen this lady for about half an hour, and she remembered my name. (3) Made me feel nice and that she cared.'

A simple act of a member of staff knowing her name seemed to mean a great deal to Charlotte and impacted positively on how she was feeling. It made her feel that she mattered to that person, to someone. A moment that was remembered by Charlotte for its significance; a moment to be treasured.

Likewise, for Sophia, kindness really helped her, but it was not easy for her to understand why:

> ‘Sorry, I feel kind of shit in here, like what am I doing in here, and then a nurse will come along and I think I will speak to that one and I think she is lovely, and I don’t know what my head is like, stupid but that helps. It is lovely.’

For Sophia, the way in which kindness helped seemed stupid, but also lovely.

7.8.5 Undeserving of staff’s time – ‘there are people who are more in need.’

Participants described how they perceived that they were undeserving of staff kindness and time, that there were other patients who were much more important than themselves. For example, Simon said: ‘Unless it is a real emergency, I would not bother them, I don’t want to take them away from something else more important.’ For Simon, ‘others’ were ‘more important’, their need greater than his: ‘There are people who are more in need than me and that’s why I don’t ask or say anything.’ Similar feelings are also perhaps reflected in Lauren’s words: ‘If I am struggling, I really struggle to say that, to say I am struggling, but they are busy people aren’t they.’ Such words from Lauren, seemed to express a thought that she did not deserve to matter. Indeed, such a thought seemed to be physically expressed by Lauren during the interview, throughout which she remained curled up in the foetal position cocooned in her hospital blanket. Her head was just visible, like she was hiding away, not wanting to bother people. Indeed, when approached for interview she was very surprised that someone wanted to talk to her.

Likewise, Ellie said, 'I just draw the curtains around me when I am on the ward and try to keep quiet, out of the way so not to bother them.' It appeared that some of the participants seemed to believe that they should stay hidden and silent. For Jasmine, this seemed to be particularly the case when staff were stressed and busy, increasing her belief that she should not bother them:

> 'I am a very emotional person, so when they were stressed, it was making me stressed and upset and felt like I shouldn't be here and that sort of thing. I am wasting their time sort of thing.'

7.8.6 Summary

In summary therefore, staff's kindness appeared to have a profound and lasting impact on many of the participants interviewed. When staff offered the participants something of their humanity, expressing genuine kindness, without any negative judgement associated with their recent suicidal behaviour, this brought them comfort and hope. Such kindness was expressed in a variety of ways, from a simple offer to talk, a willingness to listen, short words of good luck, staff sharing their own personal struggles, staff remembering their name or staff seeking to find the individual help. Although welcomed, several participants revealed how experiencing such kindness from staff was a genuine surprise. Several participants seemed to believe that they did not deserve such kindness, that they were undeserving of such time, other patients mattering more than themselves. The result of this, was that for a few participants, they felt the best thing for them to do was to hide away under their blanket, or behind their bedside curtains. The experience of kindness brought hope and positive feelings, but it was also surprising and even for some participants, uncomfortable.

7.9 Overall summary

Overall, the thematic review of the interview transcripts of the participants' experience of being in hospital following an overdose, has revealed six major themes, each broken down in to three or four subthemes.

All the participants described experiencing a fear of death when in hospital, which seemed linked to coming into the physical space of the A&E department and/or being physically unwell. The participants described how this fear was sudden and unexpected, shocking, and terrifying, an instinctive fear. For two of the participants, this fear was enhanced by witnessing the death of another patient. The effect of this fear for some participants was to seek life, for others however, it became a force to overcome, a battle to win.

Closely connected to this theme, was the hospital being valued as a place of safety. Many participants valued the hospital as a place to be saved by medical intervention, supported by close monitoring. For several participants, the hospital was also valued as a place to be safe from themselves; the presence of the staff preventing them from acting on any suicidal impulses. Furthermore, feelings of safety were also linked to the participants' environment. The noise and busyness of the A&E department increased their anxiety, this being contrasted with the peace and calm of the Admission Ward. The hospital also offered a sense of refuge from the pressures they experienced outside, providing a space to think and reflect, including about their future.

Their relationships with their loved ones were also at the heart of the participants' lived experience. For several participants, loved ones were experienced as a reason to live. Their fear of dying seemed to cause them to perceive or recognise that they did not want to die and leave their family and friends, they wanted a future with them. Many participants were also impacted by the experience of their loved ones witnessing the effects of their suicidal behaviour, which caused them distress. Several interviewees described how they would not want their loved ones to see this again, along with recognising the negative impact their death would have on those close to them.

Many participants also perceived the future, outside the hospital, as hopeless. Their experience had taught them that there would be little or no help from the Mental Health Teams. They had tried to access help and support many times in the past but had failed, often being passed around different services, but always rejected, resulting in a perception of being abandoned and unwanted. The Mental Health Teams, who visited them on the wards, also offered no hope to the participants. They came and asked the standard questions and then discharged them, experienced by many of the participants as a rejection, increasing their sense of powerlessness. Accordingly, future suicidal behaviour or death seemed inevitable. Importantly however, for the two participants for whom this was their first admission to hospital following suicidal behaviour, the future was perceived very differently. These participants were very positive about accessing and receiving mental help support, which made them feel hopeful about the future. The power seemed to be perceived as theirs, they had to ask and accept it, and it would be provided.

Several participants also believed that they were treated in hospital differently due to their suicidal behaviour. They described feeling exposed and sensed that people were judging them, particularly when placed on the corridor within A&E, increasing feelings of anxiety, along with a sense of being in danger. For two of the participants these experiences were enhanced significantly, by the doctors speaking 'loudly' on the hospital wards about the reason for their admission, so other patients could hear. One participant also believed that her asthma symptoms were dismissed because of her mental health problems; Lauren also perceiving that she was lied to about her treatment. Such negative experiences caused two participants to feel anger. Others felt abandoned by staff, despite craving contact.

When participants however, experienced genuine kindness from staff, this was greatly valued. It distracted them from their problems, and for some individuals, it gave them hope for the future. Participants valued being treated the same as other patients, valuing warmth and acceptance, but fearing judgment. Such kindness, however, was also experienced by some participants as uncomfortable, something unfamiliar. Indeed, several participants perceived that they were undeserving of such kindness and should instead remain quiet and hidden.

This thematic review, therefore, offers an insight into the participants' experience of being in hospital following an overdose, highlighting many important themes that will be discussed further below. Before we return to these themes however, we continue our analysis, with the aid of what van Manen (2014, p.324) termed 'insightful cultivators'. Thus, an opportunity to return to the transcripts again, with a different lens, in the hope of glimpsing further insights, first in relation to Heidegger's work on death and temporality, 'one of the most influential philosophers of the twentieth century' (Dreyfus & Wrathall, 2005, p.1).

8. Analysis

8.1 Analysis through the lens of Heidegger

Within this chapter, the identified themes are analysed in relation to aspects of Heidegger's work on Being-towards-death and temporality.

8.1.1 Introduction

As outlined within the thematic review of the transcripts, the experience of the fear of death appeared to impact significantly on many participants' lived experience (Chapter 7.3) and was closely related to several other themes identified, for example loved ones being a reason to live (Chapter 7.5). Accordingly, Heidegger's work around death seemed a natural place to turn to, in seeking to provoke further reflection and thought on the research findings. Heidegger wrote extensively about the perception of death, as Solomon (1998, p.163) notes: 'it was Heidegger, most prominently, who embraced death and gave it its due.'

Studying *Being and Time* (Heidegger, 2010), brought new insights. As will be discussed, I found Heidegger's writing around Being-towards-death and temporality, deeply helpful in enabling me to connect further with the participants' accounts. Equally however, as will be highlighted, some of his writing also seemed to contradict the participants' experience, as expressed within the interviews. This, nevertheless, served as a motivation for further reflection, and a challenge to my commitment to phenomenology; to see the participants' experience as the ultimate authority.

8.1.2 The tranquilisation of death

To seek to grasp something of Heidegger's ideas around Being-towards-death, we must also briefly note Heidegger's understanding of authenticity, the two being intimately linked (Young, 1998). Heidegger (2010) suggests that the individual in the world, 'Dasein' (see Chapter 5.3.3), consists of an 'I-self' and a 'One-self'. The actions of the inauthentic are driven not by autonomous choice, but rather by *das Man*, 'the They', or 'the One'. Within the state of inauthenticity therefore, the One becomes the Self; the Self therefore being determined by the thoughts, desires, choices, and actions of *das Man*. 'Dasein stands in *subservience* to others…' (Heidegger, 2010, p.122f/126). The I-self becomes dissolved, Dasein adopting, agreeing, and conforming to the One. Through thinking and acting as the One does, Heidegger (2010) argues, Dasein receives an immense 'pay-off' (Young, 1998, p.112), a tranquilisation of the greatest disturbance to Dasein; a veiling of the disturbance of Being-towards-death, the disturbance of mortality, 'the most frightening aspect of human existence – that it ends, irreparably' (Wisnewski, 2012, p.109). Indeed, as Young (1998, p.112) notes: 'In its most fundamental description, therefore, inauthentic life is a flight from death.' The authentic life, by contrast, recognises the fundamental reality of being-towards-death and care for existence itself.

Heidegger (2010) suggests however, that *das Man* does talk about death in the inauthentic state, we know that death is a frequent event, people die around us, friends, family members, colleagues. As we get older, we read their death announced on Facebook, however, importantly, the talk is always that *they* die. Within the inauthentic state, we find ourselves accepting that 'one dies', but one is 'they'. As Tolstoy (1960, p.107) describes powerfully within his work the *Death of Ivan Ilyich,* a work Heidegger (2010) refers to:

> Why, it might happen to me, all of a sudden, at any moment, he thought, and for an instant was terrified. But immediately, he could not explain how, there came to his support the old reflection that this thing had befallen Ivan Ilyich and not to him, and that it ought not and could not happen to him, and that to think that it could meant falling into a melancholy frame of mind, which was a mistake as the expression on Schwartz' face had made quite clear.

Death 'strikes the *they.* … everyone can convince him/herself that in no case is it myself …' (Heidegger 2010, p.243/253). Within the inauthentic state Dasein acknowledges death as 'something that will happen but not yet, and hence an impending event rather than as the omnipresent impending possibility of our own non-existence' (Mulhall, 2005, p.130).

As highlighted within this study, a frequent experience identified within the participants' interviews was an experience of extreme fear, in relation to their impending death (Chapter 7.3). It was noted that this fear was often connected with the participants coming into the physical space of the A&E department and with the sensation of being physically unwell; predominantly vomiting. Furthermore, it appears that for many of the participants, this experience of Being-towards-death was new, shocking, and unexpected. To recall what Naomi said:

> 'It was like a frightening shock when I felt it kicking in in A&E, panic, I thought I was really going to die. It hit me what was happening in there. It surprised me just how scary. I was so scared (3) and like I still am.'

Reflecting on Heidegger's notion of the inauthentic life, it perhaps appears that for many participants, following their overdose and, particularly within the A&E department, the comforting effects of the tranquilisation of Being-towards-death is removed, being given an antidote to this tranquilisation, an antidote that has an immediate effect. For example, as Katie recalled: 'As soon as I had come into hospital really, I regretted it, it makes it a reality then doesn't it, when you come into hospital. Yea, (3) it makes death real.' The veil of Dasein's mortality appears to have been removed for Katie and the possibility of her own death brutally exposed: ‘It was just like, (2) panic, I panicked, I thought I was going to die. (4) I panicked; you know. It surprised me really, yeah it did …’ Katie, like many other participants, now seemed to perceive their death as impending, their Being-before-death; their response is fear. Death became *her* death. It is of course beyond the focus of this study to explore how the participants perceived death prior to their entry into acute care, or indeed after they have left the hospital. What does appear striking however, is that for many of the participants, the fear of death that they experience within the hospital is new and it is shocking. As Sophia described: ‘You get to that point that you have done something to yourself and realise that you are going to die, and it is scary.’ Such comments suggest that something has changed. This was not how she appeared to have perceived death previously, the change happening suddenly, at a ‘point’. For Sophia, her mortality now seemed to be perceived very differently:

> ‘I have never been scared to die before but then I was. I had thought about dying in the past, obviously, but now in here, it was different, it was real, it felt like I was going to die.’

This fear was still evident during the interview as Sophia connected with the newness of this experience of fear, and how this was something different to the past.

> ‘I have done stupid stuff in the past when I was younger when I was like 13, it wasn’t as extreme, it wasn’t like, it wasn’t to that extent. I got that first breath of fear ((spoken softly)). ((Tears in Sophia’s eyes began to form)). (5) It wasn’t nice ((spoken very softly. Sophia cried quietly)).’

Sophia’s description of the ‘first breath of fear’ powerfully expresses that this experience was unlike anything she had felt before. It was a fear that seemed visceral, almost too terrifying to speak of, one that could only be quietly spoken about. Perhaps, before her arrival in A&E, as Heidegger (2010) suggests, her death was perceived from a detached perspective, as a future event. By contrast, in A&E, death is perceived as happening now, it was present. Death was no longer something to be thought about but was being experienced. No longer is death 'understood as an indeterminate something which first has to show up from somewhere, but right now is *not yet present* for oneself, and is thus no threat' (Heidegger, 2010, p.243/253). Instead, many participants felt, like Mollie, that death was an impending presence: 'I thought shit what have I done? I am going to die.' For Mollie, death was now a present threat for her, not 'they die' but, 'I die'. Likewise, as Olivia spoke briefly but powerfully: 'As I could feel it ((the overdose)) working, I thought shit!' A changed happened for many of the participants that was distinctive, powerful, and frightening; 'I' was now facing death in the present rather than the future.

Heidegger's understanding therefore, of the tranquilisation of death by *das man*, with its fleeting talk of death in everyday, perhaps helps bring into focus something of the meaning behind the participant's experience of being towards death in A&E, and importantly, the starkness of the apparent accompanying shock and fear, that they recalled during the interviews. Indeed, without Heidegger's insight, such feelings of shock and fear would perhaps appear surprising, even astonishing, in individuals who had at least, in part, wanted to end their life minutes or hours earlier, and, in some cases, still wanted to die. However, viewing the apparent fear of death expressed by many of the participants, through the lens of Heidegger's teaching on *das man's* fleeting everyday talk of death, helps us perhaps grasp something of the shock felt by many of the participants. The sudden change of perception when, 'I' is now towards death. Perceiving death as *their* reality, as a threat in the present rather than the future. A revelation of their own mortality in the present: 'I was so frightened that I would actually die …' (Elizabeth).

8.1.3 ‘Death is itself as one’s ownmost, nonrelational, and insuperable possibility’ Heidegger (2010, p.241/250)

Within the state of Being-towards-death, Heidegger (2010, p.241/250) suggests that death exposes three characteristics or interconnected features: ‘Death reveals itself as one’s *ownmost*, *nonrelational, and insuperable possibility.’* The first of these, to accept that death is ownmost, is to accept that death is exclusively my own; no one can take my place in my death, no one can die my death: ‘*No one can take the other’s dying away from him* … Every Dasein itself must take dying upon itself in every instance’ (Heidegger, 2010, p.231/240). Consequently, Heidegger (2010) suggests that death is non-relational; Being-towards-death ‘individualizes Dasein down to itself’ (Heidegger, 2010, p.252/263). As Wisnewski (2012, p.107f) notes:

> Death is nonrelational precisely because it is the one thing that every Dasein must do *on its own* … We learn *from the dead* that there is at least one thing regarding which we are fundamentally alone-namely, our own death.

Heidegger (2010) suggests that Being-towards-death strips away all our relationships with others and therefore is something ‘that utterly isolates’ (Mulhall, 1996, p.117). ‘When it stands before itself in this way, all its relations to any other Dasein have been undone’ (Heidegger, 1962, p.294/250). Subsequently, because of its non-relational nature, Heidegger (2010) argued that death cannot be bypassed or outstripped, it is an insuperable possibility.

Heidegger’s (2010) notion of the nonrelational aspect of death has, however, been fiercely criticised, not least by Solomon (1998) and Scarre (2007). Solomon (1998) notes that phenomenologically, ontologically and biologically, we are social animals, and we perceive ourselves, including our mortality, in relation to others. As Beings, we perceive our death, Solomon (1998) argues, as an ending of past, present and future relationships. Consequently, Solomon (1998, p.175) argues:

> What Heidegger marks off as the 'uniqueness' of Being-towards-death seems to me to be a version of morbid solipsism, a denial of the obvious in favour of an obscure and mock-heroic philosophical theory.

Solomon (1998) argues that when we think of our death, we think about the impact it will have on others, for example our spouse and our children. As noted, Heidegger (2010) argues that death can only be related to as impending, as 'death makes any Dasein's existence absolutely impossible' (Mulhall, 2005, p.25), however Solomon (1998) and Scarre (2007) argue, that through our relationships, we do indeed relate to death.

> Part of what death means to me is constituted by what I understand it will mean to others … the meaning that my death has for me cannot be divorced from the meaning that it has for those who I leave behind' (Scarre, 2007, p.36f).

My death of course marks the end of my existence in the world, but I care about that ending, because it means the ending of relationships through which I have my identity. Furthermore, I relate to my death through the ending of those relationships. 'Death, then, is far from being a wholly private affair, of concern only to the decedent' (Scarre, 2007, p.37). The facing of death Solomon (1998) and Scarre (2007) argue, therefore, while being an individual encounter, is also a shared, social event.

Indeed, in the literature review of autobiographical accounts, it was noted how the thoughts of the impact of their death on loved ones, was a factor for some individuals deciding not to end their life in the final moments of their suicidal behaviour (Chapter 4.5.4), thus highlighting the relational aspect of death for these individuals.

Likewise, Solomon's (1998) and Scarre's (2007) comments are reflected within the lived experience of many of the participants within this study. Participants perceived their death in relation to the impact it would have on their loved ones. For example, for Katie, what she was scared about was leaving her children:

> It is fear isn't it, because I have got children as well haven't I. You feel scared, you feel stupid, how can you be so careless when you have got children. … Yeah (3), I've been thinking of my children…'

Likewise, for other participants their relationships were at the centre of their perception of Being-towards-death, as Naomi said: 'To be honest, I am still scared! I was scared of leaving people behind, leaving my family …' Similarly, for Alex, his experiencing was deeply connected to his relationships: 'I came in here to get help, but I just want to die, but something scares me about dying and leaving my family and friends.' Likewise, for Sophia, her Being-towards-death was experienced in terms of a special relationship, however in this occasion, it was her pet cat: 'I have a cat as well, I can't leave my cat, I felt the biggest thing of guilt I have ever felt in my life.'

Many of the participants' words seemed to reflect what Solomon (1998, p.176) suggests: 'I want to live because of other people. I want to live because I love … I want to live, perhaps because others need me, for most of us, because we care for and about others.' Being-towards-death in acute care, for many of the participants seemed powerfully connected to relationships. Rather than being a moment when they realised that death was ultimately their own, death was perceived through their loved ones. Such findings contrast to Heidegger's teachings on the nonrelational aspect of death; such teachings enabling us to sense this relational aspect of Being-towards-death more clearly.

8.1.4 Awareness of death bringing clarity that 'my life is my own to live'

Within his writing, Heidegger (2010) suggests that the I-self is never eradicated and is in a state of turbulence, the voice of conscience calling it to accept mortality. In choosing to listen to the voice of conscience, Dasein becomes aware of the illusion of the tranquilisation of death and consequently becomes alienated from *das Man;* Dasein realising that all Being-others will fail us with death. The result, Heidegger (2010) argues, is that Dasein is plunged into a state of anxiety, of dread, in accepting mortality, facing death, the claims of *das Man* becoming insignificant. Importantly however, this mood of anxiety results in a powerful enlightening for Dasein. Anxiety brings clarity and integrity, a renewed concern, passion, and awareness of this life, causing Dasein to be reinvigorated, with its own choice and own direction, and within this authentic state one becomes resolute. Death becomes a way to live:

> Death thus makes vivid the idea that I have time, that there is a time that is "mine" to be used, perhaps wisely perhaps wastefully: only a being who can acknowledge its mortality in this way can bear this sort of relation to time (Cerbone, 2008, p.89).

Similarly, for Olivia and Harriet, their accounts suggest that in the hours following their suicide attempt, Being-towards-death brought about a change of perception of their life. It is of course beyond the scope of this research to question if such changes brought lasting action, as within Heidegger's understandings of the state of anxiety. The transcripts do reveal however, that for Olivia and Harriet their experience of Being-towards-death in hospital, brought about a change of intention. For example, for Olivia Being-towards-death caused her to review her life and seek to change her future, particularly in wanting to stay alive to care for her mum. Being close to death, had caused Olivia to reflect on her life, it had brought about a sense of clarity and perhaps even an awareness that she did indeed have a choice.

> 'I am going to stay alive this time for my mum. The reasons being that she has COPD, and I haven't, and you know what I mean, she suffered for me when I used to have fits as a child, she suffered for me, so you know, I want to suffer for her. That's my motivation. I want to be there for her now …'

Likewise, for Harriet, her Being-towards-death also seemed to cause her to discover a sense of empowerment about her future. For Harriet it felt as if there was a life to be lived:

> 'I'll tell you something one thing that I would really love is too come back here one day and see you and the staff and be able to say to you, to be able to show you that I have done it. I would love to work here, perhaps as a porter or a Health Care Assistant …'

As Heidegger suggested, for Olivia and Harriet, Being-towards-death seemed to cause them to perceive that they had a choice and a life they could embrace. Just as their death was their own, so too was their life.

It should be stressed however, that such experiences were not shared by other participants. For others, Being-towards-death seemed to have enhanced their utter sense of despair, powerlessness and hopelessness for the future. For many participants, Being-towards-Death only seemed to bring clarity in terms of the darkness of their situation and increased despondency: 'I don't feel like I have got a future as nothing is ever getting better, there is no hope' (Lauren). For most of the participants interviewed, the words of Kaufmann (2015, p.375) suggesting that through impending death 'a life is enriched', would perhaps feel very hollow and alien. Indeed, many of the participants perceived powerlessness through their experience of Being-towards-death. 'Not changed any thoughts about the future, I don't feel like I have got a future as nothing is ever getting better, there is no hope.' (Lauren). For Lauren, Being-towards-death was far from empowering or life enriching.

8.1.5 Temporality

For Heidegger (2010), it is only possible to explore Being, and to grasp the nature of Being, through the notion of temporality. Indeed, as Heidegger (2010, p.17/17) sets out on his quest in *Being and Time*, he states:

> The meaning of being [Sein] of that being [Seienden] we call Dasein will prove to be *temporality* [Zeitlichkeit] … Time must be brought to light and genuinely grasped as the horizon on every understanding and interpretation of being.

Heidegger (2010) was highly critical of the 'ordinary' notion of time, which perceived time as identifiable, distinct, self-contained, linear points that are organised and quantifiable, which flow from one to another in sequence. For Heidegger, as Blattner (2007, p.311) notes: 'Time is not the abstract "container" that we imagine "clock-time" to be, but a basic structure of Dasein's being.' Indeed, for Heidegger (2010), time is not something that Dasein simply exists in, but rather, exists *as*. Subsequently, to reinforce this distinction, Heidegger (2010) employs the concept of temporality.

According to Heidegger (2010), one of the essential features of temporality is its three-dimensional aspect; that the past, present and future exist as one unity, one integral phenomenon, operating in every moment of Dasein's existence. Indeed, Heidegger was highly critical of how traditional philosophical approaches considered the present to be the 'most real'. For Heidegger, experience of the present is always governed by our past, and by our perception of the future. Indeed, our past determines our present and future, and our perception of the future determines our present and our past. Heidegger suggests, as Wisnewski (2012, p.133) notes:

> The future is not to be constructed as later than the present; the past is not earlier than the present. Rather all these ecstasies emanate from one another in the constitution of temporality.

Subsequently, the totality of the present is always much more than what Dasein grasps in the here and now.

Indeed, within the participants' accounts, Heidegger's notion of temporality enables us to focus more clearly on the way in which both the past and the future impacted on their experiencing of the present; the participants' experience being much more than the total of 'this' admission to the hospital for 'this' experience of an overdose. For example, for Alex, her previous experience of seeking help and support from the Mental Health Teams and her constant sense of rejection, informed her perception of the future, and impacted on her present:

> The mental health help is not as it should be, they just move you from pillar to post and then they just discharge you and you are back at square one again. That's my future. … I don't have a future because there is nothing there, that is just how my low mood is and how I have and will be feeling.

Alex describes her present mood as low because she perceives that she does not have a future, as her past has shown her that there will be no 'mental health help'. Furthermore, her perception of her future causes her present to be 'low' because it shows that her past struggles to get help have all amounted to nothing – 'back to square one'; the past, present, and future existing in one unity.

Likewise, during the interview, Trevor described how 'all my life I have been working' ... 'I have had a good reputation in the community, I get on well with people', however the problem with his back had caused him to 'end up like this'. Trevor appears to compare his present with his past, and that causes him distress. He used to be hard working, which brought with it respect from his community, however as he is now unable to work, this caused him to perceive his present situation negatively. As Trevor is now unable to work; he is not 'what I was'. His experience of the past, of being respected and valued, also perhaps impact on his feelings about being poorly treated in hospital, 'in my community I am respected but here ignored.' Furthermore, his present experience impacted on his perceived future, 'the way I have been treated here, next time I will stay at home, (3) we all have to die.'

Accordingly, an awareness of temporality seems essential to grasp the experience of the participants. The participants did not leave their past at the door when they entered the hospital, nor their thoughts of the future. Both their perceptions of the past and the future, as has been shown, impacted on their present. Time is 'the horizon on every understanding and interpretation of being' (Heidegger, 2010 p.17/17). Indeed, without an awareness of temporality, it seems that any attempt to grasp the lived experience of the participants would be wholly inadequate.

8.1.6 Summary

In summary, therefore, reflecting on the interview transcripts of the participants' lived experience through the lens of some of Heidegger's concepts has offered the potential to grasp more fully that experience. First, Heidegger's understanding of the tranquilization of death enables a more acute insight into how the fear of Being-towards-death was experienced by many of the participants; its starkness and rawness being sensed more keenly. In contrast however, it has been noted that Heidegger's teaching on the nonrelational aspect of Being-towards-death seems to contradict the lived experience of many of the participants. At the time of the interviews, the participants seem to perceive their death not as something ultimately their own, but instead through their relationships.

Heidegger's notion that Being-towards-death and authenticity produced a renewed sense that 'my life is my own to be lived', was reflected by two participants. For Harriet, Being-towards death caused her to make plans for her future and to make others proud, for Olivia her experience had caused her to want to now care for her poorly mother. For other participants however, Being-towards-death, by contrast, seems to have brought a renewed sense of hopelessness and powerlessness, such present perceptions frequently founded on their past and future. Indeed, Heidegger's concept of temporality enables us to see the whole lived experience of the participants more clearly, shining a light on the nature of the participants as Beings *as* time. To seek to glimpse their present experiencing, we need to 'listen' to their past and their future. Indeed, any attempt to carve up aspects of their temporality, is, as both Heidegger and this study indicate, both artificial and futile. For the participants within this study, the past and future are all part of the present and cannot be separated; selective hearing only serves to distort or even deny their lived experience.

Accordingly, having analysed the participants' transcripts through the lens of Heidegger's writing around death and temporality, we now turn to the work of Carl Rogers, in the hope of further clarity.

8.2 Analysis through the lens of the Person-Centred Approach. Carl Rogers.

8.2.1 Introduction

Engaging with the participants' accounts of their lived experience of acute care following an overdose, caused me to reflect instinctively on the work of Carl Rogers (1961) and the Person-Centred Approach. This was the therapeutic framework that my initial training as a counsellor was based upon, and therefore a natural point of reference for me. Furthermore, the Person-Centred Approach continues to be influential within the NHS, with elements being enshrined within its values, most explicitly the focus on 'Person Centred Care' (McCormack & McCance 2016; Price, 2019). Indeed, Cross (2011, p.26) claims that: 'Roger's reputation for revolutionizing the psychological care practice and defining Person Centred Care has made him one of the most influential psychological care providers in the past century.' Roger's approach is 'underpinned by the phenomenological belief system' (Brown, 2015, p.18), expressed perhaps most explicitly through his conviction that the individual is always the expert on their experiencing.

Within this chapter therefore, I offer an analysis of the interview transcripts, through the lens of Roger's Person-Centred Approach. Such an analysis, it is hoped, offers the potential for deeper exploration and greater enlightenment on the participant's lived experience.

8.2.2 The actualizing tendency

Rogers (1980) describes on several occasions how when working even with extremely distressed clients, he was frequently aware of the presence of what he termed the actualizing tendency. Rogers claimed that this tendency which sought to protect, maintain, and enhance life, existed within every living organism. Furthermore, it never gave up, no matter what the situation, or how unfavourable the conditions. Rogers recognised that this force could be hidden and overcome by pain or thwarted due to the struggles that a person encountered in life, resulting in distress and even self-destruction. Importantly however, Roger's (1980, p.118) experience had caused him to believe that the actualizing tendency 'cannot be destroyed without destroying the organism.' Indeed, given the correct conditions, Rogers (1951, p.489) argued that the actualizing tendency may be 'most dramatically shown in very serious cases where the individual is on the brink of psychosis or suicide.'

Similarly, during the interviews, on many occasions I too experienced brief moments within the participants' words and being, that seemed to express flickers of life and hope, even amidst expressions of deep despair. For example, when Elizabeth spoke of how she wanted to die and the staff to simply leave her alone, there also seemed another desire for life:

> 'I just wish the staff would leave me alone and stop trying to make me better, it is not what I want! (3) But I knew that I must also accept their help or there was no way I was going to get better.'

Roger's (1951, p.488) description of this desire as a 'force' for life would perhaps be too strong a word in relation to this extract, but certainly a 'tendency' (Rogers, 1951, p.487) towards life, that would not give up. Elizabeth 'knew' that she 'must also accept help'. Indeed, frequently this tendency seemed to be displayed just through a phrase or a few words, amidst a description of her desire for death, as within the final sentence of this extract:

> 'Coming to A&E was scary but it is a bit of blur, I did not want to come, I wanted to die, but my friend called the ambulance, but it is all a daze, I don't know really about when I first came in. But I know I wanted help.'

Likewise, Lauren's perceptions of the future were also very despondent: 'There is nothing in here that they can do about my mental health, and mental health don't do anything…' Indeed, Lauren stated with such conviction on several occasions that, 'there is no hope.' Yet, even amidst such despair, Lauren had a wish for growth. For example, Lauren spoke of how she wanted to return to nursing: 'I want to be back doing my job, looking after other people as a nurse.' Indeed, she spoke of the joy of helping other people: 'I am young I can make a difference'. A striving for life, that perhaps reflects Roger's (1980) famous metaphor of his potatoes within his basement, the sprouts reaching out for any glimpse of light. No matter how unfavourable the conditions, no matter how desperate the situation, still striving towards the light. 'Life would not give up' (Rogers, 1980, p.118). Amongst all the participants who perceived the future as hopeless, and death by suicide certain, there were always flickers of striving for life.

Within the thematic review, the theme of a battle to overcome the fear of death was highlighted (Chapter 7.3.4). Perhaps Roger's notion of the actualizing tendency, therefore, helps us grasp that battle more fully, a battle with a life force, that would not give up. A force that despite no matter how desperate the situation is, would not give up its desire for life and growth. A force that struggled to express itself, but was always present, often just flickering amongst participants' despondent words.

8.2.3 Self-structure

8.2.3.1 Introduction

Rogers (1951) proposed that the structure of the self is formed, although always fluid, by the values and experiences of the organism, and by the values of others around us, introjected over time. Importantly, these external introjected values become fully owned, experienced as if they had come from our own internal evaluation process, 'this is me'. Rogers (1951) suggested that as individuals, we learn to act in a manner that receives positive regard from those who matter to us, evaluating ourselves and our behaviour in accordance with other people's responses, our conditions of worth; the need for positive regard, ultimately being 'the more dominant force.' (McMillan, 2004, p.6).

When analysing the interview transcripts through this framework, it is possible to grasp some common themes, in terms of the participant's self-structure. Specifically, a self-concept of being a burden, being unworthy of staff's time, a sense of shame, and a sense of self-blame.

8.2.3.2 Being a burden and being unworthy of the staff's time

For several of the participants, within their transcripts, there were noticeable references to how they perceived, prior to the overdose, or within the hospital, that they were a burden to their loved ones. For example, Harriet was shocked when she saw her father cry, because she believed that she was 'a pain and a burden':

> 'It really shocked me that he actually cared about me that much. I just thought I was a pain and a burden, but it made me really think he really wants me to get better and live. He so much wants me to be well.'

Likewise, Naomi said, referring to her family: 'I had always had it in my head that no one would be really bothered if I went.' A similar self-concept was also perhaps expressed by other participants in how they interacted with staff. For example, Simon described how he perceived that he was undeserving of the staff's time, other patients were much more important. 'Unless it is a real emergency, I would not bother them, I don't want to take them away from something else more important.' Similar feelings were also reflected in Lauren's words: 'If I am struggling, I really struggle to say that, to say I am struggling, but they are busy people aren't they'. Likewise, Ellie said: 'I just draw the curtains around me when I am on the ward and try to keep quiet, out of the way so not to bother them.' It seemed that Ellie believed that she should stay hidden and silent, not to bother the staff. For Jasmine, this seemed to be particularly the case when staff were stressed and busy, increasing her feeling that she was wasting staff's time: 'I am a very emotional person, so when they were stressed, it was making me stressed and upset and felt like I shouldn't be here and that sort of thing. I am wasting their time sort of thing.' Overall, several participants appeared to express a self-concept that they were a burden and unworthy of help and support, perhaps values introjected into their self-concept through their experience of life (Rogers, 1951).

8.2.3.3 Shame

When analysing the transcripts, several participants seemed to have negative evaluations of themselves, especially in relation to their overdose and feelings of shame. For example, Katie said: 'I just felt stupid, stupid, and regrets, it was a stupid thing to do. I felt ashamed, ashamed.' Participants seemed to feel embarrassed and ashamed of their actions, as also expressed by the way in which many participants found being on the corridor in the A&E department extremely difficult, as exemplified by Katie: 'In A&E you have people walking up and down and yeah (4). In A&E you just feel like everyone is looking at you.' Indeed, such feelings of shame were expressed by the way in which several participants wanted to hide. For example, Olivia said: 'I just didn't want to see no one, and I just slept, and I slept from last night, 4 o'clock in the day till 6 o'clock this morning. I wanted to be left alone.' (See Chapter 9.2 for a wider discussion on shame).

8.2.3.4 Self-blame

Within the account of their lived experience, many participants also seemed to blame themselves for not receiving the care that they perhaps should, having a self-concept that suggested that when things went wrong, it was their fault. For example, Mark described how, although many aspects of his care had been very positive, he had not received his mental health medication while he had been in hospital. Mark suggested, however, that this was his fault, because of his actions:

> 'My mental health medication has not been given to me, but that is to do with me and what I did, so I have no medication to take, been like that for days. It's my fault that I can't take them now, not theirs, although it makes things much worse for. It is my fault though.'

When Mark was asked further about this, he seemed to believe that it was his fault 'because of what I have done with the overdose.' Likewise, when Charlotte described how she was not getting her mental health medication and how she was confused about what was happening to her, she also seemed to instinctively blame herself:

> 'Not sure what is going on, but that is just me, they said the doctor would tell me soon. They obviously explained what they were doing and everything, but I didn't even know what they were this morning, but I can't, it was all a blur when I came in, in my head. But that is nothing to do with the staff or anything that I have not been getting my mental health meds, it's just me.'

Similarly, when Lauren spoke about not receiving her mental health medication, she also blamed herself, even though she clearly believed that she should be receiving it:

> 'Still not had any of my mental health meds, which isn't their fault, still not had my antidepressants which I should be having, it's been two days now, but that's my fault.'

When asked to explain this thought further and why it was her fault, Lauren, like Mark, seemed to believe that because she had tried to take her life, she expected that other people took priority over her: ‘They are busy aren’t they with other people, I have put myself here, it is my fault.’

8.2.3.5 Questioning of the self-concept

Within the participants’ accounts, there were also several occasions however, where individuals seemed to question their self-concept, as Rogers (1951) suggested was possible. These accounts, perhaps, highlighting the fluid nature of the self-structure and its capacity to be questioned when provided with the right conditions (Rogers, 1951). For example, when Sophia was ‘throwing up’ she was surprised that the staff were kind to her:

> ‘I felt so bad, because I was throwing up everywhere, I felt really bad for them, but they were really nice. *You seem surprised that they were nice to you?* Oh yeah, I was surprised, (3) pleasantly surprised, obviously! (4) Definitely a bit surprised.’

Sophia’s use of the word ‘obviously’, perhaps offers an insight into how she expected to be treated; the long pauses within this extract, perhaps also suggesting that this part of her self-concept was being questioned.

Likewise, receiving kindness from staff caused Noah to appear to challenge his self-concept of wider relationships: ‘Yeah, yeah, it just shows that there are people out there who do care.’ Noah had believed and accepted that there was ‘no one to whom he mattered in the world’. The kindness of the staff he had experienced however, caused him to question this self-belief. As expressed by Noah when describing how staff spoke to him: ‘Like there are people out there that do care, they are not, they are not just out for themselves. ‘

8.2.3.6 Self-concept defended when threatened

Rogers (1951) suggests however, that when the individual's self-concept is threatened through their experiencing, individuals may also strive to maintain and defend it; beliefs becoming more rigid, and experiences that contravene the self-concept, denied, or distorted. This is evidenced within the transcripts. For example, on many occasions Olivia spoke very positively about how 'brilliant' the staff had been. How they had been 'great' and 'fantastic', how they had helped her, being 'absolutely brilliant', only to follow such comments, however, with describing how the positive impact of the staff on her, was 'stupid'.

> 'Sorry, I feel kind of shit in here, like what am I doing in here, and then a nurse will come along and I think I will speak to that one and I think she is lovely, and I don't know what my head is like, stupid, but that helps.'

Indeed, later in the interview, Olivia, when speaking again of the positive care she had received from the staff, dismisses its importance: 'That does not really bother me'. Olivia, moving from saying the staff have been 'really good', to 'all right', to 'just there to do their job'. Olivia pausing and reflecting, before saying again that they have been 'really brilliant.'

> 'It has been all right, it has been all right on this ward … They are really good, yeah. (4) The staff have been all right, (3) but that does not really bother me. I don't like follow them, they are just there to do their job for me. (3) But they are brilliant. Really brilliant.'

For Olivia, suggesting that the kindness of staff matters to her, seems to be something she struggled to absorb, and battled with.

Likewise, Sophia, when speaking about the kindness of staff throughout the interview, always followed such comments with the same phrase: 'I am an awkward person'. For example:

> 'They have been really nice, they have been trying to help and trying to kind of like, so I have tried to avoid them to be fair, I

> don’t know, I just do, I don’t like, I am awkward, I am an awkward person. I am really awkward.’

The staff being ‘really nice’ and helpful, and ‘kind’ seems to make Sophia feel uncomfortable and so she tries to avoid them. Being an ‘awkward person’, she perhaps believes that she does not deserve such kindness, seeking to preserve this self-belief. As Rogers (1951, p.515) suggested, experiences that are inconsistent with the structure of the self are ‘perceived as a threat’ and defended against.

8.2.4 The relationship is fundamental

8.2.4.1 Introduction

Rogers believed that a person’s growth and enhancement could only be facilitated through relationship. Indeed, Rogers (1961, p.33) states his overall hypothesis as: ‘If I can provide a certain type of relationship, the other person will discover within himself the capacity to use the relationship for growth and change and personal development.’ Furthermore, Rogers (1961 p.40) explicitly stated that the importance of offering a helpful relationship included ‘the relationship between the physician and his patient’ and nurses, writing: ‘I had thought I was writing for psychotherapists, but to my astonishment discovered I was writing for people – nurses ….’ (1980, p.xvi). Rogers (1990b) suggested that there were six conditions, that if present in any relationship, were necessary and sufficient to cause that relationship to be beneficial and helpful. Three of these conditions have become known as the ‘core conditions’, conditions that encapsulate ‘the essence of Roger’s approach’ (McLeod, 2013, p.175). Namely: Unconditional positive regard, Empathy, and Congruence. Importantly, Rogers (1990a, p.138) asserted that these were not skills, or techniques, but rather an attitude, ‘a way of being’, or a ‘philosophy’.

Within the thematic review, the importance of human relationships was highlighted (Chapter 7.8) and therefore the transcripts are now analysed further, to consider if these 'core conditions' were present within the encounters the participants experienced as helpful.

8.2.4.2 Unconditional positive regard

Rogers (1961) suggests that unconditional positive regard refers to an attitude or embodiment of acceptance of the individual's experiencing at that given moment, no matter how distressing they are, along with a seeking to convey this acceptance to the individual. Unconditional positive regard is the absence of any form of judgement or evaluation on behalf of the helper, enabling the individual to feel safe and able to freely symbolise their feelings without any fear of reproach. 'No attitude is too aggressive, no feeling too guilty or shameful, to bring into the relationship' (Rogers, 2007, p.88). The person is accepted as they are, rather than as the helper may wish them to be or become.

Within the thematic review, it was noted how the absence of judgement was an important aspect of helpful relationships (Chapter 7.8.3). As Katie summarised: 'The most important thing is just to be treated like everybody else, not judged, don't treat me differently.' Roger's (1961) understanding of unconditional positive regard is, however, significantly more than an absence of judgement. It is a genuine prizing, a caring and warmth that is expressed towards the individual, which can create a sense of safety. Furthermore, upon reviewing the transcripts, such warmth and prizing seems significant, alongside the absence of judgement. For example, Ellie spoke of the positive impact of the staff valuing her as a human being, treating her as a person that matters: 'Here they also talk to you like a human being, like a person and they are caring, makes you feel good'. Likewise, Naomi experienced a caring attitude towards her from the staff, not just by the words they used, but also by their tone and their general attitude. Indeed, Naomi uses the word 'lovely', a word that suggests a very human quality that she experienced within her encounters with the staff, which enabled her to feel valued and cared for at a human level.

> 'The staff in A&E have been really good, everyone really lovely, not judgemental, … you could also tell by the way they were speaking to me, being polite, they had a soft tone of voice, that made it feel like it was safe to speak to them and they really cared.'

Interestingly, within this extract, we can also sense how, as Rogers (1961) suggested, qualities found in his teaching of unconditional positive regard created a sense of safety. Likewise, the absence of judgement that Simon experienced from the staff, also made him feel safe: 'The staff here don't look at you like you are the devil, here you can chill and be yourself, no one here is going to judge you, outside people are well judgemental.'

Within the interviews, it was noticeable that some participants also perceived expressions of what Rogers (1961) termed unconditional positive regard, through actions. For example, Harriet, described receiving a hot chocolate and how that made her feel 'like I mattered, I felt cared for'.

Importantly however, reflecting on the transcripts and in contrast to Roger's (1951) teaching, many of the participants did not value the absence of judgement being extended to their choice to end their own life. Positive regard was not valued unconditionally. Connected with their fear of death, as highlighted above, the hospital and staff were prized as a place where participants would be saved from themselves (Chapter 7.4.3); their suicidal wishes being overridden by the actions of the staff.

8.2.4.3 Empathy

As noted by Thorne (2003), Rogers wrote extensively about empathy during his lifetime, often lamenting how he considered that this quality was so absent among caring professionals. Rogers (1990b, p.226) defined empathy as: 'To sense the client's world as if it were your own, but without losing the "as if" quality – this is empathy.' Through empathy therefore, the helper is seeking to fully enter the individual's world as far as possible, to grasp accurately their perceptions of the world around them as they perceive it; to become a 'companion to the person in his or her world' (Rogers, 1980, p.142).

When analysing the participants' accounts of their encounters with staff, although frequently described in positive and helpful terms, they were not, based on Roger's definition, empathic encounters. For example, when a member of staff shared his experience with Noah of being in the forces and suffering with mental health problems, although experienced as helpful, this is not empathy. The staff member is sharing his experiences rather than purely seeking to grasp Noah's. Likewise, when Charlotte described how she did not want to go home because in hospital 'they listened to me, to what I was saying', it is important to note that listening is not the same as empathy (Rogers, 1961). It is possible that staff were empathic and that the participants did not perceive this, however Rogers (1990b) argues that for a relationship to be helpful, empathy must be present *and* perceived.

Overall, therefore, the transcripts suggest that participants did not recall encountering empathy with staff, even though many found their relationships with them helpful; one participant even declaring that talking with one nurse was 'better than all the counsellors that have been to the house'. Accordingly, such findings challenge Roger's (1990b) claim that empathy is *necessary* for a relationship to be helpful. When staff listened, or shared something of themselves, even without empathy, this was experienced as helpful.

8.2.4.4 Congruence

McLeod (2013) suggests that the most distinctive aspect of Roger's whole approach to helpful relationships was his focus on congruence, McLeod (2013, p.182) noting that 'no other approach gives as much importance to the realness, authenticity and willingness to be known…' As Rogers (1990a, p.135) notes:

> The more the therapist [or helper] is himself or herself in the relationship, putting up no professional front or personal façade, the greater is the likelihood that the client will change and grow in a constructive manner.

Importantly, congruence is interconnected to unconditional positive regard and empathy and therefore Rogers is not suggesting that we should express our anger and frustration at people. Rather, he is suggesting that in our helpful encounters with people we are 'committed to *being* rather than *seeming*' (Natiello, 2001, p.6). Indeed, Rogers (1961, p.185) argued, that in offering help, professionals must seek to relate 'not as a scientist to an object of study, not as a physician to diagnose and cure, but as a person to a person.'

In accordance with Roger's experience, for many of the participants, congruence seemed very important. For example, when Mark recalled how a member of staff said she had 'been through similar things', what seemed significant for Mark, was that he perceived this remark to be real and genuine:

> 'You can tell when someone says that and they have learnt it at college or at university and you can tell those who have been through it and understand, you can feel the emotion, she knew what I was feeling. I could feel the emotion ((tears developed in Mark's eyes)).'

Furthermore, the nurse was offering something of herself, a connection between the two of them, a meeting as fellow sufferers, fellow humans, relating as a human, rather than as a 'professional nurse'. This powerful encounter between Mark and the nurse lasted only for the briefest of moments; it was just one sentence, but it appeared to have an incredible impact on Mark, as expressed by his tears. Likewise, Mark described another powerful moment with a different member of staff, again, very brief, but once more fully charged with congruence; Mark recalling how one of the paramedics in A&E came back simply to wish him 'good luck'.

> 'You can tell when someone is just saying it for the sake of saying it, or because it is the right thing to do. But when they mean it, it means a lot. The paramedic also took the extra 2 minutes after she had booked me in to come and see me and say good luck, she cared. That meant a lot too.

What seemed significant for Mark was the congruence of the paramedic, her care was perceived as real. Several participants seemed to know when staff were being genuine, as Noah said, you can tell 'who is faking it and who is definitely not', who is being genuine:

> They don't have to do, it is not part of their job to do it, it is not part of their job role to do it, but they wanted to help and um, of their own back and everything. Because they wanted to, not because they had to. It's genuine, yea. You can tell the difference, you can definitely, definitely tell the difference, and who is faking it and who is definitely not.

When congruence was not offered however, some participants felt angry. For example, in Lauren's description of being given the drug diazepam when she was told by the nurse that she was having an antibiotic, what seemed to drive her anger was not that she was being given diazepam, but that she was lied to: 'If I needed diazepam and if she told me that she was going to give it me, I would have taken it. … It just made me angry that she lied to me.' What distressed Lauren was her perceived lack of congruence from the nurse caring for her.

8.2.5 Summary

In summary, analysing the interview transcripts through aspects of Roger's work has enabled further insight into the participants' lived experience. Specifically, reflecting on Roger's notion of the actualizing tendency has enabled me to notice, within many accounts, the presence of a desire for growth and life. Interestingly, such a tendency seemed to be present even amongst participants who were very despondent about their future.

Furthermore, Roger's (1951) understanding of the self-concept enabled several common beliefs to be noted within the participants' accounts. For example, individuals perceived themselves to be a burden, unworthy of staff's time, feeling ashamed, and blaming themselves for their difficulties. For some participants, such self-concepts were defended when threatened through the experiencing of kindness from staff. For other participants however, kindness caused them to question such self-concept.

This analysis has also enabled greater clarity to be gained about the nature of helpful relationships, highlighting the value of the qualities of unconditional positive regard and congruence within participants' accounts. Importantly however, many participants did not value unconditional positive regard being extended to staff respecting their wish to end their life; the staff and the hospital being valued as a place of safety. Furthermore, empathic encounters with staff were not widely recalled by participants, although relationships were still experienced as helpful. This perhaps therefore questions Roger's (1990b) claim that empathy was *necessary* for a relationship to be helpful.

In offering this analysis it is acknowledged that Roger's work closely reflects my own beliefs, values, and practices which undoubtedly impacts on my analysis. My critique of aspects of his teaching however, based on the participants' accounts, hopefully indicates my desire that the participants' experience be the greatest authority within this research.

I now consider the concept of ‘kindness’, a word frequently used by the participants themselves and a subtheme within the overall thematic analysis of the transcripts.

8.3 Kindness

8.3.1 Introduction

Haskins and Thomas (2018, p.9) note that although the words 'kind' and 'kindness' are part of everyday language, these two words are 'rich in meaning'. Kindness is generally considered to be related to, but distinct from, compassion (Chapter 8.4). For example, kindness is not always a response to suffering, unlike compassion, we may show kindness to someone who is celebrating (Haskins & Thomas, 2018). Furthermore, Gilbert (2009) suggests that compassion expresses a deeper awareness of suffering than kindness, with an element of distress caused to the individual due to their perception of the suffering of the other. Likewise, Haskins and Thomas (2018) note that kindness is related to but distinct from empathy, suggesting that empathy conveys a higher level of awareness of the experiences of the other, compared to kindness. Furthermore, empathy is not always kind and can be used to control others or aid suffering (Haskins & Thomas, 2018). The Cambridge University (2020, para.1f) on-line dictionary therefore defines the adjective of 'kind' as: 'Generous, helpful, and thinking of other people's feelings.' Likewise, as a noun, 'kind' is defined as: 'A group with similar characteristics or a particular type.'

Within this section of the thesis, the participants' use of this word 'kindness' is therefore analysed further, via the interview transcripts. In doing so, it is hoped we can grasp something more of what kindness means for the participants, and its effect.

8.3.2 A sense of connection

For several participants, kindness seemed closely related to a sense of connection with a member of staff. For example, Olivia related kindness to being offered attention and to being listened to: ‘They were really kind, they listened to me, instead of just standing there making notes about something else whilst you are talking.’ Perhaps therefore, for Olivia, as Forrest (2011, p.1) suggests: ‘Kindness is about paying attention to another person and acknowledging their situation … It requires us to be other-centred, instead of focusing on own needs.’ Through Olivia’s talking and the staff members listening, Olivia perceived that they were connected, and the staff member experienced as ‘kind’. Later within the interview, Olivia also related a member of staff being kind, to an experience of a nurse being on her ‘level’. Olivia perceived a connection between herself and the nurse, through a common struggle with mental health, which was described by Olivia as kind.

> ‘One nurse was brilliant; she was really kind. She brought her own experiences into it. So, there was one point where she said my daughter suffered with mental health and that sort of thing and then she was on my level which was kind. She was brilliant; she seemed to understand which was lovely.’

The nurse, therefore, through the offering of her own personal experience, reaching out to Olivia, recognised and expressed a commonality between them both, despite their differences. The nurse enabled them to connect through their shared experience. In a sense they were not that different, they were of one kind. Indeed, Ballatt *et al.* (2020, p.9) notes, perhaps as Olivia’s experience suggests, being kind is closely related to a sense of common humanity:

> It describes a condition in which people recognise their nature, know and feel that this is essentially one with that of their kin … It emerges from a sense of common humanity, promotes sharing …

Furthermore, perhaps as Phillips and Taylor (2009 p.10) suggest, ‘the pleasure of kindness is that it connects us with others ...’

The sense that kindness is related to connectiveness, is also suggested within Trevor's account of his experience, where he describes how he longs for the staff to be kind:

> 'They feed me, give me tablets, help me go to the toilet because my legs are not working, but no one talks to me. People don't come to me, just chuck the medications and go. I would like people to talk to me. … Even if they would just say hello when they start the shift that would be kind.'

For Trevor, being kind seems to be a reaching out to him and making a connection.

8.3.3 Small acts or gestures

For several participants, being kind, and kindness, also seemed closely related to small intuitive human acts or gestures. For example, Jasmine related being kind to staff smiling at her in the A&E department: 'Even just the little things make you feel better inside, someone smiling at you when you are in A&E, just tiny little things may you feel a bit better. Just being kind.' Likewise, for Katie, kindness was also linked with the simple action of staff smiling at her, which made her feel more 'at ease':

> 'They have been really friendly, they just check if you need anything, they are just really nice, always smiling ((laughter)) which makes you feel more at ease when somebody is smiling doesn't it. ((laughter)) … kind if you know what I mean.'

Even the briefest moment of kindness seemed be remembered, treasured by participants. For example, Mark described how it was 'really kind' when a paramedic took just 'two minutes' to come back after he had booked him in, to wish him good luck. As Forrest (2011, p.2) suggests: 'Patients remember kind action, as we all do, and will tell you about a small gesture or conversation years later that had a significant effect on their mood or their health.'

8.3.4 Genuine care

Mark's perception of kindness, in connection with the paramedic briefly returning to wish him good luck, also expresses another aspect linked by several participants to the word kindness, that of genuine care. The return of the paramedic after booking him into the A&E department, seemed to express to Mark that this health care professional genuinely cared; the paramedic expressing hope that his future was better for him. It felt a very personal, human, and genuine encounter. Likewise, for Harriet, her perception of a nurse being kind, also seemed to be associated with genuine care and concern for her future: 'The other thing that has made a big difference is my nurse, she was being really kind, really helpful, like she wanted me to get better as well.' Similarly, for Mollie, she contrasted her experience of the doctors speaking openly, telling 'everyone what had happened', with the nurses who seemed to be more thoughtful and caring of her feelings. 'The nurses have been a bit kinder, did not tell everyone about what happened. They care, not like the doctors who just announce it to everyone. The nurses think about me.' Likewise, Jasmine, when stressing the importance of kindness, also indicated that kindness was an expression of care: 'I think that it is important just to be kind, it shows that you care, like speak nicely.'

8.3.5 Vulnerability

For a few participants, kindness seemed to be perceived as especially powerful and important when the participants were vulnerable. For example, when participants were particularly unwell, frightened of dying, simple words of reassurance, or human presence, described as kindness, seemed significant. For example, when Katie felt that she was going to die when she was being sick, she recalls how the nurse was reassuring and kind.

> ‘I didn’t really see many people, there was like a, I saw a doctor, I saw, I think it was like a man nurse, they were really nice, very nice and when I started being sick, really sick, they were really reassuring and kind, yea.’

The presence of the nurse seemed to be interpreted as kindness in her experience of fear. A moment of human connection in a time of terror. Likewise, reflecting on her experience in A&E, Sophia also spoke of the importance of kindness when coming into hospital, due to an expectation of staff being ‘mean and harsh’. Kindness was significant when she felt vulnerable:

> ‘Definitely that kindness, that understanding, because you don’t expect it, you expect cold, mean and harsh and judgement and it is important to just not be like that, they might be a bit awkward and a bit short, a bit whatever, but that kindness helps a lot.’

Indeed, Sophia’s words seem to closely reflect Ballatt’s *et al.* (2020, p.xi) words regarding the power of kindness:

> When we are most vulnerable, the most ordinary acts of kindness have very extra-ordinary effects – the patient or service user recovers some sense of trust in a world that seems harsh and unforgiving of weakness.

8.3.6 Summary

In summary, within the thematic analysis of the interview transcripts, human kindness was identified as a subtheme (Chapter 7.8.2). Within this section, the participants’ perception of kindness was therefore explored further. This analysis indicated that for several interviewees, kindness was associated with staff reaching out and connecting with them as fellow humans, being of one kind. Kindness was also often expressed through simple, instinctive gestures, such as a smile, which had a significant positive impact on the interviewees’ experience. Kindness also appeared associated with the perception that staff genuinely cared about them, going beyond their professional roles. Finally, kindness seemed to be particularly valued by individuals when they were frightened, for example when they perceived that they were dying. Such analysis therefore enables us to have a clearer sense of what kindness means for some of the participants within this study.

As noted above, a concept related but distinct from kindness, is compassion. Accordingly, within the final part of the analysis, we consider the role of compassion within the participants’ lived experience, particularly in relation to the writings of Aristotle on compassion.

8.4 Compassion

Within this chapter I consider the role of compassion within the participants' lived experience.

8.4.1 Introduction

Although compassion is frequently referenced by health care leaders and policy makers as a 'value' to aspire to (see Chapter 9.4.2), within the participants' transcripts, none of the interviewees explicitly used the word compassion in association with their experience. Within this section however, the participants' lived experience is explored further in relation to this concept, to discover if aspects of their perception reflect our understanding of compassion. Through this discussion, it is hoped that we can continue to illuminate further and grasp more fully, aspects of the participants' lived experience.

Compassion is a concept that is subject to a variety of interpretations (Ballatt, 2016), indeed, as Schofield (2016) highlights, the concept of compassion is regularly used, but rarely defined or explained. Schantz (2007, p.51) notes how the word derives from the Latin *compassionem,* to mean 'together' and 'to suffer', and therefore in the purest form, denotes a sense of distress when someone is suffering. We become aware of the suffering of another, understanding or sharing to some degree that suffering, and are affected by it. Their pain and suffering impacts on us when we experience compassion. Importantly however, compassion is also intrinsically associated with action.

8.4.2 Compassion and action

von Dietze & Orb (2000, p.168) highlights how compassion is more than an emotion, more than a feeling of distress at the suffering of another, compassion also compels, even ‘demands’ action. ‘Compassion is about not only having some feeling of what someone may be going through, but also caring enough to want to help and do something to make the situation better’ (Nursing & Midwifery Council, 2009, p.16). Indeed, as Jones & Pattison (2016, p.53) notes: ‘Compassion involves a feeling or emotion which inspires us to reach out in practical ways to those in need.’ Schofield (2016) argues that it is this drive to act which profoundly distinguishes compassion from other qualities such as empathy or sympathy. For example, in the case of empathy, there is an awareness and understanding of the other person’s experience. Someone being empathic however, does not signify that they are taking action to relieve that distress. Rather they are grasping aspects of the person’s feelings and seeking to have a sense of their being. Furthermore, empathy can be related to a variety of emotions, unlike compassion that focuses on suffering. Likewise, in terms of sympathy, the individual may share in the other person’s feelings and experiences, but again the term does not suggest a sense of action or desire to relieve it. We can feel sympathy for someone’s situation, while doing nothing to help them. ‘Only compassion impels and empowers people to not only acknowledge, but also act toward alleviating or removing another’s suffering or pain’ (Schantz, 2007, p.51). We *show* compassion through what we do, ‘we value it for its outcome, not its essence’ (Jones & Pattison, 2016, p.47).

When reviewing the interview transcripts, the *action* of the nursing staff seemed to matter significantly for several participants, within their lived experience. Perhaps because of what that action achieved, but perhaps also because such actions were an expression of being valued. For example, for Harriet, as noted above (Chapter 7.8.2), it was the nurse phoning her GP to book her an appointment, being on the ‘phone ages’ to arrange it, which impacted significantly on her. It made ‘a big difference’. The action seemed important, as it enabled her to have an appointment with her GP the following afternoon, who is ‘really good’, as you ‘normally … can’t get to see.’ Furthermore however, Harriet’s comment that the nurse was on the 'phone ages' also seems significant, perhaps because it expressed to Harriet that she was valued by the nurse, the nurse taking the time to do this phone call and not to give up. The nurse perhaps being perceived as going above and beyond what is required within her role as a nurse, and therefore causing Harriet to feel valued. Likewise, for Harriet, being given a leaflet by the nurse with 'some numbers on for charities', impacted on her similarly (Chapter 7.8.2). Such deeds seemed to express compassion; awareness by the nurse of Harriet's suffering along with action to help her, which made her feel valued.

Likewise, Noah described the action of the staff and the impact it had on him: 'No they have been brilliant, phoning places for me that needed to be phoned. Um about where I live and stuff like that and helping me out, they have been brilliant.' These actions made Noah feel that 'that there are people out there who do care'. Again, the action seemed significant for what it achieved in a practical sense, but also as an expression of being valued and cared for. Similarly, for Noah, the action of another nurse coming to see him from the 'other side' because they knew him from a previous admission, made him feel 'good, really good … like they care' (Chapter 7.8.2). The nurse doing something to try to help, expressed to Noah a sense that he mattered to someone. Similarly, for Jasmine, the act of a member of staff making her a hot chocolate, expressed a sense of worth, making her feel less alone:

> 'One of the nurses also made me a hot chocolate, like a hot chocolate can cure everything! It is not even the drink, (laughter) it what it shows, she was just trying to help make me feel a bit better, more at ease, it makes you feel less on your own, like you are worth something.'

Therefore, for several participants, the action of helping, an essential part of compassion, was prized.

8.4.3 The suffering must be significant for compassion

Nussbaum (2001) in her comprehensive study of the notion of compassion[2], draws extensively on the writing of Aristotle (2018) found within his work, *The art of Rhetoric.* Aristotle proposes that compassion contains 'three cognitive elements', which, he suggests, are necessary for compassion to be present. The first of these beliefs is concerned with value; the suffering is serious rather than trivial (Nussbaum, 2001). Aristotle highlights how we do not generally show compassion for someone who has suffered a loss if we perceive that loss to be small, for example, the loss of a pound coin. In contrast however, we might show compassion to someone who had lost their life savings. Our perception/judgement of the seriousness of the suffering of the other, as we perceive it, determines, in part, the presence of compassion. Indeed, Aristotle (2018, p.80) offers a list of conditions where we may feel compassion towards someone, all of which he perceives as serious: 'Death, physical injury and impairment, old age, illness, malnutrition – these experiences are painful and life-threatening.'

In relation to suicidal behaviour, wider research appears to endorse Aristotle's observations. For example, Saunders *et al.* (2012, p.212), in their systematic review of attitudes of clinical staff regarding people who self-harm, note the 'lethality of an act of self-harm influenced attitudes of nursing and medical staff … with more positive attitudes expressed regarding those who were clearly suicidal.' Likewise, Doyle *et al.* (2007, p.9) in their study of nurses' responses to caring for patients with suicidal behaviour noted that, 'great compassion' was shown towards those patients whose suicide attempts appeared 'genuine.' Doyle's *et al.* (2007) study suggested that the level of compassion expressed by staff was

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[2] In her study Nussbaum (2001) notes how although the ancient Greek terms 'oiktos' and 'eleos' are often translated into English as 'pity', they can also be translated as compassion. Indeed, Nussbaum (2001) argues that the manner in which the English use of 'pity' has become associated with a sense of superiority and condescension, nuances not found within the Greek, compassion being a more suitable translation.

determined, at least in part, by the seriousness of the suicidal attempt as the staff perceived it. Likewise, Martin and Chapman (2014, p.101), when researching emergency health professionals' attitudes towards patients presenting with deliberate self-poisoning, noted: 'If the admission was due to an actual suicide attempt, then staff were empathic and felt compassion for the patient.'

Within this study, it is not possible to determine if the participants perceived higher levels of compassion from staff depending on the medical 'seriousness' of their suicide attempt. Interestingly however, Sophia recalls high levels of what may be termed compassion, when she was most poorly, the nurse helping her and being 'there' when she 'was throwing up everywhere'. Equally however, what may be termed as uncompassionate care, as perceived by the participants, also occurred when participants were very poorly. For example, it was when Lauren was moved to Resus, due to the deterioration in her health, that she recalls being told to 'calm down', being 'lied to', 'the Resus nurse wasn't that nice…'.

For several participants however, it seemed that they did believe that because their mental health difficulties were less visible, they received less compassion. For example, Charlotte described:

> 'Obviously, my partner really looks after me, but I don't get it from anybody else, … They think oh you look presentable, you look this way, so you know there can't be something wrong with you, you know, because mental state is up there [points to her head].'

Likewise, Lauren recognised that not being able to see 'mental health' made it harder for nurses when reflecting on negative aspects of her experience of care: 'It is hard for staff however, I am a nurse and it is hard to take everything in, you can't see mental health.'

Accordingly, it appears that several individuals perceived that the 'hidden' nature of their mental health problems was a reason for experiencing what may be termed less compassionate care, especially compared to other patients with physical problems.

8.4.4 The role of fault in compassion

Aristotle (2018) suggests that a second belief that must be present for the emotion of compassion to be experienced, is the belief that the suffering of the other is 'undeserved'. As Aristotle (2018, p.82) writes: 'Someone who is distressed by undeserved misfortune will be pleased, or at any rate will feel no distress, at deserved misfortune.' Indeed, as Nussbaum (2001, p.311) notes:

> Insofar as we believe that a person has come to grief through his or her own fault, we will blame and reproach, rather than having compassion. In so far as we do feel compassion, it is either because we believe the person to be without blame for her plight or because, though there is an element of fault, we believe that her suffering is out of proportion to the fault.

As discussed above (Chapter 2), the notion of intent lies at the very centre of the classification of suicidal behaviour. Many participants within this study, as discussed above, strongly perceived being in hospital and being unwell to be their fault (Chapter 7.8.5; 8.2.3.4). As Jasmine said, 'it was my fault', as Naomi commented, 'I was very low because what I had done', and as Mollie said, 'I thought shit what have I done.' Many participants blamed themselves. Furthermore, as discussed, many participants perceived that they were judged by others because their suicidal behaviour was perceived as their fault (Chapter 7.7) and equated this with judgment and negative experiences; fault therefore being linked with the perception and experience of compassion.

8.4.5 The role of relatedness in compassion

Aristotle's (2018, p.79) third belief in relation to the experiencing of compassion, was that the suffering being experienced by the other must be something that 'one might experience oneself or people dear to one to meet with, and which seems close at hand.' Within his writing, Aristotle (2018) notes how compassion is felt by those who can relate to the person suffering, perhaps because they, or someone close to them, had or could, suffer in similar ways. We express more compassion when we can relate to the person suffering, perhaps due to their situation, misfortune, age, background, or social status. As Nussbaum (2001, p.317) notes, Aristotle claims:

> Without that sense of commonness … I will react with sublime indifference or mere intellectual curiosity, like an obtuse alien from another world; and I will not care what I do to augment or relieve the suffering.

Compassion, therefore, requires the acknowledgement of our own or our loved one's potential to suffer similarly; related vulnerability (Nussbaum, 2001).

When reviewing the transcripts, several participants appeared to experience high levels of what may be termed compassion from staff members, when they related to the participants situation and suffering. For example, Mark described how the nurse who was 'really nice' 'said she had been through similar things' (Chapter 7.8.2). Likewise, Noah found the nurse who had also undertaken military service in the same region as him and been in a 'similar situation', helpful. As Noah also commented:

> 'Yea with my illness I can find it hard to just approach people in general. The staff here have made that so much more easy for me to do, especially the ones who have been through similar stuff. Um, these staff have been, yea, they have been brilliant, absolutely fantastic.'

For several participants therefore, the experience of care that reflects aspects of compassion seemed linked to relatedness; staff offering something of themselves due to their own personal experiences and vulnerabilities, perhaps even going beyond professional boundaries (see discussion in Chapter 9.4.3.5). Indeed, as Chambers and Ryder (2009, p.2) notes: ‘The distancing of ourselves compromises our ability to be compassionate.’

8.4.6 Summary

Although none of the participants used the word compassion within their accounts of the experience of being in hospital following an overdose, when reviewing the transcripts in relation to this concept, we can glimpse further aspects of their experiencing. First, compassion being associated with action. When staff showed action to alleviate aspects of the participant’s suffering, this was experienced positively by the participants. The action itself, for example, the making of a GP appointment, being valued, but the action also causing the participant to feel valued themselves, and of worth. In contrast however, the transcripts did not suggest that those patients who were more physically poorly received more compassion from staff. Participants, however, did perceive that because their mental health struggles were largely hidden, they received less understanding than other patients. Furthermore, because participants perceived that the reason for their hospital admission was their fault, many perceived that they would experience less compassion; compassion being related to fault. When participants encountered staff who could relate to their suffering however, perhaps through their own past personal struggles, they experienced high levels of what may be termed compassion. Such staff were showing them care and seeking to help them, even going beyond their professional roles to help. A sense of commonness or related vulnerability, motivated such a response from staff; compassion being associated with relatedness.

8.5 Overall summary

In overall summary, my analysis of the transcripts through the lens of Heidegger has enabled me to grasp more fully the starkness of Being-towards-death and associated fear within the participants' accounts. In contrast to Heidegger's writing however, the participants frequently experienced their death through their relationships. Several interviewees did however, as Heidegger suggested, experience a renewed sense of clarity as to the value and purpose of life through Being-towards-death. For many of the participants however, their perception of the past and future caused their present to be experienced as hopeless; Heidegger's writing on temporality highlighting how the totality of the participant's experience of the present, is influenced by their perception of the past and future.

Through the lens of Roger's, the concepts of the actualizing tendency enabled us to notice within the participant's accounts, words of hope and growth, even among despondency; fleeting words that may have otherwise been overlooked. Common self-beliefs were also noted among the interviewees, for example, many individuals perceiving themselves as a burden, at fault, and feeling ashamed. For some participants, their relationships in hospital with the staff caused them to question such self-concepts, but for others these self-beliefs were defended. Although helpful relationships with staff were noted as significant within the thematic review, this analysis has helped us grasp further the qualities valued by participants within these encounters, including unconditional positive regard and congruence.

Through kindness, several participants also perceived that staff were expressing a sense of connection, genuine care, and a shared vulnerability; these qualities being valued and often experienced via small gestures from the staff. Qualities associated with compassion were also experienced from the staff, participants valuing action which sought to improve their situation; also making them feel valued as individuals.

Higher levels of compassion were perceived by participants from staff who could relate to their distress. The perception of fault however, also seemed to cause several participants to believe that they were undeserving of compassion.

Accordingly, the analysis has brought themes already noted within the thematic review into sharper focus and offered new insights into aspects of the lived experience, previously overlooked. Such analysis is therefore carried forward as we now turn to our discussion.

9 Discussion

Having completed the thematic review of the transcripts and analysis, these findings are now discussed further with reference to the literature review and wider research and publications, beginning with the fear of death.

9.1 The fear of death

The fear of death was identified as a significant theme within the analysis of the participants' transcripts, being described, to varying degrees, by all the interviewees (Chapter 7.3). Arriving within the physical space of A&E and the experiencing of physical symptoms, particularly vomiting, seemed to initiate a realisation for many individuals that they could die. Furthermore, it was noted that such fear was often experienced as sudden, surprising, and confusing. It was also noted how coming close to death and witnessing death around them, seemed to cause some participants within the study to experience a desire to live. For other participants however, there was a sense of a battle taking place to overcome the fear of death, a battle which they seem to indicate, required resolve. This theme was also analysed further in relation to Heidegger's (2010) notion of the tranquilisation of death and *das man's* fleeting talk of death. This discussion perhaps enables us to glimpse more powerfully and clearly, the starkness of this experience; when 'they', turns to 'I', before death; the veil of mortality being removed.

Within the academic papers reviewed for this study, the experience of the fear of death is not widely recognised. Indeed, only two academic papers refer to the experience of the fear of death, and then only briefly. First, Hughes *et al.* (2005) in their study of the experience of attending A&E following self-harming or suicidal behaviour, and secondly, Sigurdardottir *et al.* (2012) on men's suicidal thoughts associated with childhood sexual abuse. Interestingly, the theme of the fear of death was more prominent within the review of the autobiographical accounts of the lived experience of suicidal thoughts and behaviour (Haigh, 2015; BBC iPlayer, 2018; Grashoff, 2007; Blauner, 2002). Within these accounts, as for several participants within this study, the fear of death seemed to be triggered as they came close to death (Blauner, 2002) and something to battle against (Haig, 2015; Grashoff, 2007). Accordingly, within this section, the experience of the fear of death, as described by many of the participants within this study, is discussed further in relation to wider research.

9.1.1 A fear identified in history and modern research

Although Katie and other participants within this study, seemed surprised and shocked by their perception of the fear of death, such fear has been recalled throughout history. Indeed, similarly to Alex's and Elizabeth's description of their struggle to overcome the fear of death, different cultures and writers have presented suicide as a courageous act; something that required resolve in the face of fear. For example, Schopenhauer (1892, p.46) notes how the Stoics praised suicide 'as a noble and heroic action.' Likewise, Alvarez (1990, p.72) notes how within Viking times, an instinct towards self-preservation was recognised, with suicide being perceived as 'honour'; 'the surest qualification was death in battle, next best was suicide.' Freud (1918) also recognised this fear of death in some of his patients, terming it thanatophobia, from the Greek meaning fear of death. Freud (1918, p.249) observed how, 'we have shown an unmistakable tendency to put death aside, to eliminate it from life. We attempted to hush it up …'.[3]

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[3] It should be noted however, that Freud believed that the fear of death was an expression of unresolved childhood trauma, Freud also arguing that we cannot truly imagine our own death and when we seek to do so, it is only as a spectator (Meyers *et al.* 2009).

The theme of having to overcome the fear of death to end life, as described by Alex and Elizabeth (Chapter 7.3.4), has also been noted by philosophers. For example, Schopenhauer (1892, p.49) powerfully stated in connection with suicide: 'But the terrors of death offer considerable resistance; they stand like a sentinel at the gate leading out of this world.' Likewise, modern writers within suicide research also highlight the presence of fear when approaching suicide. For example, Shneidman (1996, p.3) suggests that 'each day contains the threat of failure and assaults by others, but it is the threat of *self*-destruction that we are most afraid to touch…'

Furthermore, accounts of the experience of the fear of death occurring suddenly, as individuals come close to death as they perceived it, has also been widely recalled within modern suicide research (Joiner, 2005; 2010; 2016; Joiner *et al.* 2009). For example, Joiner (2016) highlights research into the lived experience of survivors who have jumped from the Golden Gate Bridge in San Francisco; Joiner (2016, 28:37) recalling accounts of how 'a gripping fear of death overtook them' just before they hit the water. Similarly, other survivors have recalled the resolve required to take that final leap from the edge of the bridge (Joiner, 2016). Such accounts perhaps, therefore, reflect the experience of being in acute care for many of the participants within this study.

The experience of how coming close to death can cause an individual to seek life, is also highlighted by Sullivan (1953, p.48f) in his accounts of caring for people who had ingested bichloride of mercury:

> One is horribly ill. If one survives the first days of hellish agony, there comes a period of relative convalescence – during which all of the patients I have seen were most repentant and strongly desirous of living.

Such wider literature, therefore, supports the findings of this research. Furthermore, there are several possible reasons why this finding is not reflected in the previous studies of being in hospital following suicidal or self-harming behaviour, as outlined within the literature review. For example, as noted, such papers were focused on the experience of care, rather than seeking to reveal the whole of the lived experience, as this study seeks to do. Secondly, as discussed, such papers combined suicidal and self-harming behaviour without distinction, the fear of death perhaps not being so significant in the latter.

9.1.2 Ambivalence

The presence of contrasting feelings of seeking suicide and seeking life, as highlighted within this study, is also reflected in wider literature; frequently referred to as the ambivalence of the suicidal mind (Shneidman, 1996; Joiner 2005; 2010). Similarly to Alex describing how, ‘part of me does want to hurt myself and part of me doesn't, part of me wants to feel safe’, Shneidman (1996, p.133) powerfully describes: ‘The prototypical suicidal state is one in which an individual cuts his throat and cries for help at the same time and is genuine on both sides of that act.’ Indeed, Shneidman highlights how individuals are often subjected to competing forces tugging at them, causing them to oscillate between life and death. Shneidman (1996, p.53) recalls the account of a woman who jumped from a high-level balcony in a hospital and survived, even as she was preparing to jump, she was also hoping to be saved:

> … she walked from one building to another on a narrow steel I-beam, high above the ground dressed only in a short hospital gown “hoping that someone would see me out of all those windows, the whole building is made of glass.”

Joiner (2010) also notes how those affected by suicidal thoughts may at one moment be making plans for their future, booking holidays, arranging meetings with friends, but however, moments later finalising plans to end their life. Such evidence, therefore, reflects the lived experience of many participants within this study, and the pull to both life and death almost simultaneously, perhaps influenced by the actualizing tendency. As Alex described:

> When I came in it was bit blurry, I felt ill and upset because I had taken the overdose, upset because it hadn't worked, I wanted it to work, lots of mixed emotions because it hadn't worked, angry and upset but also relieved that I was alive.

Indeed, as discussed in Chapter 2, such ambiguity is recognised by the United States Centre for Disease Control (Crosby *et al. 2011)*, as part of the very definition of suicide.

9.1.3. The focus of the fear

For Olivia and Sophia, the focus of their fear of death seemed closely related to their beliefs about what happens after death. Olivia believed that when someone was dying, they would see a glimpse of 'heaven', or a 'white light'. In contrast however, in A&E, she just experienced 'blackness', an experience she described as 'horrible.' Interestingly, by contrast, Fischer and Mitchell-Yellin (2016) highlighted how near-death experiences have been shown to be associated with reported decreases in the fear of death. For Olivia, however, this was not the case. Similarly, for Sophia, the fear of judgement by God scared her: '…if there is a God, like I am fucked and I am so scared right now.' Like Hamlet, for Sophia, her fear seemed driven by 'the dread of something after death, the undiscovered country, from whose bourn no traveller returns …' (Shakespeare, 2008, p.241).

For many participants, their fear of death was related to a perception of a loss of relationships. In contrast to Heidegger's (2010) writing, for many of the participants, the perception of death was a relational event, as Naomi described: 'To be honest, I am still scared! I was scared of leaving people behind, leaving my family …'. Likewise, as Nyatanga (2008, p.25) notes: 'Death causes a multitude of losses and at different levels of human existence, e.g., social, psychological, emotional, physical and spiritual.' As noted in Chapter 8.1.3, for many of the participants, the greatest loss appeared to be related to the ending of relationships and a sadness of losing their future with loved ones. As Hinton (1991, p.28), noted, death 'forces people to part … imposed and unsought-for separation.' For example, Naomi describing how she was '…scared of leaving people behind, leaving my family…'. Likewise, Alex stating, '…something scares me about dying and leaving my family and friends'. Interestingly, such findings also reflect research around the experience of dying more generally, Russell *et al.* (2018, p.292) noting that: 'Dying is as much a social experience as it is a biomedical event.' Research conducted in relation to palliative care, for example, suggests that when individuals approach death, relationships are often brought into increased focus and accompanied by a wish to strengthen them (Macleod, 2011). The dying person grieves for the future that will be lost with their loved ones, due to their death (Freeman *et al.* 2015). Individuals at the end of life, become concerned about how loved ones will manage after their death (Russell *et al.* 2018); as expressed by Olivia in relation to who would care for her mother if she died. Indeed, the fear of dying, caused some participants to value relationships more than had been previously perceived, as Katie described: 'You feel scared, you feel stupid, how can you be so careless when you have got children.' As explored in our analysis in relation to Heidegger, for several participants, the awareness of death brought about clarity in terms of relationships (Chapter 8.1.4).

9.1.4 Summary

The experience of a sudden and shocking fear when an individual perceives that they are coming close to death, as described by participants within this study, is evidenced in philosophical writing, history, and other cultures. Recent research around suicidal behaviour also indicates that individuals frequently experience fear when they perceive that they are close to death, for example, before hitting a surface following a jump. Wider research also mirrors the feelings of ambivalence reported by many participants within this study, as being commonly associated with suicidal thoughts and behaviour. For many participants within this study, the fear of death was closely associated with their relationships, a perceived loss of future encounters and concern for loved ones, a finding that reflects wider studies around the experience of dying more generally.

Overall, therefore, wider research associated with the experience of suicidal behaviour and dying reflects the findings of the participants within this study. Interestingly, the prominence and significance of the fear of death within the lived experience of being in acute emergency care following suicidal behaviour, has not been identified within previous studies in this area, as shown through the literature review. The findings of this research therefore, offer a new contribution to research.

9.2 The role of stigma and shame

Within this study, several participants reported that they were negatively labelled as a 'suicidal patient'. Six of the sixteen participants described how they experienced being exposed and judged due to their recent suicidal behaviour, by both members of staff and other patients. Furthermore, some participants felt dismissed, ignored, and treated negatively, resulting in feelings of anger and abandonment. Such findings reflect many negative experiences noted within the historical review of the experience of individuals following suicidal behaviour. Furthermore, the findings of this study also reflect those outlined within the literature review. Such studies indicate that such individuals report negative experiences within emergency departments (Taylor *et al.* 2009; MacDonald *et al.* 2020; Hughes *et al.* 2005; Owens *et al.* 2016; Anderson 2018). Accordingly, the findings of this study, as will now be discussed, reflect the wider understanding and experience of stigma and shame.

9.2.1 Stigma

Goffman (1990) described stigma as the process through which society and people move from labelling a specific behaviour negatively, to labelling the whole person in a similar manner. Subsequently, the individual comes to be perceived through a negative lens, being eclipsed by negative stereotypes, including perceptions of their past, present, and future: 'The stigma is the defining feature of the self' (Lewis, 1998, p.128). Furthermore, evidence suggests that stigma can have a profound and lasting impact on the individual's self-image and behaviour (Goffman, 1990) and further increase suicidal intent (Hibbins, 2015); the experience of stigma being closely associated with feelings of the whole person being negatively judged due to their suicidal thoughts/behaviour (Hibbins, 2015).

9.2.2 Anticipatory stigma

The findings of this study, however, suggest that the process of stigmatization is complex. For example, alongside accounts of individuals perceiving experiences that reflect stigma, several participants also questioned these perceptions. For example, Katie used the word 'paranoid', with reference to her perception of people looking at her and judging her due to her overdose. Furthermore, some participants openly acknowledged that they expected to encounter negative stigma within the hospital setting, which may have influenced their perceptions. For example, the expectation of stigma was clearly expressed by Sophia when reflecting her experience of coming into the A&E department. She was reluctant to attend, even though medically unwell, because 'you expect cold, mean and harsh and judgement'. Indeed, Sophia's use of the word 'harsh', perhaps expresses the extent and the power of this anticipatory judgement. Additionally, the sense in which some participants anticipated experiencing stigma is also highlighted by how several interviewees were surprised when staff members were kind to them. For example, it was noted how Charlotte was shocked when she walked past the nurse's station and a staff member called out her name.

Three participants also seemed to defend negative self-concepts of themselves. For example, even when Olivia experienced what she perceived as kindness, this was later dismissed by her as, 'staff just doing their job'. What Olivia anticipated influenced what she perceived and her interpretation of that experiencing. Olivia did not anticipate kindness, and so when it was experienced, it was reinterpreted to align more comfortably with her self-concept, helping her avoid closer contact with the staff.

In many ways, such findings reflect anticipatory stigma. As Thornicroft (2006, p.155) notes:

> There is now strong evidence that people with a diagnosis of mental illness expect to be discriminated against, whether or not this happens in fact, and that these expectations can themselves be profoundly disabling.

Indeed, drawing on Heidegger's notion of temporality, direct and indirect past perceptions of stigma flow without distinction into the individual's present and future experiencing. Consequently, individuals may perceive stigma in situations where they are not actually experiencing it 'externally' (Rayner & Warne, 2015).

The presence and impact of anticipatory stigma is widely evidenced by research conducted over many years, perhaps most famously by Farina *et al.* (1971). Farina *et al.* (1971) showed that, for individuals affected with mental illnesses, their experience of other students was significantly influenced by what they *believed* other people knew about their mental health. More recently Thornicroft *et al.* (2009) in an international cross-sectional survey of 732 participants affected by mental illness, noted higher levels of 'anticipated' discrimination, than 'experienced' discrimination, as recorded by individuals themselves. For example, during interviews regarding intimate relationships: '60% of participants reported anticipated discrimination, but more than half of these (56%) had not experienced discrimination' (Thornicroft *et al.* 2009, p.412). From a phenomenological perspective, anticipated stigma is still experienced stigma, however, such evidence highlights how individuals may experience stigma even in moments when it is not externally observed. In seeking to glimpse the lived experience of the participants, the potential role of anticipatory stigma must therefore be acknowledged.

The evidence around anticipatory stigma has also recently been referenced to explain perceived difficulties in offering help to those affected by suicidal behaviour. For example, Murphy (2017, p.122) argues that: 'A suicidal person is hell-bent on rejecting help, killing off the good as well as believing he or she is all bad and utterly rejectable.' The evidence within this study, however, would not support the strength or the generalisation of such statements. Although this research suggests that, perhaps due to anticipatory stigma and negative self-concepts, individuals affected by suicidal behaviour may find the acceptance of kindness and help both surprising and difficult. Such bold statements as Murphy's are not reflected in the transcripts. The participants' accounts suggest that self-beliefs can be challenged and questioned as shown within the analysis. For example, although Olivia dismissed the kindness of staff as 'just doing their job', at other points during the interview she seemed to fully acknowledge their help and compassion.

Likewise, as highlighted within the analysis, other participants seem to accept kindness and be significantly impacted by small actions and gestures. Rather than being 'hell bent on rejecting help' (Murphy, 2017, p.122), several participants allowed the kindness from a member of staff to impact on them. Indeed, one of the six major themes identified within the interview transcripts was the 'impact of human kindness' on participants. As Hibbins (2015, p.32) writes: 'The power of kindness. It has the power to break through all the barriers which a person has placed around themselves. It is so hard not to respond to someone who is being kind to you.' To explore this further however, it would be interesting to observe the staff interacting with the participants. For example, in the case of Trevor, who felt ignored and rejected by staff, was this an expression of anticipatory stigma and Trevor defending his self-concept, rather than a reflection of the staff's perception of him. Perhaps kindness can be missed, especially if not expected.

9.2.3 Staff self-reported stigma

Overall, however, six participants strongly perceived that they were externally judged and treated differently due to their suicidal behaviour. For example, Lauren described how she was lied to about her medication due to her mental health condition and furthermore, her views were dismissed due to her recent suicidal behaviour. Likewise, Trevor strongly perceived that the staff ignored and abandoned him: 'They will talk to everyone else on this bay, apart from me, they can't get away from me fast enough.'

Such findings reflect wider research which suggests that staff in acute settings, and particularly in emergency departments, do indeed have self-reported negative opinions towards individuals affected by mental illness, self-harming, and suicidal behaviour. As Turner (2017, p.205) notes: 'Perhaps one of the most concerning areas of stigma and discrimination around mental illness is that it is present within the medical profession itself. There are many examples in the literature…' In 2012 for example, Saunders *et al*. conducted a systematic review of the attitudes and knowledge of clinical staff caring for those affected by self-harm and suicidal behaviour. Saunders *et al.* (2012, p.207) noted that staff reported negative attitudes within medical settings; 'feelings of irritation and anger were the most pronounced.' Furthermore, Saunders *et al.* (2012) highlighted how general hospital staff reported 'hostile attitudes' towards individuals attending emergency departments due to self-poisoning. Furthermore, recent studies have confirmed the continuing presence of self-reported negative views among emergency staff. For example, Briggs (2018) conducted a questionnaire of emergency nurses' attitudes towards patients following suicidal behaviour. Data was received from 38 respondents; Briggs reporting that 40% of nurses disclosed negative attitudes towards people who are suicidal. Likewise, a systematic review with meta-analysis by Rayner *et al.* (2019, p.51) reported, 'continuing high levels of negative staff attitudes in ED staff when working with people who self-harm[4].'

Qualitative studies have also evidenced self-reported feelings of frustration among emergency department doctors and nurses, towards repeated suicidal behaviour (Anderson *et al.* 2003; Doyle *et al.* 2007; Rees *et al.* 2015;). Indeed, research suggests that medical staff perceive

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[4] Rayner's *et al.* (2019) working definition of self-harm including suicidal intent.

themselves as the preservers of life, suicidal behaviour therefore being opposed to their work (Anderson *et al.* 2003; Saunders *et al.* 2012; Rees *et al.* 2015).

9.2.4 The experience of shame

Lewis (1998) suggests that the emotional consequence of stigmatization is the experience of shame, a phenomenon he describes as 'wishing to hide, disappear, or die…' (Lewis, 1998, p.137). Indeed, Crowe (2004) highlights how the word 'shame' has its roots in the words disgrace, contempt, scorn and exposed. Furthermore, within the literature review of the wider experience of suicidal behaviour, it was noted how within their autobiographical accounts, several individuals wrote of a feeling of shame associated with their suicidal feelings. Wider research also associates the experience of shame with self-harm and suicidal behaviour. For example, Milligan and Andrews (2005) evidenced a significant relationship between shame and suicidal/self-harming behaviours among women prisoners. Individuals described feeling ashamed of their behaviour, character, body, and appearance because of these acts. Likewise, Rayner and Warne (2015, p.62) highlight how 'self-injury could be conceptualized as a maintenance cycle of anger and shame.'

Within the interview transcripts, Katie is the only participant to use a word directly drawn from the word 'shame' when describing her experience. Despite this however, our analysis of some of the participants' self-structure highlighted a self-concept of shame. Furthermore, the sub-themes identified in association with the theme of being labelled a suicidal patient, closely reflects the understanding of the experience of shame. Participants like Naomi, Trevor, and Mark, for example, described being exposed, watched, and judged due to their recent suicidal behaviour; experiences that resulted in a desire to hide away. As Tangney *et al.* (1996, p.1257) notes: '… shame leads to a desire to escape, hide and sink into the floor and disappear.' Indeed, for Trevor the desire to avoid judgement and hide was so powerful that he sought to seek again to end his life, while feeling exposed on the A&E corridor.

Gilbert (1998) also notes that a further consequence of the experience of shame for some individuals can be anger. As DeYoung (2015, p.24) notes, 'shame explodes into rage…'. Likewise, such comments mirror the sub-theme of 'anger' identified in relation to the experience of being labelled as a suicidal patient. For example, Ellie (Chapter 7.7.4) wanted to 'punch' the nurse whom she experienced as patronising. Similarly, Lauren physically expressed anger during her interview when describing being lied to about her medication (Chapter 7.7.3). Indeed, Tangney *et al.* (1992, p.673), in a study involving undergraduate participants, found that 'shame proneness was consistently positively correlated with anger arousal…' Likewise, Thornicroft (2006) notes how the most common response to anticipated and external discrimination, is anger; shame and anger 'rekindling the other' (Rayner & Warne 2015, p.62)

Finally, the sub-theme of abandonment, also commonly associated with shame, was identified as an emotional consequence of the experience of labelling. DeYoung (2015, p.18) notes how 'shame feels like solitary pain.' As noted above, the experience of abandonment (Chapter 7.7.5) was most articulated by Trevor; an incredibly distressing experience for him. Indeed, Miller (2008, p.374f) recalls the depth of such pain:

> I believe that the most terrifying and destructive feeling that a person can experience is isolation. This is not the same as 'being alone' in the more straight forward sense. It is feeling locked out of the possibility of human connection. This feeling of desperate loneliness is usually accompanied by the feeling that you, yourself, as the reason for the exclusion. It is because of who you are. And you feel helpless, powerless, unable to act to change the situation. People will do almost anything to escape this combination of condemned isolation and powerlessness.

Indeed, Miller's words predict Trevor's attempt to end his life again in hospital, desperate to escape this painful experience of isolation and powerlessness.

Jordan (1997) notes how powerlessness is frequently associated with shame. Likewise, several participants, when speaking of feelings associated with shame, seemed to relate to this sense of powerlessness. For example, when Mollie (Chapter 7.7.2) described the doctors standing at her bedside and speaking loudly about what had happened to her, sharing 'personal stuff' … 'which other people could hear', she kept silent, she did not complain, powerless in that situation.

Finally, Lewis (1998, p.127) also notes that stigma and shame are closely connected with the concept of blame:

> The degree to which stigmatized persons can blame themselves or are blamed by other for their condition reflects their degree of shame. The idea of responsibility and perceived responsibility is central to stigma and shame.

As indicated by the definition of attempted suicidal behaviour employed within this study, suicide has at its core, individual responsibility. The action is self-directed. Likewise, Katie, when using the word 'ashamed' within her interview, related this closely to a feeling of personal responsibility for causing distress to her son.

> He is like 19 but it was unfair of me to make him go through seeing me like that, it's not right. (2) I felt ashamed, ashamed that I had let my son go through that really.

Katie, although suggesting elsewhere in the interview that she suffered with mental health problems, clearly, however, placed the sense of responsibility upon herself. As Lewis (1998, p.128) notes: 'Holding oneself responsible is a critical feature of stigma and in the generation of shame.'

9.2.5 Stigma and the impact of contact

The presence of stigma reported by participants, along with the wider research around self-disclosed negative views of medical staff towards such individuals, is clearly concerning; especially in a 'caring' environment. Such levels of stigma, however, may be considered surprising, considering the high levels of contact between these two groups. For as Yanos (2018) notes, studies have generally found that people with high levels of contact hold fewer negative stereotypes. Indeed, anti-stigma programmes have repeatedly evidenced that in-person contact is the most effective method of reducing negative stereotypes and stigma. For example, Yamaguchi *et al.* (2013) conducted a systematic review of 35 anti-stigma programs. Their findings suggesting that in-person, and video contact, was the most effective in improving attitudes. Within emergency care however, this process does not appear to correspond. Indeed, Saunders (2012) noted that frontline medical staff and especially those who had more experience, have higher levels of negative attitudes towards patients attending due to self-harming or suicidal behaviour.

One possible explanation for this finding may be in Allport's (1979, p.262) work where he suggests it is not the amount of contact that reduces stigma, but rather 'the nature of the contact that is established.' Indeed, Allport (1979, p.264) argued that casual, superficial contact between different individuals may indeed reinforce stereotypes, noting that we are 'sensitized to perceive signs that will confirm our stereotypes.' In contrast however, contact that reached 'below the surface', Allport (1979, p.276) argued, was effective in altering prejudice. For example, where contact moved beyond perceiving the person belonging to a certain group, to making their 'acquaintance', prejudice is reduced (Allport, 1979, p.264). Such contact, although not a relationship of friendship, Allport (1979) suggested, does however require individuals to seek some level of knowledge of the person, independently of labels. Indeed, Allport (1979, p.281) suggested that direct contact was most effective in reducing prejudice when 'it is the sort that leads to the perception of common interests and common humanity between members of the two groups.' Furthermore, positive contact, Allport (1979) suggested, reduced prejudice, when individuals perceived each other as being of equal status.

Such reflections are evidenced within the findings of this study. For example, stigma seemed to be least experienced by participants when staff were perceived as relating to them as fellow humans, even fellow sufferers, as Mark experienced when a nurse spoke of going through similar things. Likewise, for Noah, stigma was perceived as absent in his encounter with a nurse, who spoke of having been in the forces also and described how 'he was in a similar situation to me'. The nurse and the participant encountered each other in their common humanity. Indeed, such findings closely reflecting Rogers' (1961) notion on congruence, as discussed within the analysis section of this thesis; Rogers (1990b) suggesting that when professionals have the courage to remove the façade, to be themselves, and seek an encounter as fellow human beings, rather than as professionals, helping relationships may be formed. Furthermore, our analysis highlighted how at the root of kindness is the awareness of a sense of connection, and likewise, for compassion, a sense of relatedness.

9.2.6 Summary

In summary therefore, within this study, stigma impacted significantly, in a variety of ways, on the lived experience of participants in hospital, following an overdose. Indeed, many participants seem to anticipate being judged and treated differently because of their suicidal behaviour, this impacting on them negatively. To grasp the lived experience of several of the participants, it is vital, therefore, that the possible role of anticipatory stigma is acknowledged. Equally, however, this does not suggest that anticipatory stigma is any less real or important than any other forms of stigma for the participants. Furthermore, the accounts of the participants within this study do not support the view that anticipatory stigma prevents individuals from accepting or experiencing qualities such as kindness and compassion, when expressed towards them.

Furthermore, it must be recognised that the experiences of stigma described by many interviewees, does also reflect the self-reported views of many medical staff towards such individuals. Many of the participants describe feelings associated with the understanding of shame, including feeling exposed, watched, and judged; feeling angry, abandoned, powerless and to blame.

Despite emergency care staff having frequent contact with individuals affected by suicidal behaviour, such stigma appears to persist. One possible reason for this is due to the type and depth of contact that is occurring in this setting. Accordingly, the context and nature of the staff/patient relationship within acute care will be discussed in detail in Chapter 9.4. For, as evidenced within the transcripts, when contact went beyond being superficial to staff encountering patients as fellow human beings, making their acquaintance, stigma and shame was reduced, and the experience of compassion and kindness was perceived.

9.3 Hopelessness and Hope

Within the research findings, hopelessness was identified as a significant theme, with thirteen of the sixteen participants expressing such feelings during their interview. These participants felt rejected and abandoned by the mental health services outside the hospital setting, and likewise perceived that those working within the hospital would also fail to give them the help that they wanted. Consequently, the future was experienced as hopeless.

9.3.1 The role of hopelessness in the suicidal experience

The presence of such feelings of hopelessness within suicidal thoughts has been widely acknowledged, as Freedenthal (2017, p.186) notes: 'Whatever the pain, loss or despair that feed a person's wish to die, suicide is essentially a crisis of hope.' Likewise, within the literature review in this thesis, hopelessness was identified as a theme in both the academic papers reviewed and the autobiographical accounts, of the wider experience of being suicidal outside a hospital setting. Such findings have also been evidenced within large quantitative studies. For example, Beck *et al.* (1985) in a 10-year follow-up study of patients hospitalized and considered 'suicidal', evidenced the presence of hopelessness as a strong long-term indicator of eventual death by suicide. Likewise, in a similar study with outpatients, Beck *et al.* (1990) again evidenced that hopelessness was a strong predictor of death by suicide and interestingly, more directly related to death than depression alone. More recently, O'Connor *et al.* (2015) also employing Beck's Hopelessness Scale, evidenced that hopelessness among 388 patients hospitalized following a suicide attempt, was a strong predictor of further suicidal behaviour. Accordingly, as noted by Galynker (2017), feelings of hopelessness are now generally incorporated within suicide risk assessments.

Overall, therefore, such findings reflect the lived experience of many participants, revealed within this study. Importantly however, the transcripts within this study can also enable a deeper grasp of this experience of hopelessness for these individuals.

9.3.2 Goals, pathway, and agency

Strikingly, many of the participants who expressed feelings of hopelessness also, during their interview, expressed a clear positive goal for the future. Reflecting the notion of Rogers' concept of the actualizing tendency, even individuals who seemed despondent still had a desire for life and growth. For example, Lauren wanted to be well enough to return to her work as a nurse; Mollie wanted to be able to cope with the loss of her best friend; Charlotte wanted the pain to stop; Naomi wanted to feel safe. Although these participants expressed feelings of hopelessness, they also had a clear goal for their future that appeared positive, something that they aspired to. Likewise, within the interviews, many of the participants also articulated a clear pathway to obtaining these goals; they needed help from the Mental Health Service. This help was perceived in different forms for different participants, but significantly the interviewees had a clear sense of what they needed to achieve their goals. For example, for Simon his pathway to feeling better was to see a psychiatrist. For Sophia it was therapy, for Elizabeth it was contact and someone to talk to:

> 'I would like someone to talk to, someone to check up on me, that's what I would like outside, the future depends on if I get any help, that is what my future depends on.'

For Ellie, it was a bed on a mental health ward. Interestingly however, although the participants had a goal, and perceived the means to achieve that goal, where hopelessness seemed to strike was in their capacity or ability to embark on that pathway. For example, Ellie perceived that there was no possibility that she would receive a mental health bed:

> ‘There is no choice in that because of the bed shortage with mental health. At one point the other day there were three of us here for mental health in the four beds of this bay. The future, feels, … dreadful, like I dread it.’

As expressed by Ellie, where hope seemed to be lost for many of the participants was not in the existence of goals, or pathways towards that goal, but their own capacity or ability to embark on that pathway. The participants who expressed feelings of hopelessness had universally perceived rejection and abandonment by the Mental Health Services in the past. As highlighted through our analysis in relation to Heidegger’s writing on temporality, their past, present and future perceptions were intrinsically woven together. Several participants related feelings of hopelessness to struggling to access what they believed to be the correct mental health support and services. Such experiences, therefore, reflected those noted in the review of the care of the suicidal throughout history, including in the community. This finding was also noted within the literature review, for example, as Taylor et al. (2009, p.106) comments: ‘Many service users interviewed said that at the time of discharge they were told they would be contacted to schedule after-care. However, often they heard nothing further.’

Snyder (2000), in his theory of hope, also suggested that the existence of hope requires the presence of goals, pathways, and agency. Reviewing the transcripts, many of the participants therefore had clear goals and clear pathways towards those goals. Interestingly however, for many of the participants within this study, there seemed to be only one perceived pathway to achieving that goal; help from the Mental Health Service. For the participants, all their hope seemed to be founded on achieving that help, and when experience had suggested that such help was not accessible to them, hope was lost. For example, no participants mentioned accessing support from charities, despite there being a large range of help available from the third sector, such as Papyrus (2021). Consequently, when Mental Health Services were unable to offer the support that participants believed they needed, the future felt hopeless and future suicidal behaviour inevitable. Indeed, Murphy (2017, p.65) notes how 'constriction-the narrowing of focus, an almost complete tunnel vision' is one of the main characteristics of the 'suicidal state of mind'. For many of the participants there was just one single pathway and when that was blocked, suicide became the only other option.

Accordingly, for many participants, hopelessness was related to what Snyder *et al.* (2018, p.28) terms agency: '… the perceived capacity to use one's pathways so to reach desired goals.' Along with perceiving only one pathway to achieving their goal, participants believed that access to that pathway was dependent on other people; being provided with help from Mental Health Services. Indeed, such findings reflect wider research evidencing a strong association between feelings of interpersonal dependency and suicidal behaviour (Nuns & Loas, 2005). Furthermore, for the two participants who had strong feelings of hope (Harriett & Katie), again hope was founded on the belief that help would be *provided* for them. For example, it was the nurse's action, phoning up Harriett's local primary care practice and arranging an appointment for her with her general practitioner, that gave Harriet hope.

Overall, therefore, participants had a variety of clear goals, a singular pathway to achieving such goals, and a dependency on others to embark on that pathway that many believed would not be met, resulting in feelings of hopelessness.

9.3.3 Experiencing hope through kindness

In reviewing the transcripts however, although the participants seem to strongly equate hope with accessing help, another factor seemed to also produce hope, namely kindness from staff. Indeed, even for Harriet, was it the appointment that mattered with the GP, or the effort that the nurse had made to make the appointment for her: '… she was on the phone for ages and arranged it!' Likewise, within the findings of this research, it was noted that the concern expressed by family and friends to the participants, was frequently perceived as a surprise and even a reason to live. Likewise, within the lived experience of many participants, when they experienced kindness from staff, they valued this, causing hope to flicker.

Kindness seemed to produce hope. Indeed, Mark even suggested that the brief encounter he had with a member of staff who shared his experience and offered him time, 'was better than all the "counsellors" that have been to the house'. As Joiner (2005, p.220) reflects:

> There is surely at least one common theme through the centuries – it is the provision of human contact, the comfort of another concerned person, often authoritative but maybe not, convey a message of hope consonant with the assumptions and values relevant to that particular time.

Such findings also reflect Roger's (1961) writing on the actualizing tendency. He claimed that hope and growth would occur within relationships where empathy, congruence and unconditional positive regard was present.

Interestingly, the apparent association between the experience of positive encounters with hospital staff, and hope, may also be related to the interviewees' linking hope with the receiving of help from mental health services. Perhaps, being offered a bed, or therapy, or a medication review, is at a more fundamental level, the same as a kind word or a smile; it expresses that someone cares; that someone believes you matter and wants to help. As Cole-King (2015, p.136), notes:

> For many suicidal individuals who are ambivalent about their wish to die, a compassionate interaction with another person can be the

> tipping point back to safety. … Small acts of compassion that last minutes may be remembered for a lifetime.

Indeed, such an experience is perhaps the opposite of the word ‘discharge’, pronounced to so many participants and experienced as a rejection and dismissal.

9.3.4 Summary

In summary, feelings of hopelessness, as identified within many of the participants’ transcripts, is also evidenced in wider research around suicidal thoughts and behaviour. Reflecting Snyder’s (2000) model of hope, many participants expressed positive goals for the future as an alternative to death through suicide. The participants however, appeared to identify a single pathway to achieving that goal, via various forms of support from Mental Health Services. Indeed, their perception of the pathway to achieve their goals seemed very narrow, a phenomenon evidenced in wider suicide research, termed constriction. Furthermore, participants seemed to perceive that their ability to access this help was dependent on other people; their own agency limited. Interestingly however, independent from such thoughts and beliefs, their experience suggested that the perception of positive encounters with staff, also seemed to produce hope. Accordingly, the relationship between participants and staff is now discussed.

9.4 The relationship between participant and staff

Overall, the findings of this research suggest that positive relationships between participant and staff were very significant for many individuals within their lived experience of being in hospital following an overdose. Positive relationships also appeared to foster a sense of safety for many participants; safety being more than simply a place. Likewise, although many participants appeared to explicitly articulate that hope was linked to accessing support from the mental health teams, it was also noted that the transcripts suggest that feelings of hope were also generated through positive relationships with staff. In addition, when analysing the transcripts further, such perceptions of positive and helpful relationships with staff seemed closely aligned to Roger's (1961) descriptions of unconditional positive regard and congruence. Further analysis suggested that positive encounters with staff also closely reflect the perception of what may be termed relational encounters that expressed kindness and compassion. Conversely, negative relationships, and particularly perceived judgement, resulted in feelings of distress, anger, and entrapment for participants. Indeed, such emotions seemed to reflect feelings often associated with the experience of stigma and shame.

Therefore, considering the apparent significance of such encounters with staff, within this section the nature of the impact of the relationship between staff and professionals is explored further. Firstly, I discuss the findings of this study in the context of wider research in supporting individuals affected by suicidal thoughts and the importance of the relationship. Secondly, the participants' accounts are explored in relation to wider research into the role of the relationship between patient and health care professional, considering both the espoused theory and the theory in action. Accordingly, some of the challenges in fostering positive relationships between acute hospital staff and patients are explored and evaluated in relation to the findings of this research.

9.4.1 The role of the therapeutic relationship in the care of those affected by suicidal thoughts

The findings of this study align with research into the impact of professional/patient relationships, in the care of those affected by suicidal thoughts. For example, Winter *et al.* (2013 & 2014) in their systematic review into therapeutic outcomes and processes, in relation to suicide and self-harm, evidenced the importance of the therapeutic relationship and Roger's 'core' conditions. For example, quantitative studies indicated the importance of the therapist's attitudes in relation to successful outcomes (Winter *et al.* 2013); clients wanted to be listened too, accepted, and treated with respect and understanding. Indeed, Winter *et al.* (2013, p.173) commented:

> From the process findings, it may be concluded that any approach towards treating a suicidal client should emphasise establishment of the therapeutic alliance. This seems more important than the technical skills and professional qualifications of therapists.

Likewise, in their review of qualitative studies, Winter *et al.* (2014, p.76) further endorsed this finding:

> Across all studies that looked at clients' views there was an overwhelming consensus that when the therapy was delivered by someone who was understanding, empathic and non-judgmental, it was seen as an effective vehicle to promote change with the client. These specific components are the same conditions that Carl Rogers identified as sufficient for personality change.

Such findings therefore reflect those found within this study, of the positive impact of helpful relationships associated with unconditional positive regard and congruence. Accordingly, such findings support Rudd's (2006, p.19) claim that: 'The importance of establishing a strong relationship with the suicidal patient cannot be overstated.'

9.4.2 The value of relational moments within the NHS – the 6 Cs

Alongside counselling and psychotherapy, the importance of the relationship between health care professional and patient has also been advocated for many years. For example, Peplau's (1991) influential theory of nursing, first published in 1952, suggested that the relationship between nurse and patient was the foundation of nursing practice (Wild, 2018). Likewise, Arnold and Boggs (2020) note how the nurse–patient relationship continues to be central to nursing today, such values being asserted within the NHS via the so called, '6Cs'.

The 6Cs were published by the Department of Health in 2012 as a means of embedding the values of Care, Compassion, Competence, Communication, Courage, and Commitment within the NHS. Indeed, the 6Cs are now found throughout numerous NHS policies, strategies and documents and used in the recruitment, training, and assessment of nurses (Snelling & Sellman, 2017). The establishment of the 6Cs however, were a response to a deeply disturbing period within the history of the NHS; a period where the lack of human care and compassion in healthcare relationships was horrifically exposed, through the events at the Mid-Staffordshire NHS Foundation Trust, evidenced in the subsequent Francis enquiry (2010). Accordingly, the NHS sought to place the caring relationship between health professional and patient at the very centre of everything that it does, not least, in part, through the establishment and advancement of the 6Cs.

Rassin (2008, p.615) suggests that: 'Values are active standards that define social and professional behaviour and affect moral judgement.' Indeed, Rassin (2008, p.614) claims that values 'motivate professional behaviour'. The assertion that such espoused values impact on care and the behaviour of staff has, however, been questioned. For example, Seedhouse (2017, p.14) argues that the belief that self-proclaimed organisational values can change staff behaviour, are an 'extreme delusion.' Indeed, Seedhouse (2017, p.xiii) argues that staff's working values are not defined only by textbooks or even leaders, but also by 'more powerful forces: by our peers, friends, and colleagues, by our biology, by our personal histories, by our education, by our environment and countless other factors.' Indeed, one of the criticisms of Francis's (2010) recommendations and the NHS's response, is that both reports failed to recognise the impact of context on behaviour (Seedhouse, 2017). Many of the failings at Mid-Staffordshire were due to the culture within the hospital, a culture that was driving the staff's approach to care (Seedhouse, 2017). Indeed, within their assignments and lectures, students may outwardly proclaim the espoused theory of the central importance of the nurse-patient caring relationship. In contrast however, their theory in use, during a busy and stressful 12 hours A&E shift, with an organisational focus on targets, may be very different. Accordingly, as Paley (2014, p.274) argues, contextual factors that resulted in the appalling care described by Francis 'cannot be corrected or compensated for by teaching ethics, empathy, and compassion to student nurses.' Indeed, Paley (2014, p.282) notes that when Francis (2010) suggests that compassion can be showed by any member of staff, 'he seriously underestimates the power of contextual factors.'

For example, it could be questioned that within this study, when Trevor described being ignored and abandoned on the corridor by staff members in A&E, crying and screaming out in pain and nobody being 'bothered', was this a result of a lack of compassion from staff in terms of their espoused values, or the result of the context within which they were working. The fact that Trevor was on the corridor in A&E indicates that the department was full; would staff have 'ignored' his crying and screams if there were less patients? It seems highly possible that the context of a busy A&E department impacted on the levels of relational care displayed by staff, that Trevor perceived. Indeed, phenomenology reminds us that we are all Being's-in-the-world. Just as self and world are not two beings but one entity, who we are, how we act and indeed the values we display, cannot be divorced from our context. Indeed, such context causes Grant and Goodman (2019, p.50) to note how the suggestion that Rogerian principles (identified as helpful within this study) should be incorporated within health care today, has been criticised as 'naïve humanism'.

In recent years however, there has been considerable focus on the delivery of person-centred care within health care settings (McCance *et al*. 2021) which seeks to recognise the 'the broad biological, social, psychological, cultural and spiritual dimensions' (McCormack *et al*. 2017, p.3). Person centred care seeks to uphold and develop the core values of 'respect for personhood, authenticity, shared autonomy, respect, mutuality, therapeutic caring and healthfulness' (McCormack *et al.* 2021, p.20) within healthcare practice. Indeed, in literature, person-centred care is 'commonly regarded as a crucial component of delivering high quality health care …' (Bolster & Mania 2010, p.154). As McCormack *et al*. (2017, p.7) recognises however: 'It is also fair to say that there is a gap (or even a gulf!) between the strategic rhetoric of person-centredness and the realities of experiences for patients, families, communities and staff.' McCormack *et al*. (2017, p.7) highlights how the context of healthcare delivery today, impacts significantly on the delivery of person-centred care, resulting in 'contradictions in determining priorities and ultimately the erosion of the quality of person-centredness.' This context is now explored in relation to the values participants expressed in this study, in terms of relationships with staff within an acute hospital setting.

9.4.3 The context of patient – staff relationships in acute care

9.4.3.1. Dualism

Western society and its systems of health care continue to be deeply influenced by Descartes's concept of dualism; the belief that within humans there are two separate, although connected, entities or substances, namely, a non-physical mind and a physical material body (Freeth, 2007). Indeed, Freeth (2020) notes how this 'splitting' continues to influence the way our health systems are delivered today; the NHS dividing conditions of the mind from conditions of the body. For example, it is still common that we locate neurologists within one Hospital Trust who deal with the brain, and psychiatrists who deal with the mind, within another. Indeed, our health care system works within a model of 'either/or', as highlighted in the process of treating patients following an intentional overdose. For example, within a medical hospital, patients are treated solely for the medical effects of their overdose by the hospital staff there. Generally, the mental health teams visit from another Hospital Trust to undertake 'their' assessment (Cross *et al.* 2017). Subsequently, if inpatient mental health care is required for further assessment or treatment, then the patient is moved to another hospital, when a bed becomes available.

Similarly, within nurse training, before commencing their studies nurses are required to choose their pathway, a choice of studying adult, children, learning disability, or mental health nursing. Mental health, therefore, is split from physical health. Such an approach has been openly criticised, not least within the *Shape of Care Review,* Willis (2015) highlighting the need for greater integration between physical and mental health and a more holistic approach to caring.

One of the consequences of nurses specialising is that adult nurses receive little training to support patients with mental health needs. For example, the National Confidential Enquiry into Patient Outcome and Death (Cross *et al.* 2017) reported that of 208 general hospitals surveyed, 54.3% had no mandatory training for staff in any aspect of the care of patients with mental health conditions. Furthermore, a survey completed by 1,340 general hospital frontline staff, including many doctors (45.5%) and nurses (32%), evidenced that in relation to self-harm and suicide: '38.9% of respondents stated they had not had any training in this area at either undergraduate, postgraduate or continued professional development stages of their career' (Cross *et al.* 2017, p.78). Although as highlighted above, A&E is often the only place an individual can attend when they feel suicidal, the staff they encounter are trained to deal with physical problems. Consequently, as Doyle *et al.* (2007, p.1220) evidenced, nurses in emergency departments report a perceived lack of skill when working with patients impacted by suicidal behaviour, 'leaving some nurses feeling as though they were out of their depth.' Understandably, Doyle *et al.* (2007) found that staff therefore perceive that their primary role is that of dealing with the patient's physical needs, and then referring the patient to the Mental Health Teams. Likewise, Crowley (2000) notes how A&E staff believe that communication with mental health patients was the role of counsellors or psychotherapists, or those who had undergone specific training, rather than general A&E nurses. Accordingly, Crowley (2000, p.2) notes that staff generally gravitate towards patients with physical needs that they feel comfortable dealing with, therefore giving mental health patients a 'low status'. Indeed, within this study, Trevor's perception seems to indicate that the medical patients, and their care, took priority:

> Being here I found some staff good, but they seem to spend ages with everyone else, and they just say one minute. … I have to wait a very long time; the staff keep saying they are very busy, and they can't leave this patient. This patient needs them at the moment.

Trevor perceived that the medical patients were more important: 'They seem to think they are more important than me, the way they treat them is right, but they seem to ignore me.' It could be argued therefore, that the dualistic approach within health care fosters such attitudes and behaviour. The medical staff are trained to deal with physical problems, that is their role and their priority.

9.4.3.2 Fear

The lack of training around mental health for adult nurses, can also lead to a sense of fear. Within the ethical discussion section of this thesis, wider research highlighted the presence of fear among medical professionals when talking to people suffering with suicidal thoughts. Indeed, as Freeth (2020) highlights, the fear of having to give an account of your actions in a coroner's court when a patient ends their own life following contact with you, is very real for professionals. Arnold & Boggs (2020) notes how one of the consequences of anxiety among health care professionals is the negative impact it can have on the establishment of relationships with patients; anxiety creating a barrier between the two parties. Likewise, as Bergmans *et al.* (2016, p.140), notes: 'Suicide as a word instils fear, and this in turn elicits a reaction. Sometimes these reactions manifest themselves as defence mechanisms that distance us from the person and their pain …'. Perhaps fear was connected to Trevor's experience:

> No one comes to talk to me, when they do it is just a single question, not are you ok, they laugh and joke with everyone else, they come to me, and they just chuck the medicine at me and then go. It makes you feel bad. Like I am not here, they seem to talk to everyone here apart from me, like they are scared to talk to me.

Furthermore, it can be argued that the adoption of the 'medical model' within health care, also opposes the development of relationships that recognises individuality.

9.4.3.3 The Medical model

Influenced by dualism, western health care systems have generally adopted what is known as the medical model of caring for individuals (Freeth, 2020). Indeed, Rizq (2013, p.20) suggests the 'language' of the medical model has become ‘obligatory’ for those working in the health profession, a ‘lexicon’ that is ‘essential’. The medical model is an umbrella term that is used to describe an approach that essentially perceives people as problems that need effective quantifiable treatments, to produce defined outcomes that are measurable (Mearns & Cooper, 2005). Therefore, within medical care, patients are defined by their condition, their illness determining their pathway. Indeed, their condition becomes their identity. Accordingly, such patients are perceived the same, treatment standardized by condition, the individual not prioritized (Perry, 2019). Furthermore, notions of a caring relationship can be easily overshadowed by the need for diagnostics and treatments, as Adams (2016, p.4) notes: ‘The value placed on the medical model of caring … only reinforced the distance between nurse and the patient because the emphasis was on the disease process itself, not the person or their needs.’ Additionally, the medical model seeks explanation and understanding and, as Gordon (2008, p.19) notes, ‘a search for understanding, for comprehension, can often get in the way of real atunement, real listening.’ Indeed, such a model offers little focus on the importance of relationship, as valued by many participants within this study; the medical model presenting patients not so much as human beings, ‘but as projects to be accomplished or puzzles to be solved’ (Shapiro, 2008, p.5).

Weston and Brown (2014, p.171) notes how such an approach is embedded within medical school training, where the principal focus is on ‘gaining of medical knowledge and technical competence in dealing with disease.’ Accordingly, Weston and Brown (2014, p.171) argue that more person-centred aspects of health care, ‘may appear peripheral.’ Indeed, research suggests that qualities associated with person-centred care deteriorate as medical students progress through their career (*Neumann* et al. 2011; Bombeke *et al. 2010;* Tsimtsiou *et al.* 2007). Furthermore, as Haidet (2020, p.644) reflects, the most determining factor for this, is students’ experience of senior staff; ‘our students often see things that are not patient-centred.’

9.4.3.4 Business model

In conjunction with the medical model, the NHS aims to deliver services that are both evidenced based but also cost effective. Consequently, the NHS is governed by business models of working that seek to focus on accountability and standardisation, with interventions and outcomes measured and costed to produce maximum efficiency (Freeth, 2020). Within such a culture however, it is perhaps understandable to conceive that the value of medical staff offering emotional contact with patients may be reduced, even lost. As Freeth (2007, p.114) comments:

> In a health care culture of demonstrating competencies and ‘doing’ for or to others, preferably performing activities and tasks that are visible and measurable, relationships can easily be, and often is, overlooked or viewed in the most superficial terms.

Likewise, Lewis (2003, p.39) suggests that in the age of corporate management within the NHS, ‘caring is often thought of as the rim versus the *core* of nursing practice.’ The findings of this research, however, highlight how, for the participants within this study, the forming of relationships and contact with staff matter significantly in their perception of care. Rather than being superficial, it was central to their lived experience.

9.4.3.5 Time and workload

Perry (2019, p.560) suggested that a further challenge to providing a caring relationship to patients is time: ‘Nurses have less time to spend with patients, making it much harder to know who they are.’ Indeed, Crowley (2000, p.4) notes how when departments, such as A&E, are experiencing pressure, relationships and talking with patients can 'justifiably be abandoned'. Indeed, 'when time is lacking, nurses can perform only technical functions and are unable to nurture' (Carnevale, 1991, p.25). Although it is recognised that time is 'essential to develop therapeutic communication' (Arnold & Boggs, 2020, p.214), in the NHS, time can be incredibly pressurised. For example, Aiken's *et al.* (2012) in their large-scale study of nurses' attitudes across 12 European countries and the United States, evidenced that England had the second highest levels of self-reported rates of burnout among nurses (42%). Indeed, within our review of the care of the suicidal, such pressures on staff within the acute sector were highlighted, particularly due to staff shortages and high demand for services within A&E (Chapter 3.4). For many participants however, in this study, like Jasmine, staff having time to talk to her was important, although she also seemed to be aware that sometimes they were simply too busy.

> It is just nice, it is nice to, cause I am naturally a chatty person anyway, and so when like someone comes over, I know they have to do their job sort of thing, but it is nice when they say are you ok like, just making general conversation rather than just in and out, in and out sort of thing. I get when they are busy, they just have to do their job sort of thing, but it is nice when we can just chat about normal stuff just like a normal person.

Interestingly however, the findings of this research also suggest that time is not always a fundamental factor in offering a helpful encounter. For example, for Naomi, it was simply the words of a member of staff saying that if she needed to talk to 'give her a buzz', which gave her hope. Likewise, for Charlotte, a busy nurse remembering her name as she went out for a cigarette, made her feel good about herself. This study perhaps suggests therefore, that positive encounters with staff may not always require significant time, perhaps reflecting the value of what

McCormack *et al.* (2011, p.1) terms ‘individual person-centred moments’; brief moments, leaving an enduring encounter.

9.4.3.6 Professional boundaries

When teaching the importance of relationships, nursing and medical textbooks invariably also stress the importance of maintaining professional boundaries within such encounters. Within health care settings, professionals generally occupy positions of power over patients, who are normally vulnerable by virtue of their health care needs (Arnold & Boggs, 2020). Accordingly, boundaries seek to create a safe space within which patient and staff relationships can occur. Furthermore, as evidenced by Lyth (1988) nurses have come to use defensive techniques such as a means as self-protection, Pompili (2015, p.228) noting how the establishment of boundaries within health care relationships prevents staff from becoming ‘over involved’, therefore avoiding ‘emotional contagion’. Indeed, Pompili (2015, p.228) notes, it can feel more comfortable to ‘deal with a “label” and not their internal suffering’. Accordingly, as Gask (2004, p.74) notes: ‘Junior doctors cope with the demands of all the medical specialities by learning how to be emotionally detached.’ For example, professional distance is seen as a mark of professional competence (Gask, 2004), a ‘health coping strategy’ (Sladden, 2005, p.1). ‘During our medical training we are taught to examine facts, remain objective, and not get emotionally involved’ (Sladden, 2005, p.1). Accordingly, Arnold and Boggs (2020, p.184) list ‘warning signs’ that over-involvement may be occurring within a nurse/patient relationship, offering a list of indicators that ‘essential objectivity’ is being lost, that boundaries are being violated. Interestingly, one such indicator noted is: ‘... disclosing personal intimate details about aspects of the nurse’s life that would not be common knowledge’ (Arnold and Boggs 2020, p.184), a ‘warning sign’ also identified by other authors (for example, Lavender, 2017). Indeed, Dowling (2006a) notes how within clinical practice, nurses quickly learn that communicating their feelings to a particular patient frequently leads to criticism from colleagues, with even restrictions being placed upon them.

Such comments, however, appear in sharp contrast to the positive encounters that several participants had with nursing staff within this study, from the participants' perspective, and the importance of congruence. As has been highlighted, participants recalled staff members sharing with them their personal struggles with mental health issues. For example, a nurse who had previously served in the same field of military operation, sharing a little of his experience with Noah and Noah perceiving such offering of personal information from the staff member as positive, even giving him hope. Likewise, Ellie also suggested that when staff shared something of themselves, including personal information such as 'where they were from', it made her feel more positive and increased her sense of self-worth. Such conversations, or congruence, however, would appear, according to Arnold and Boggs (2020), going beyond professional boundaries.

Of course, it is outside the focus of this research to consider if the self-disclosing of such information had a negative impact on the staff members concerned. Or as Grant and Goodman, suggest (2019, p.71), that when nurses feel 'an emotional connection', becoming 'over-involved is most likely to happen.' It is however an approach not advocated by all health professionals, as Yalom (2002, p.26f), pleas: 'I urge you, let the patients matter to you, to let them enter your mind, influence you, change you – and not to conceal this from them.' Indeed, Yalom's (2002) accounts suggests that through supervision, self-awareness, and self-care, it is possible to safely connect emotionally with patients, to offer that authentic caring human encounter that the participants within this study drew hope and comfort from. As Rogers (1980, p.179) suggests: 'We are deeply helpful only when we relate as persons, when we risk ourselves as persons in the relationship …' Indeed, perhaps as Bergmans *et al.* (2016, p.149) observes, it is the fear of that risk, that so often, 'the cloak of professionalism can sometimes be a burden to our humanness.'

9.4.3.7 The risk of kindness

Ballatt (2016) suggests that the NHS is founded on principles closely related to the notion of kindness; an awareness that we are of one kind, having shared human needs, that should therefore be met by a common health system, treating everyone equally. The NHS being 'one of the world's most ambitious (and successful) embodiments of kinship' (Ballatt, 2016, p.94). Despite such principles, Phillips and Taylor (2009), note how kindness has come to be looked upon with suspicion, even as unprofessional; the offering of kindness violating boundaries. As Phillips and Taylor (2009, p.10f) comment: 'The pleasure of kindness is that it connects us with others; but the terror of kindness is that it makes us too immediately aware of our own and other people's vulnerabilities.' Kindness involves risk, as it connects us with people, as highlighted within the analysis. Indeed, Phillips and Taylor (2009) argue that the displaying of kindness has come to be perceived as a temptation, something we may naturally want to do, but something to be avoided for our own protection. '… when we are being kind, we are endangering ourselves with other people - as indeed we are' (Phillips & Taylor, 2009, p.71). Consequently, the offering of kindness can be perceived as the crossing of boundaries that exist to protect professionals. As Chambers and Ryder (2009, p.52) observes: 'Kindness is not always valued in health care though, and worse than that, it is often treated with suspicion, or perceived as being unprofessional or a waste of clinical expertise and time.'

Conversely however, just as the thematic review and analysis of this research indicates, kindness was perceived positively by participants and deeply valued. Furthermore, such findings are also reflected in wider research on the importance of kindness as perceived by patients in health care. For example, Greensweig (2014) notes how evidence from America suggests that 87% of patients consider a physician's kindness to be more important than waiting times, travelling distance, cost, or other skills. Likewise, in relation to the NHS, Chambers and Ryder (2009, p.51) comment: 'Kindness is valued highly by patients and people in general. It is often the absence of kindness that is most criticised when care is seen to be lacking.'

Accordingly, therefore, due to the value of kindness as perceived by patients, despite our suspicion of it, we have come to seek to teach kindness and other relationship qualities, less as a 'way of being' as Rogers (1980) suggested, but more as a skill that we can learn, control, and use when required to meet a particular goal, as now discussed.

9.4.4 Relationship and skills

Hartrick (1997) notes how, while advocating the importance of relationship in medical care, such values have become equated, in training curriculums, to skills that can be learnt and administered for the benefit of patients. Indeed, modern nursing textbooks frequently list large numbers of skills that nurses can use to establish and develop relationships with patients. For example, opened questions, clarification, paraphrasing, and validation (Arnold and Boggs, 2020). 'While relationship may be included in the discussions, it is assumed that forming and being in-relationship is *done* through these behaviour skills' (Hartrick, 1997, p.524). Indeed, Savage (1995), in her study of nursing encounters, found that even human touch was employed by nurses, as a skill with a clear aim. Furthermore, Savage (1995) noted how some nurses used touch, even when they themselves felt uncomfortable with it, because they believed it should be done in certain situations.

Interestingly, for several participants within this study, such practice appears contrary to what they identified as helpful within their relationships with staff. As highlighted within the analysis of transcripts through the work of Rogers (1961), congruence was perceived as very important for many of the participants. For example, as Mark described: 'You can tell when someone says that, and they have learnt it at college or at university'. As Rogers (1961) suggested, what many participants seemed to value within their relationships with staff was not skills, but an encounter with an individual person who was experienced as genuine. Indeed, one of the challenges with seeking to equate relationships with the use of skills is that encounters may become mechanical. Although the medical model of health care embraces practices that are measurable, observable, and knowable, as Hartrick notes (1997, p.524), 'the attributes of human relating extend far deeper into human experience than behaviour skills.' Indeed, it would seem from Mark's comments, that he was aware of this truth.

Furthermore, textbooks on relationship skills also frequently present such methods as a means of achieving an aim; the use of relationship skills often coming with an agenda. Indeed, Sladden (2005, p.3) notes how basic psychotherapy skills can be useful for doctors in their work, referring to them as extra skills 'in your treatment toolbox.' However, as Mearns and Cooper (2005, p.114) note:

> One of the things that often gets in the way of a relationally deep encounter is the desire to do something *to* our clients; for if our attention is orientated towards the outcomes of our work, then it will not be on the client and their experience.

Indeed, such implicit notions of acceptance also reflect aspects of the value of unconditional positive regard discussed above; the individual being fully accepted as they are, without any desire to bring about change.

9.4.5 Summary

In summary, when caring for individuals affected by suicidal thoughts and behaviour, research widely suggests that the quality of the therapeutic relationship is crucial in terms of positive outcomes; such relationships being highly valued by clients and patients. Such findings therefore replicate those of this study. It has also been highlighted how the importance of positive relationships is enshrined within the values of NHS, although the context and culture of health care today mitigates against this. While openly stating the vision of caring, compassionate relationships through values such as the 6 Cs, the environment and culture within which care is delivered negates and hinders this vision. The dualistic approach to health care causes some staff to feel unskilled in the emotional care of patients following suicidal behaviour, even fearful. Likewise, the medical and business model focuses on standardisation and efficiency, rather than individuality and personhood, vital in offering relational care. Furthermore, time and workload may also prevent staff offering the human care that patients within this study appeared to value so much. Additionally, professional boundaries promote emotional distance, in the pursuit of self-care and the protection of patients. Indeed, the offering of kindness to patients perhaps is perceived with suspicion and even as unprofessional, including the relational encounters that the findings of this study suggest made participants feel safe, cared for, and even gave them hope. Furthermore, training within the NHS for medical staff frequently equates the establishment of relationships to skills that can be taught and used. Evidence from this study, however, concurs with Roger’s (1961) suggestion that helpful relationships are more fundamental than skills; it is about genuine attitudes, a way of being.

Accordingly, we now explore the implications for practice, drawn from this research, along with its limitations.

10. Implications for practice, limitations, and unique contribution to knowledge

Within this chapter the main implications for practice arising from this research are presented, followed by a discussion of the limitations of the research and the unique contribution to knowledge. Further details of how the findings of this research have been used and plans for further dissemination can be found in Appendix 10 and 11.

10.1 Implications for practice

'Phenomenology encourages in us the possibility of more thoughtful actions and wiser conduct' (Madjar & Walton, 1999, p.14). Accordingly, in seeking to improve the care of patients attending hospital following an overdose with suicidal intent, the following recommendations are made, based on this study.

1. When caring for individuals following suicidal behaviour, staff should recognise that such patients may be fearful of dying and therefore seek to provide an opportunity for such fears to be heard and acknowledged. Patients who are unlikely to die because of their overdose, should be explicitly reassured where possible. Given the patient's recent suicidal behaviour, this may be surprising to staff, however, this study, along with wider research, highlights the role of fear within the lived experience of suicidal behaviour.

2. Staff should be aware that, following suicidal behaviour, patients may experience high levels of shame and embarrassment. Loud, busy, and unpredictable environments can also enhance feelings of anxiety and increase thoughts of being exposed. Accordingly, patients should be offered privacy, where possible and safe to do so. For example, within

A&E, where possible, staff should avoid placing such patients on corridors where they are in view of other patients and members of the public. Furthermore, when staff talk with patients about their suicidal behaviour, the patient should be offered privacy.

3. Staff should be supported, through reflective practice and supervision, to recognise their own feelings around patients who attend hospital following suicidal behaviour; being encouraged to explore and acknowledge these. Effective supervision has been highlighted within wider literature as a means of promoting and enhancing person centred care, including many of the qualities experienced as helpful by participants within this study, such as kindness and compassion (Bombeke *et al.* 2010; Bond & Holland, 2010; Wallbank, 2016). Effective supervision has also been highlighted as a means of reducing the effects of staff burnout, including depersonalisation (Chambers & Ryder, 2009). The findings of this research highlight how positive relationships with staff are closely associated to patient experience and their perception of their future. For example, to advance the aim of supporting staff and reduce burnout, 'Listening Lounges' have now been established at East Lancashire Health Care Trust. This model, of supportive supervision, has been highlighted by NHS England (Randall, 2021) as an important learning for the NHS. This framework has also been presented to CQC and is to be piloted regionally in the autumn of 2021 by their inspectors. An occasional research paper on 'Listening Lounges', is also to be published in the autumn of 2021. This approach links with the NHS wider *People Plan* (NHS England, 2020) which states that during 2020/21, employees must have access to supportive supervision, funding being provided.

4. The findings of this research suggest helpful support may be offered to patients following suicidal behaviour through the expression, and the patient's perception of, qualities that reflect genuine unconditional

positive regard, kindness, and compassion. Importantly, this study suggests that even the briefest moments of genuine kindness, compassion, and unconditional positive regard, can have a profound effect on such patients, even giving them hope. Training should be offered to staff to enable them to recognise the impact of such qualities when caring for individuals following suicidal behaviour, and staff given the confidence to engage with these patients accordingly. For example, within East Lancashire Health Care Trust, this training is now provided as part of the mandatory Health Care Induction Programme, where staff listen to past patients' experiences of being in hospital and connect with them to gain confidence.

5. Patients, following suicidal behaviour, while often having positive goals that they wish to achieve, may benefit from support being offered to them, to enable them to determine possible pathways to achieving these goals and help in their ability to access them. It may be helpful, to assist patients to consider a variety of pathways for support. For example, within East Lancashire Health Care Trust, all patients admitted to hospital following suicidal behaviour, are now offered a leaflet outlining a range of support services available, including various charities and helplines. These are discussed with the patient by a member of staff. Access to the Samaritans has also been provided via a 'fast dial button' on all hospital bedside phones, with patients being encouraged to use this support during their stay. The offering of this service has now been extended across the Northwest and could be offered nationally.

6. The findings of this study should be shared widely to enable staff to reflect on the possible lived experience of a patient attending hospital following suicidal behaviour, being encouraged to see the person behind the diagnostic label. Within Appendix 10, details of how this has been done to date, and further plans, are outlined. For example,

the findings of this study have been shared with the NHS England Lead for Mental Health. Training based on this research, has also been added to the student Nurses Associates and Medical Students teaching programme, and the Health Care Assistant induction programme, at East Lancashire Health Care Trust. Appendix 11 outlines details of plans for publication of the findings and an application to present at a workshop as part of a national conference on suicide prevention.

10.2 Limitations

Within this research, the following limitations are highlighted:

- Data was collected from a relatively small section of individuals, at one hospital, at one moment in time. Furthermore, the study focuses on one method of suicidal behaviour, for patients who were admitted to hospital. Arguably, this limits the generalisation of the findings. Phenomenology does not however seek to reveal generalisations, but rather aims to produce rich individual data that causes the reader to wonder and glimpse beyond standard labels. Furthermore, as explored above, suicide is a complex and diverse phenomenon, which this study seeks to honour within its research approach.

- The study was conducted by a single researcher, therefore potentially increasing research bias. To seek to mitigate this factor, reflexivity was central to the whole of the study, the author seeking to be visible throughout the thesis, including within the reflective section of the thesis. The researcher also worked closely with his supervisors to support such reflexivity.

- Only six of the participants agreed to have their interview recorded, the other interviewees requesting that notes were taken. This limits the capturing of the fullness of the accounts offered, including the effective capturing of subtle changes in participants’ tone of voice and silences. Notetaking inevitably limited my ability to stay fully focused on the participants’ experience, their words, and their body language. To seek to mitigate this factor, I sought to ensure that the interview notes were as comprehensive as possible, including recording non-verbal data. It was, however, an explicit ethical requirement of the HRA for note taking to be given as a clear alternative to audio recording. Furthermore, with any data collection method, it is vital that the participant feels comfortable if they are to openly share their experience.

- Seven interviews were conducted at the patient's bedside, in bedded bays where other patients were present. Participants may therefore be less open about their experience due to this environment, limiting disclosure. It should be noted however, that although conducting the interviews within the unit's quiet room was the stated preferred choice, it was important to respect the participant's choice and for the interviews to be conducted in a location that participants were comfortable with.

- Arguably, the interviews were relatively short in length, with a range of 15-51 minutes. This was mainly due to the clinical environment and the wellbeing of the patients, which must always be paramount. Equally, short interviews can produce rich data.

- There is more to be revealed of the participant's lived experience. As van Manen (1997a, p.xv) notes, the 'phenomenological conversation is unending.' Phenomenology does not aim to be comprehensive, but rather seeks to offer rich glimpses; lived experience always being more complex and enigmatic than any study or indeed any language can convey (van Manen, 1997a).

10.3 Unique contribution to knowledge

This research offers a unique contribution to knowledge in revealing aspects of the lived experience of being in acute NHS emergency care following an overdose with suicidal intent. The study captures this experience in depth, while the participants were still receiving lifesaving hospital treatment and within 48 hours of their suicidal behaviour. This research upholds the distinction between self-harm and suicidal behaviour.

11. Reflexivity

11.1 Introduction

Along with being the motivation for this study (Chapter 1.2), my work and experiences have also inevitably impacted on every part of the PhD process, from conception to conclusion. As Dowling (2006b, p.7) notes: 'The researcher is intimately involved in both the process and product of the research endeavour.' Within this section, I therefore seek to highlight some of the key factors I sense have shaped this study, drawing on my reflective journal. Within phenomenological research, such reflexivity is considered critical. We can never encounter the experience of another without presuppositions, but through reflexivity we can seek to make the reader aware of such presumptions and seek to contain their impact on the study; to seek to overcome these 'incessant habits of thought' (Holroyd, 2007, p.3) or distractions (Heidegger, 2010). My own fore structures are an inevitable product of my situatedness in the world.

11.2 Wrestling free from the medical model and positivism

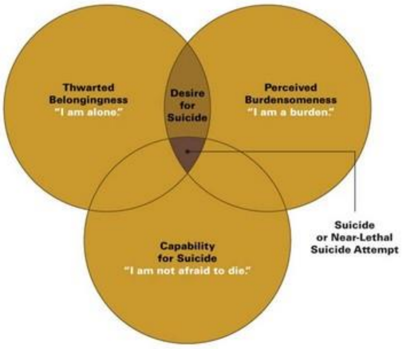


Image 2. The Interpersonal Theory of Suicide model (Messina, 2020).

My work within the NHS inevitably means being immersed within the culture of the medical model and the positivist approach to knowledge; an approach that strives to obtain *the* objective truth, with science being perceived as the method to reveal such knowledge. As I began this study, this model deeply influenced me. Within my work for the NHS, we frequently use a suicide model largely based on 'objective' quantitative research, to help us grasp the suicidal process: The *Interpersonal Theory of Suicide* (Joiner, 2005). A model (Image 2) which as, Chu *et al.* (2017, p.1313) states, 'has contributed to substantial advances in the scientific and clinical understanding of suicide and related conditions.' Indeed, Joiner *et al*. (2009, p.3) claims that this model seeks to offer 'a comprehensive and empirically defensible answer to the question, why people die by suicide?'

It was a model that I believed was helpful, although I always questioned the claim that such a model could account for *all* suicidal actions. Through my work encountering individuals within the hospital, my experience suggested that suicide was much more complex than a model based around three interconnected circles. (From the beginning I seemed to place value on the validity of lived experience). It was, however, a model that made teaching about suicide straightforward, and that was a significant attraction. Nurses and doctors could quickly grasp how notions such as perceived burdensomeness and feelings of loneliness, impacted on the suicidal process. Furthermore, it was a simple model to enable them to reflect on how their care could impact on suicidal feelings. In many ways the interpersonal theory of suicide, for me, was a model that 'tidied' suicide up, made it understandable, squeezing it into a scientific model that perhaps even made suicide feel safer. Through the model I could understand and explain it, and the model even gave me the capacity to influence patient's suicidal processes through the delivery of care. Consequently, it was this model, following the positivist approach, that I first planned within this study, to test within a hospital setting. Were feelings of burdensomeness and being alone, which are central to this model, present in the experience of individuals in hospital, in the hours following suicidal behaviour?

Alongside this desire however, I also passionately wanted to listen to the patient's experience as fully as possible. As noted, and discussed above, the voices of those with lived experience of suicidal behaviour have largely been excluded from research, and I was acutely aware of this

(Chapter 5.2). Moreover, so often in my work, attending Multidisciplinary Team meetings (MDT) about patient care, it frustrated me that as professionals we so often made decisions, determined what was 'right' for patients, with little or no reference to the patient voice. Within such meetings it was felt that the 'professional experts' knew best, especially in relation to those suffering with mental health problems or suicidal behaviour. I would often sit in MDT meetings and become aware that many of the team had not even met the patient being discussed. They were making decisions on the 'patients notes' written by other professionals. This approach was so different from my own approach to working with patients as a counsellor. For example, perhaps unusually, when I get asked to see a patient for the first time, I never read the notes beforehand and always begin by explaining this to the patient. I want them to tell me their experiencing because, for me, that is the highest authority, such beliefs clearly reflecting my Person-Centred philosophy. Consequently, I felt a draw towards phenomenology and its approach to reveal lived experience; I began reading and wrestling with the philosophical underpinnings of this approach.

Over time, I realised however, that I had an important choice to make. If I was going to be authentic to the desire to seek to give voice to the patient's lived experience as fully as possible, as within the phenomenological approach, I had to let go of the notion of testing a predetermined model. The two aims that I was trying to hold were philosophically incompatible, writing in my journal: 'Finally concluded that this is simply not going to work! I have done so much reading around this [interpersonal] theory [of suicide]!' If I wanted to listen and seek to make known the lived experience of the patients as fully as possible, I had to be fully open to that experience. I had to abandon or recognise preconceived ideas and 'scientific' models and seek to be available to whatever I encountered. Indeed, in time I came to believe that to explain and classify participants' lived experience of suicidal behaviour by a pre-determined model, would betray the very desire that was my motivation for undertaking this research. Writing in my journal: 'The aim now, to reveal that lived experience as fully as possible, full stop!'

11.3 Theory constrains expression

My study of the foundations of phenomenology gave me the strength to believe and defend this approach. It is an approach, that I came to realise, is based on deep and profound reflections on what it means to 'be' in the world. Furthermore, the notion that our perceptions are our reality, seemed very important in respect of suicidal behaviours. It is the individual's perception of their Being, from which their choices are made.

In the past I had been aware of the suggestion that phenomenological studies were open to the criticism of 'so what?' They share the lived experience, but 'so what?' In time however, simply observing the world around me, I came to realise the power of lived experience. It was stories of individual's experience that caused people to be moved, to question practices, and even change government policy. It seemed that research that caused us to encounter with individuals, had the power to bring about change, where statistics might fail. Within my own teaching at work, I also saw the impact of using patient stories on staffs' preconceived ideas. I began bringing in speakers more to my teaching sessions around mental health care in the acute sector. Enabling them to share their stories; the impact was powerful. The deep and profound philosophy of phenomenology enabled me to perceive the world around me and people's experience of it differently. Individual experience was so much more complex and multifaceted than any suicidal process model. I began to believe that scientific models took us away from the individual, seeking generalisations, focusing on processes and not people. Furthermore, I realised experience was always in a state of flux and consequently always unique. It was such realisations that caused me to further let go of theories and to embrace a phenomenological approach;

an approach that was far removed from where my beliefs about the PhD journey had begun with the notion of testing an established scientific model.

11.4 With privilege also comes responsibility

The opportunity to research the lived experience of individuals in hospital and within 48 hours of admission, felt an enormous privilege. It was a chance to gather experience with a group of individuals that many researchers would perhaps shy away from due to ethical reasons. Furthermore, I was mindful that it was because of my role within the hospital and the relationships I had with the Executive Team, that gave me this opportunity that many other students would perhaps not be offered. Considerable time was spent reflecting on the ethics of doing this research as safely as possible, but it still felt a huge responsibility. I was also mindful from reading other theses, that other students had been forced to change their plans to conduct research around the lived experience of being suicidal, for example, one such research project being described as 'dynamite' by one university ethics review committee (Moerman, 2011, p.161). Furthermore, despite receiving IRAS approval, with only one minor change and without the need to go to committee, I still knew that the hospital was only allowing me to do this because they trusted me. When I discussed this research with the research department at work, they were open that it was because they 'knew me' that I was being granted permission to conduct research with such a vulnerable group of patients. That trust felt heavy and impacted on the research findings in at least two ways.

First, the interviews were taking place within a hospital that was under pressure and on the busiest hospital ward, the Assessment Ward. I was therefore acutely aware of the need to minimise the impact of my presence on the medical care being delivered; medical care that was frequently lifesaving. The staff on the ward fully supported the research taking place, but to be safe, the interviews, I believed, needed to be focused and relatively short. The participants were still undergoing vital medical treatment, and many were still affected by the physical impact of their recent overdose, and consequently very tired. It was a very different setting from perhaps other phenomenological interviews. It still however, felt like an amazing opportunity and privilege to gather raw data while it was being lived. I was always mindful however, of keeping the interviews focused, for the wellbeing of the patients.

Secondly, I was very mindful that these participants were very vulnerable in several ways. Although most days I work with individuals following suicidal behaviour, conducting this research felt very different. Within my normal work, the patients' needs are normally the only agenda, however here there was also an additional aim, to collect data for my research. At times this felt uncomfortable, I was concerned about almost using these participants for my purposes, although I knew that they had all given informed consent. Furthermore, I was reassured by how participants appeared enthusiastic to take part in the study. Within the interviews however, emotions were frequently extremely raw. Many participants cried, some wept, others were angry and expressed that anger. As Bridges (2015, p.91) notes: 'To "go there" at depth requires also that we are able to come back.' I was very conscious of such a requirement and the fine line between encountering and invading (Mearns & Cooper, 2005). I felt a need to tread softly and sensitively, as I sought to enter a world that was so evidently painful, personal and encounter emotions that seemed raw.

Upon reflection, these two factors, the interview setting and the vulnerability of the participants, impacted on me and therefore the interviews and findings. Reviewing the interviews, on occasions I perhaps could have asked more questions, explored deeper, gone further to understand more fully the background to the stories and emotions that were being expressed. Paradoxically, I believe that my qualifications as a counsellor, caused me to hold back at times in my questioning. In my journal I wrote about how it felt as if being a counsellor gave me a 'power I am very wary of'. I was conscious that through my skills, there was a risk of causing interviewees to connect and disclose beliefs, feelings, and emotions that they might not otherwise do within such an interview. As I approached each interview, I always sought to be mindful that I was there not as a counsellor, but as a research student, and perhaps sought to express this to myself and the participant by wearing my student ID badge, rather than my NHS one. Equally however I was very aware, that I perhaps over-compensated.

For me, the participants' safety always remained paramount. If that caused me to hold back occasionally from asking further questions when the participant became very distressed, as I believe it did at times, this is something I am happy to accept. These participants were individuals, who were incredibly fragile and deeply distressed. My journal during that period was full of such comments: 'Lauren seemed so broken and hurting so much. Desperate on so many levels.' The participants were always people first, and participants second in my eyes. Indeed, the participants' wellbeing always felt so much more important than this research, something I still feel strongly now. Indeed, at times, when discussing the transcripts in my transfer viva I found myself being protective over them. My compassion was noted, but also my defensiveness. I do care about the individuals whose experience are the essence of this thesis. Likewise, just as it has always felt a privilege that the participants let me sense their world at that moment, it has also felt a responsibility; to prevent further harm to them.

In many respects however, once more, the phenomenological approach gave me the confidence to accept this. Phenomenology does not claim to ever seek to describe the lived experience in its completeness; to be comprehensive. Rather it seeks to offer a glimpse of something of that experience, enough to make us wonder, to question, and to take notice. This is something I believe this research, despite these challenges and limitations, has the potential to do. Indeed, when reviewing the interviews, I feel that the power of this research is not in any sense about being complete, tidy, or comprehensive, but rather that it enables aspects of that experience to shine forth with a brutal rawness. This research, therefore, perhaps enables us to glimpse incomplete shafts of light, to illuminate an experience that often remains hidden in the shadows. Through working with my supervisors, reviewing the transcripts, particularly over a long period of time, returning to them again and again and discussing them, I also came to realise what depth was within the accounts I had captured. Each time we returned to the transcripts new elements would be noticed. Furthermore, such discussions with my supervisors also enabled me to become more aware of the impact of my fore structures on the interview process, for example how I noticed words that resonated with my interest.

11.5 Words that resonate with my interest

Although phenomenology had enabled me to appreciate that it is impossible to carve up human experience into distinct unrelated segments, at times during the interviews, upon reflection, my own interests are evident. At points of crossroads, where participants had shared a range of feelings or ideas, and therefore a choice of follow up questions were available, generally I found that I focused on those areas that related to care. I seem to focus on their experience of care within the hospital; both positive and negative. At times I 'heard' more 'loudly' those words that resonated with my work.

I also feel my non-directive approach when working with clients, based on my person-centred approach, is also reflected in the interviews at times (Gillon, 2007). Although I offered questions, I also often followed the participants' lead. I frequently sought clarification, asked for more information, shared what I thought they were saying, to check my understanding and to invite the participant to go deeper. Sometimes however, I seemed to place the locus for the decision making on the areas to be explored with the participants themselves. Again, such practice may also reflect my concern noted above, to encounter, but not to invade. Writing in my journal: 'It feels like in these interviews I am entering such a personal, painful and private world, I don't want to be taking them places they don't want to go.'

In connection with this tendency however, I believe that my reading around phenomenology and concepts, such as the existential life worlds (van Manen, 2014), helped to limit this tendency of mine to enable the participants to control the direction of the interview. Indeed, although not formally used within the thematic analysis, I believe that the awareness of such concepts caused me, for example, to enquire about space, time, and body, even if these areas were not instinctively spoken about by participants. Such reading and awareness, I believe, enabled me to gather more of the wholeness of the participant's lived experience within the interview process and analysis, than would have otherwise occurred.

11.6 A focus on feelings and emotions

Being a counsellor, based within the person-centred approach, also impacted on the things I noticed the most and therefore the responses explored within the interviews. For example, I tended to notice feelings and emotions, more than story or facts. The words that expressed deep emotion; these are the areas that are explored and undoubtedly reflected within this thesis rather than details. Indeed, one of the hardest sections of the thesis to write was the introduction to the participants. This section would have been more comprehensive and perhaps helpful, if I had asked more questions around such things as the participant's age, the gender they associated with, if they had been in hospital before for similar reasons, if they had a family. However, as a counsellor, I rarely ask directly about such information. Frequently, however, it was possible to obtain such information from the story within the accounts. Asking more direct questions about such information, however, might have been helpful, although within phenomenology, the focus should always be on the experience. When struggling with this section I wrote: 'It can be hard, perhaps impossible, to switch between different roles even when we are mindful of our tendencies.'

11.7 A fear of dying

Perhaps based on my experience in work, of being with the dying and sensing the fear that can often be associated with this, this was a theme I am also aware that I explored further, when spoken about by the participants. Furthermore, as the fear of dying is an important aspect of the interpersonal theory of suicide that we teach at work, I believe this may have also influenced my follow up questions (Joiner, 2005).

The fear of death, upon reflection, *is* one that I believe is there within the lived experience of all the participants' accounts, as explored in this thesis. Equally however, it is a theme that I am aware that I was perhaps drawn to explore more fully within the interviews and the study. Its presence as a theme, however, was one that I constantly questioned; indeed, at times it felt uncomfortable that it kept appearing in each account. Within my journal I wrote:

> 'Again, another participant spoke about fearing death, it seems uncanny that this theme keeps coming up in every interview, I hope it is not the way I am asking the questions! I must try to ensure that I never lead participants to this theme.'

Being with people who are facing death, however, is very much part of my working life, indeed in a sense, each working day, 'I walk in the valley of the shadow of death' (Psalm 23.4). Such encounters cause death to be something I think about, frequently being reminded of my own mortality and the fragility of life. Personally however, I do not believe I fear death, although I say that very tentatively. Indeed, until we each face death, I suspect none of us know how we will experience it.

11.8 The journey of reflexivity

One of the greatest benefits afforded by undertaking a part-time PhD, is time. Such time can enable us to gain different perspectives; to look back and see the journey we have made and the reasons for our choices, often due to the horizons at that moment in time. If I were beginning this thesis now, the journey would be very different as I would find myself at a very different starting point; my 'being' different. As phenomenology reminds us, this thesis is an offering of my encounters with this subject and with these individual participants, in a moment in time that will never occur again and can never be repeated.

Within this study, I hope that the reader meets me; throughout its writing I have sought to be visible. Indeed, as Dowling (2006b, p.17) notes: 'Reflexivity is a concept central to qualitative research in general, where it is viewed as a means of adding credibility.' To achieve this, a variety of tools have been employed, most importantly, my reflexive journal. My journal has been a place where I have written openly and freely about my joys and frustrations, but also a place where I have wondered about the roots of these emotions within myself. Roots however, which have frequently been reluctant to be exposed and are sensitive to the light. Just as self-reflection and journaling is a fundamental part of my work as a counsellor, it has also been very much part of the PhD journey. Likewise, my discussions with my supervisors have enabled me to notice myself along this journey. They have also challenged me to notice other paths along the way, to explore different routes, even dead ends, and to question the choices I have made. At times they have also encouraged me to pause and return to parts of the journey already travelled, retracing familiar ground in a more mindful manner. Indeed, during my induction for the PhD course, we took part in a walking labyrinth and were told how the PhD journey is a very similar type of process. It is an image that I have found helpful and reassuring along the way. I think however, at the start I believed a PhD was mainly about producing a thesis to be examined. Now however, I sense the greatest value is in the journey I made in seeking to achieve that goal. For example, the skills learnt in making a IRAS ethical application, and the personal strength I have discovered to keep going when the journey ahead seemed so long. Perhaps most importantly however, has been the discovery of the power and depth of the phenomenological approach that has caused me to question the notion of objective truth. It is a journey that has made me encounter the world around me differently in my daily life; to look through a slightly different lens.

11.9 Covid 19

Finally, I find myself wondering what impact Covid 19 has had on this journey. Covid 19 has undoubtedly changed the world and has changed my being within it. Although the interviews were undertaken before the first wave, the analysis and discussion continued throughout.

During Covid 19, I have witnessed unimaginable suffering, fear, and hundreds of deaths. I have held countless hands of patients as they have gasped for breath, with utter fear in their eyes. I have been with many patients as they were put into induced

Image 3. Myself, working on a COVID 19 ward (BBC North West Tonight, 2020, 4:09 min).

comas so that they could be placed on ventilators, the patient pleading: ‘David, don’t let me die, don’t let me die.’ Most died. Too many times I have stood with iPad, listening to the screams and cries of children saying goodbye to their parents. I wonder if this is why I sensed the fear of death within the participants accounts within this study. Currently, however, I am too immersed in the dark woods, within those shadows, to clearly see the impact of this experience on this thesis. This reflexive journey continues however, through my own therapy as it does for many of us within the NHS who have lived through Covid 19. The impact, undoubtedly however, is there within this thesis.

12. Conclusion

In conclusion, it has been highlighted that suicide is a major cause of death in England, with A&E departments in many parts of the country now being the ‘default pathway’ for individuals in crisis (HLSC, 2019, p.23). Furthermore, the impact of the Covid 19 pandemic is predicted to cause further pressure on mental health services and increase presentations of individuals impacted by suicidal behaviour in emergency departments.

Despite the important role of A&E and general medical admission wards in caring for individuals impacted by suicidal behaviour, the literature review for this study highlights how very limited research has been published into the experience of such individuals in these settings. Indeed, within the search strategy, only five academic papers and two governmental reports were located. Overall, such papers highlighted frequent negative experiences of participants, including the perception of negative judgement and poor experiences of care. Positive experiences were limited. All the papers located failed to distinguish between self-harm and suicidal behaviour as distinct phenomena; this study has focused on suicide specifically. Significantly, none of the papers located revealed the lived experience of individuals in depth. Furthermore, data collection for all the studies located, occurred after hospital discharge, sometimes after a substantial period. It was recognised, that to capture the lived experience as authentically as possible, data collection should occur as close as possible to the phenomenon being explored.

Accordingly, this research sought to offer a unique contribution to knowledge in revealing aspects of the lived experience of being in acute NHS emergency care, following an overdose with suicidal intent. The study sought to capture this experience at depth, while the participants were still receiving lifesaving hospital treatment.

A wider review of the lived experience of suicidal behaviour outside emergency care, also highlighted the complex nature of the suicidal experience. It was noted that phenomenological studies frequently produced findings that revealed lived experience in depth, recognising its multifaceted nature. Accordingly, the writing of key phenomenological thinkers was explored, including the work of van Manen, whose research approach for this study was adopted; the rationale for this choice explored in relation to his six methodological activities.

The ethics of interviewing participants in hospital following suicidal behaviour was discussed, with reference to wider research around suicidology; ethical approval being received. In total, 16 interviews were conducted, and the overall findings presented for each participant. The transcripts were subjected to thematic analysis, six principal themes being identified: 1. Fear of death and dying. 2. The hospital as a place of safety. 3. Loved ones, a reason to live. 4. Hopelessness. 5. Eclipsed as a suicidal patient. 6. The impact of human relationships. The interview transcripts and themes were further analysed in relation to Heidegger's writing on the perception of death and temporality, followed by aspects of Roger's work. Additionally, the interviews were analysed in relation to the concepts of kindness and compassion. Finally, the thematic review and analysis were discussed in relation to wider research.

All the participants recalled experiencing in A&E a fear of death which was both sudden and shocking; Heidegger's writing enabling us to grasp this fear more acutely. Furthermore, this fear seemed related to being in the physical space of the emergency department and vomiting. Coming close to death and witnessing the death of others around them, caused several participants to want to live; the experience of the fear of death being perceived in relation to the ending of relationships with loved ones, and the loss of future contact together. Accordingly the hospital, and the presence of staff, was valued as a place of safety. For a few participants however, the fear of death was something to battle against. Such perceptions of the fear of death, was evidenced within historical and philosophical writing and wider research, ambivalence being common within suicidal thought.

Several participants also perceived that they were negatively judged by staff due to their suicidal behaviour, being dismissed and ignored, leading to feelings of anger and abandonment. Such perceptions reflect the concepts of stigma and shame, although the potential role of anticipatory stigma was acknowledged, reflecting Roger's understanding of the individual's self-concept and its defence. Such findings reflect wider research that indicates negative perceptions among emergency department staff towards patients attending following suicidal behaviour.

Heidegger's concept of temporality highlighted how participant's perception of the past and the future impacted on their experience of the present. Being close to death, for several participants, brought clarity as to how they wished to live their life. For many participants however, while frequently having a future positive goal, reflecting Roger's notion of the actualizing tendency, feelings of hopelessness were very common. This was associated with the participants' perception that the only pathway to achieving their goals was via support from the Mental Health Teams, which they were unable to access. Indeed, it was noted that experiences of constriction and dependency are evidenced within wider research into suicidal thoughts. Significantly however, experiences reflecting positive encounters with staff also seemed to produce feelings of hope, independent of such thought processes.

Positive relationships with staff were deeply valued by participants, such encounters reflecting Roger's descriptions of unconditional positive regard and congruence; empathic encounters with staff not being widely experienced. Descriptions of helpful encounters with staff also reflected qualities associated with kindness and compassion. Perhaps due to anticipated stigma or individual self-concepts, such positive contacts with staff were experienced as surprising by several participants, even uncomfortable. For many participants however, such experiences brought comfort and hope, positive encounters being brief, but impactful.

These findings reflect wider research around the central role of the relationship in supporting individuals impacted by suicidal thoughts. Such relationship values are also promoted within the NHS through the '6 Cs', although its culture and context frequently mitigates against them. Furthermore, within the NHS, relationships are commonly equated to skills that can be learnt and used to produce results. Such an approach does not reflect the experiences of participants within this study, who related helpful encounters with staff, not with skills but with congruence.

Based on this analysis, six implications for practice have been made, with the aim of improving the experience of individuals in acute hospitals following suicidal behaviour.

The impact of some of my own fore-structures have been acknowledged and their influence on this research discussed. This PhD was a journey of discovery for me; wrestling free from the medical model, and a positivist approach within which I work, to the discovery of the power of phenomenology alongside my passion for the experience of patients to be acknowledged, and care improved. Significantly, my own person-centred philosophy impacted on this research, along with my awareness/concern in researching a vulnerable group of individuals.

Kierkegaard (2000, p.460) stated, that if you really want to help somebody, 'one must first and foremost take care to find him where he is and begin there.' This study has sought to connect with 16 individuals in emergency care following an overdose; to dwell in their lived experience. Through this study we have glimpsed their fear and hopelessness, their perception of stigma and shame, the power of loved ones, and the impact of positive staff encounters. Indeed, our eyes have been opened to a lived experience rarely glimpsed.

13. Appendices

Appendix 1: Literature review search strategies

Search strategies

During October and November 2018 and updated in August 2021, electronic literature searches (S.1 & S.2) were conducted using the Boolean operators, via seven databases: MEDLINE, PubMed, PsychoINFO, British Nursing Index, CINAHL, AMED, SCOPUS. The results are listed in table form below.

Search strategy 1 (S.1)

Terms used to search title and abstract:

‘A&E’ OR ‘Accident and Emergency’ OR ‘Emergency Department’ AND ‘Self-Harm’, OR ‘Self-Injury’, OR ‘Suicide’.

Date limit: 2000-August 2021. The start year 2000 was selected as it marked the implementation of *The Department of Health’s* ten-year plan for mental health, which signified significant changes in the care of individuals in crisis (see Chapter 3.4).

Only papers and documents were included within this part of the literature review if they related, at least in part, to the United Kingdom. Many other countries have very different models and levels of health care compared to the NHS, which could impact significantly on individual’s experience of acute emergency care following suicidal behaviour. As expressed within the title of this thesis, the focus of this study is the experience of individuals within acute care within the NHS.

	MEDLINE S. 1	PubMED S. 1	PSYchoINFO S.1	BNI S.1	CINAHL S.1	AMED S.1	SCOPUS	S.1 total articles
Total hits reviewed	835	921	400	135	429	4	1,181	
Patients' views	1	0	1	2	1	1	2	8
Patient views not duplicated	1	0	0	2	0	0	1	4

3,905 articles were subjected to further review with 3,901 rejected due to one or more of the following reasons:

1. The article must be, at least in part, relate to NHS hospitals in the United Kingdom (due to the focus of this study being on the NHS).
2. The article must include, at least in part, the direct experience of individuals suffering with self-harming or suicidal behaviour. For example, not only the views of staff, family, or friends,
3. Duplication.

Due to the small number of studies located and their diverse methodologies, a formal quality assessment tool was not employed, each paper being reviewed individually with the aim of offering a thorough and unbiased synthesis and interpretation of the sources identified (Whittemore & Knafl, 2005).

Search strategy 2 (S.2)

Aveyard *et. al.* (2016) highlights the limitations of relying solely on electronic searches within any comprehensive literature review, suggesting that such an approach would identify possibly only 80% of relevant studies. Consequently, reference lists from the 4 articles located were studied in detail, 3 author searches were conducted, a request was placed on 'ResearchGate', and the BBC news website was searched for links to possible government and third sector reports within this area. The main Governmental website (Gov.uk) was also searched.

Search Terms used:
'A&E' OR 'Accident and Emergency' OR Emergency Department' AND 'Self-Harm' OR 'Self-Injury', OR 'Suicide'.

Date Limit: 2000- August 2021. The article/report must also relate to the United Kingdom and the NHS (see S.1).

The following additional papers/studies were identified:

Patient experience not duplicated s1.	1
Government papers: Patient Experience	2

Due to the small number of studies located and their diverse methodologies, again a formal quality assessment tool was not employed, each paper being reviewed individually with the aim of offering a thorough and unbiased synthesis and interpretation of the sources identified (Whittemore & Knafl, 2005).

Search strategy 3 (S.3)

Terms used to search title and abstract:
'Lived experience' OR 'Phenomenology' OR 'Phenomenological' AND 'Suicide'.
Limits: Date: 2000-2019. Research suggests that attitudes towards self-harm change over time (Barbagli, 2015).

	MEDLINE	PubMED	PSYchoINFO	BNI	CINAHL	AMED	SCOPUS	Total
Total hits examined	239	394	402	33	170	6	557	1799
Suitable for inclusion in Lit Review	6	9	6	0	5	0	11	37
Not duplicated in previous data bases	6	2	0	0	0	0	2	10

1799 articles were subjected to further review with 1789 rejected due to one or more of the following reasons.

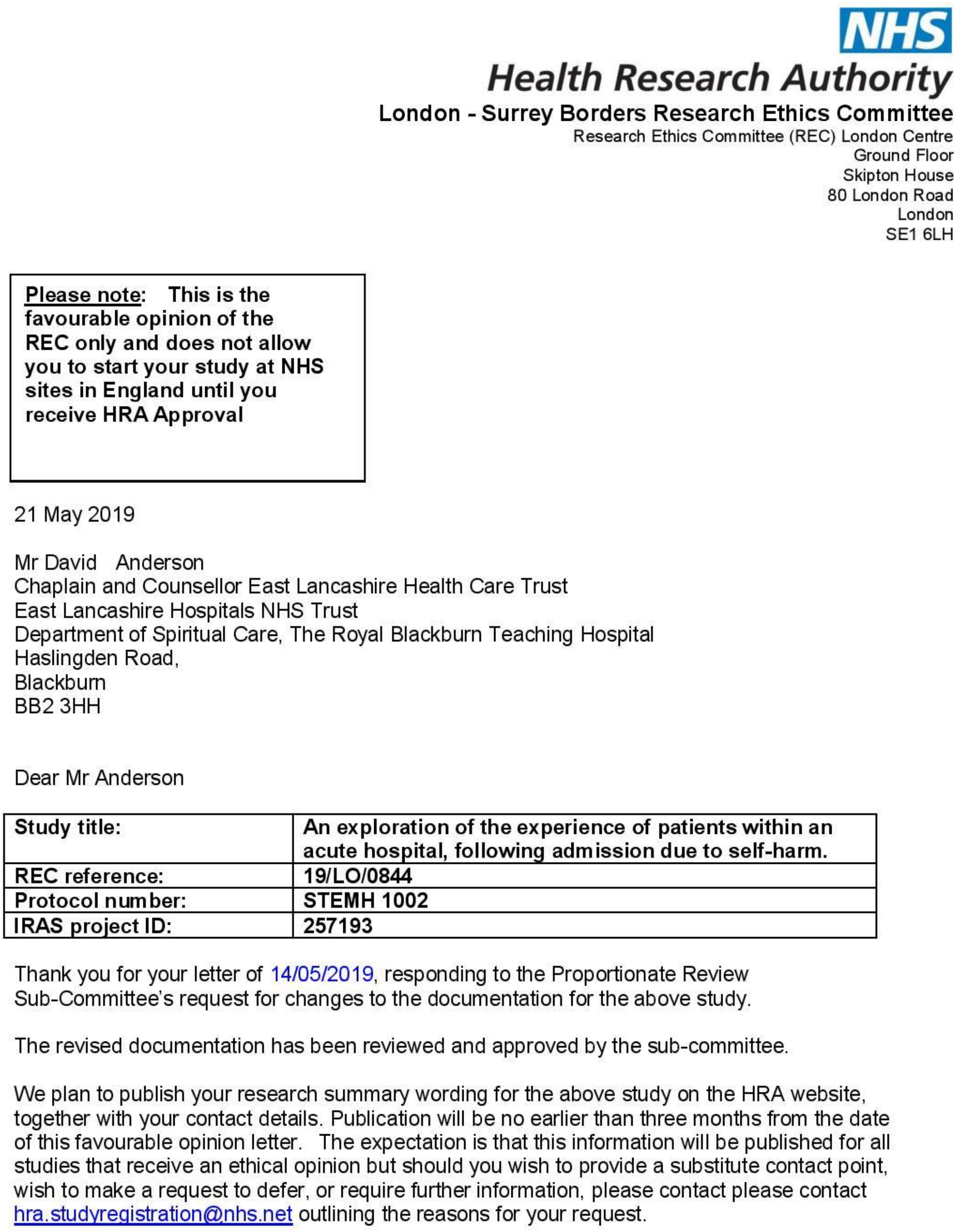
1. The article did not, at least in part, include direct actual lived experience accounts of people who have experienced suicidal feelings. For example, articles that solely shared the views or interpretations of family members or professionals were excluded. Likewise, articles that focused on recovery from suicide and treatment were also excluded if they did not offer insight into the lived experience at the time of feeling suicidal.
2. Articles were excluded if the role of the social culture setting of the study was deemed to have a very significant impact on the lived experience accounts, where this experience was significantly different from the social cultural experience of living in United Kingdom. For example, as noted by Osafo *et. al.* (2015) people who attempt suicide in Ghana were subjected to criminal

prosecution. Sufferers are also frequently subjected to violent physical assaults and experience extreme social ostracism along with their family in connection with suicidal thoughts. Such cultural norms are significantly different from within the United Kingdom and would therefore inevitably impact on the lived experience.

3. Where the focus was on euthanasia rather than suicide.
4. When the article was not written in English.
5. The article had been duplicated in previous searches and already included within the literature review.

Appendix 2: Ethical approval documentation

2.1 Research Ethics Committee ethical approval



NHS
Health Research Authority
London - Surrey Borders Research Ethics Committee
Research Ethics Committee (REC) London Centre
Ground Floor
Skipton House
80 London Road
London
SE1 6LH

Please note: This is the favourable opinion of the REC only and does not allow you to start your study at NHS sites in England until you receive HRA Approval

21 May 2019

Mr David Anderson
Chaplain and Counsellor East Lancashire Health Care Trust
East Lancashire Hospitals NHS Trust
Department of Spiritual Care, The Royal Blackburn Teaching Hospital
Haslingden Road,
Blackburn
BB2 3HH

Dear Mr Anderson

Study title:	**An exploration of the experience of patients within an acute hospital, following admission due to self-harm.**
REC reference:	**19/LO/0844**
Protocol number:	**STEMH 1002**
IRAS project ID:	**257193**

Thank you for your letter of 14/05/2019, responding to the Proportionate Review Sub-Committee's request for changes to the documentation for the above study.

The revised documentation has been reviewed and approved by the sub-committee.

We plan to publish your research summary wording for the above study on the HRA website, together with your contact details. Publication will be no earlier than three months from the date of this favourable opinion letter. The expectation is that this information will be published for all studies that receive an ethical opinion but should you wish to provide a substitute contact point, wish to make a request to defer, or require further information, please contact please contact hra.studyregistration@nhs.net outlining the reasons for your request.

Under very limited circumstances (e.g. for student research which has received an unfavourable opinion), it may be possible to grant an exemption to the publication of the study.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised.

Conditions of the favourable opinion

The REC favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements. Each NHS organisation must confirm through the signing of agreements and/or other documents that it has given permission for the research to proceed (except where explicitly specified otherwise).

Guidance on applying for HRA and HCRW Approval (England and Wales)/ NHS permission for research is available in the Integrated Research Application System, at www.hra.nhs.uk or at http://www.rdforum.nhs.uk.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of management permissions from host organisations.

Registration of Clinical Trials

All clinical trials (defined as the first four categories on the IRAS filter page) must be registered on a publically accessible database. This should be before the first participant is recruited but no later than 6 weeks after recruitment of the first participant.

There is no requirement to separately notify the REC but you should do so at the earliest opportunity e.g. when submitting an amendment. We will audit the registration details as part of the annual progress reporting process.

To ensure transparency in research, we strongly recommend that all research is registered but for non-clinical trials this is not currently mandatory.

If a sponsor wishes to request a deferral for study registration within the required timeframe, they should contact hra.studyregistration@nhs.net. The expectation is that all clinical trials will be registered, however, in exceptional circumstances non registration may be permissible with prior agreement from the HRA. Guidance on where to register is provided on the HRA website.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Ethical review of research sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" above).

Approved documents

The documents reviewed and approved by the Committee are:

Document	*Version*	*Date*
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Professional Indemnity]	version 1	02 August 2018
Interview schedules or topic guides for participants [Interview Questions]	version 1	27 March 2019
IRAS Application Form [IRAS_Form_23042019]		23 April 2019
Other [Further Support Information after participation in research]	version 1	27 March 2019
Other [How to Implement the Mental Capacity Act 2005 and apply the Supporting Code of Practice]	ELHT/C082 Version 7	07 May 2018
Participant consent form [Consent form with change highlighted]	Version 2	13 May 2019
Participant consent form [Consent form - change not highlighted]	Version 2	13 May 2019
Participant information sheet (PIS) [PIS Change highlighted]	Version 2	13 May 2019
Participant information sheet (PIS) [PIS change not highlighted]	version 2	13 May 2019
Research protocol or project proposal [Protocol]	version 1	27 March 2019
Summary CV for Chief Investigator (CI) [CURRICULUM VITAE David Anderson]	version 1	27 March 2019
Summary CV for student [CURRICULUM VITAE David Anderson]	version 1	27 March 2019
Summary CV for supervisor (student research) [CURRICULUM VITAE Gillian Clare Rayner]	version 1	27 March 2019
Summary CV for supervisor (student research) [CURRICULUM VITAE Jean Ellen Duckworth]	version 1	27 March 2019
Summary of any applicable exclusions to sponsor insurance (non-NHS sponsors only) [Public / Products Liability]	version 1	10 August 2018
Summary of any applicable exclusions to sponsor insurance (non-NHS sponsors only) [Certificate of Employers' Liability Insurance]	version 1	01 August 2018

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Reporting requirements

The attached document "After ethical review – guidance for researchers" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The HRA website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

Feedback

You are invited to give your view of the service that you have received from the Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website:
http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance

HRA Learning

We are pleased to welcome researchers and research staff to our HRA Learning Events and online learning opportunities– see details at:
https://www.hra.nhs.uk/planning-and-improving-research/learning/

19/LO/0844 **Please quote this number on all correspondence**

With the Committee's best wishes for the success of this project.

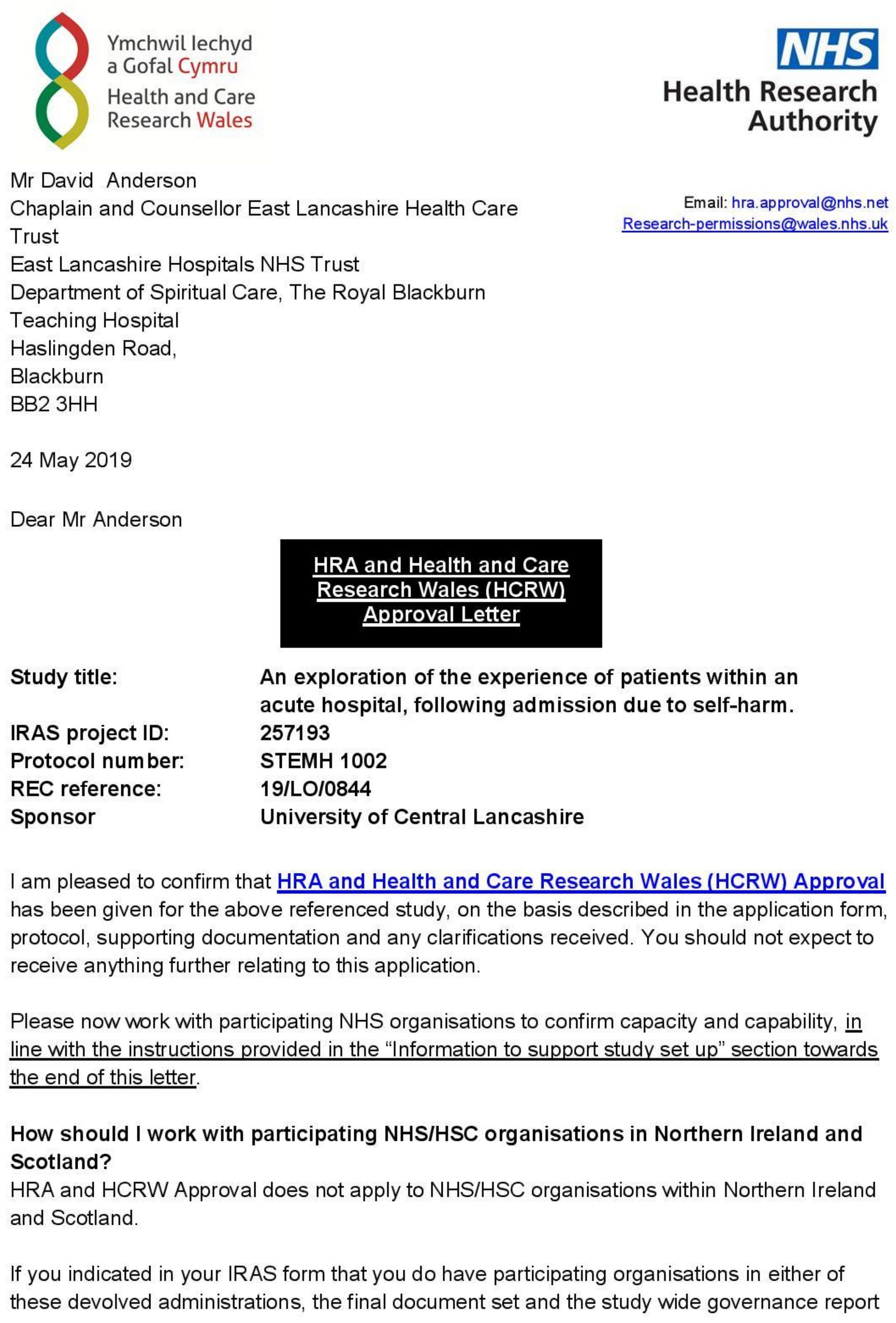
Yours sincerely

P.P. GMartin

Sir Adrian Baillie
Chair

Email: nrescommittee.london-surreyborders@nhs.net

2.2 Health Research Authority ethical approval



Ymchwil Iechyd a Gofal Cymru
Health and Care Research Wales

NHS
Health Research Authority

Email: hra.approval@nhs.net
Research-permissions@wales.nhs.uk

Mr David Anderson
Chaplain and Counsellor East Lancashire Health Care Trust
East Lancashire Hospitals NHS Trust
Department of Spiritual Care, The Royal Blackburn Teaching Hospital
Haslingden Road,
Blackburn
BB2 3HH

24 May 2019

Dear Mr Anderson

HRA and Health and Care Research Wales (HCRW) Approval Letter

Study title:	**An exploration of the experience of patients within an acute hospital, following admission due to self-harm.**
IRAS project ID:	**257193**
Protocol number:	**STEMH 1002**
REC reference:	**19/LO/0844**
Sponsor	**University of Central Lancashire**

I am pleased to confirm that HRA and Health and Care Research Wales (HCRW) Approval has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

Please now work with participating NHS organisations to confirm capacity and capability, in line with the instructions provided in the "Information to support study set up" section towards the end of this letter.

How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?
HRA and HCRW Approval does not apply to NHS/HSC organisations within Northern Ireland and Scotland.

If you indicated in your IRAS form that you do have participating organisations in either of these devolved administrations, the final document set and the study wide governance report (including this letter) have been sent to the coordinating centre of each participating nation. The relevant national coordinating function/s will contact you as appropriate.

Please see IRAS Help for information on working with NHS/HSC organisations in Northern Ireland and Scotland.

How should I work with participating non-NHS organisations?
HRA and HCRW Approval does not apply to non-NHS organisations. You should work with your non-NHS organisations to obtain local agreement in accordance with their procedures.

What are my notification responsibilities during the study?

The document "*After Ethical Review – guidance for sponsors and investigators*", issued with your REC favourable opinion, gives detailed guidance on reporting expectations for studies, including:

- Registration of research
- Notifying amendments
- Notifying the end of the study

The HRA website also provides guidance on these topics, and is updated in the light of changes in reporting expectations or procedures.

Who should I contact for further information?
Please do not hesitate to contact me for assistance with this application. My contact details are below.

Your IRAS project ID is **257193**. Please quote this on all correspondence.

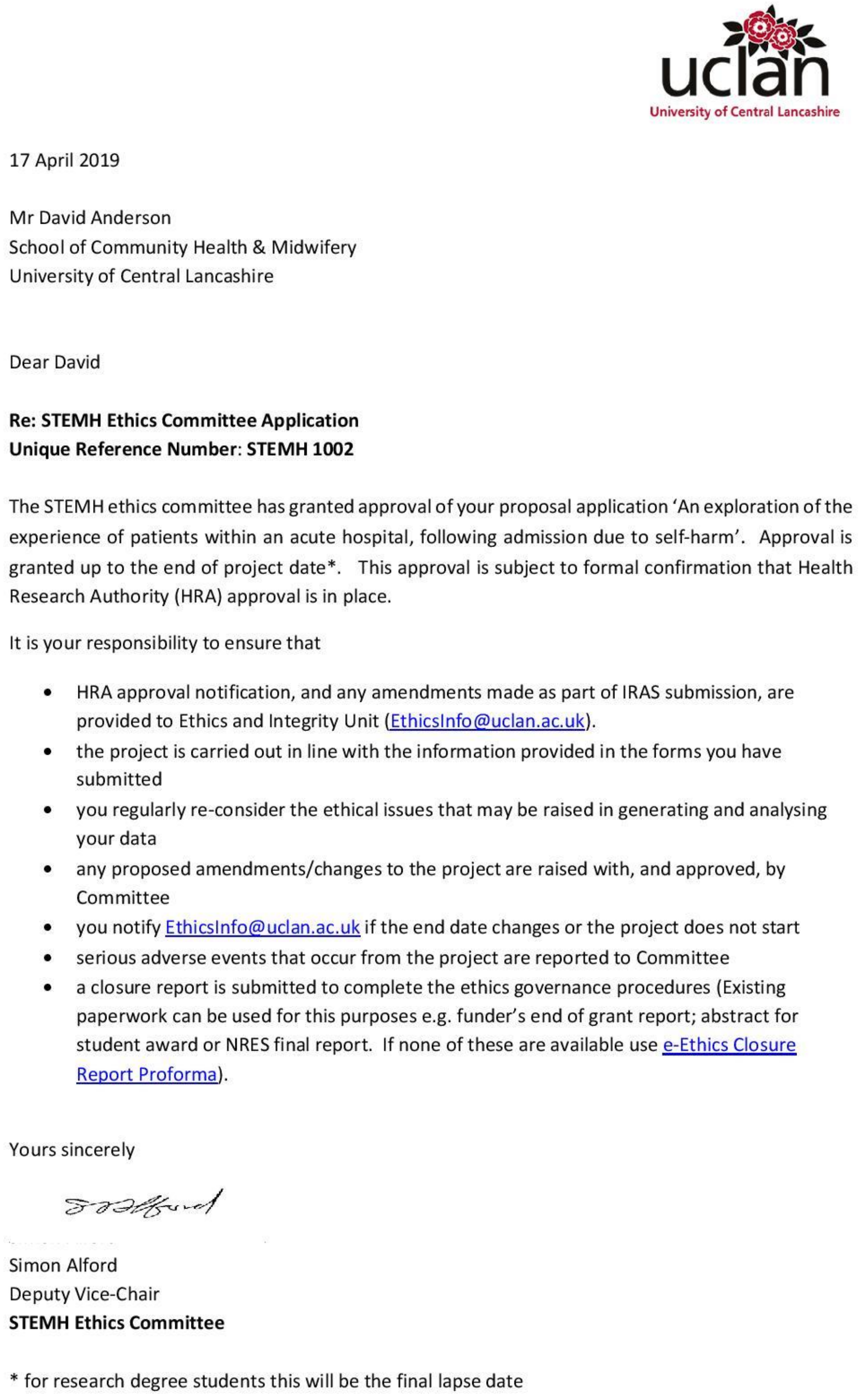
Yours sincerely,
Barbara Cuddon

Approvals Specialist

Email: hra.approval@nhs.net Research-permissions@wales.nhs.uk

Copy to: *Professor St John Crean*

2.3 University of Central Lancashire ethical approval



uclan
University of Central Lancashire

17 April 2019

Mr David Anderson
School of Community Health & Midwifery
University of Central Lancashire

Dear David

Re: STEMH Ethics Committee Application
Unique Reference Number: STEMH 1002

The STEMH ethics committee has granted approval of your proposal application 'An exploration of the experience of patients within an acute hospital, following admission due to self-harm'. Approval is granted up to the end of project date*. This approval is subject to formal confirmation that Health Research Authority (HRA) approval is in place.

It is your responsibility to ensure that

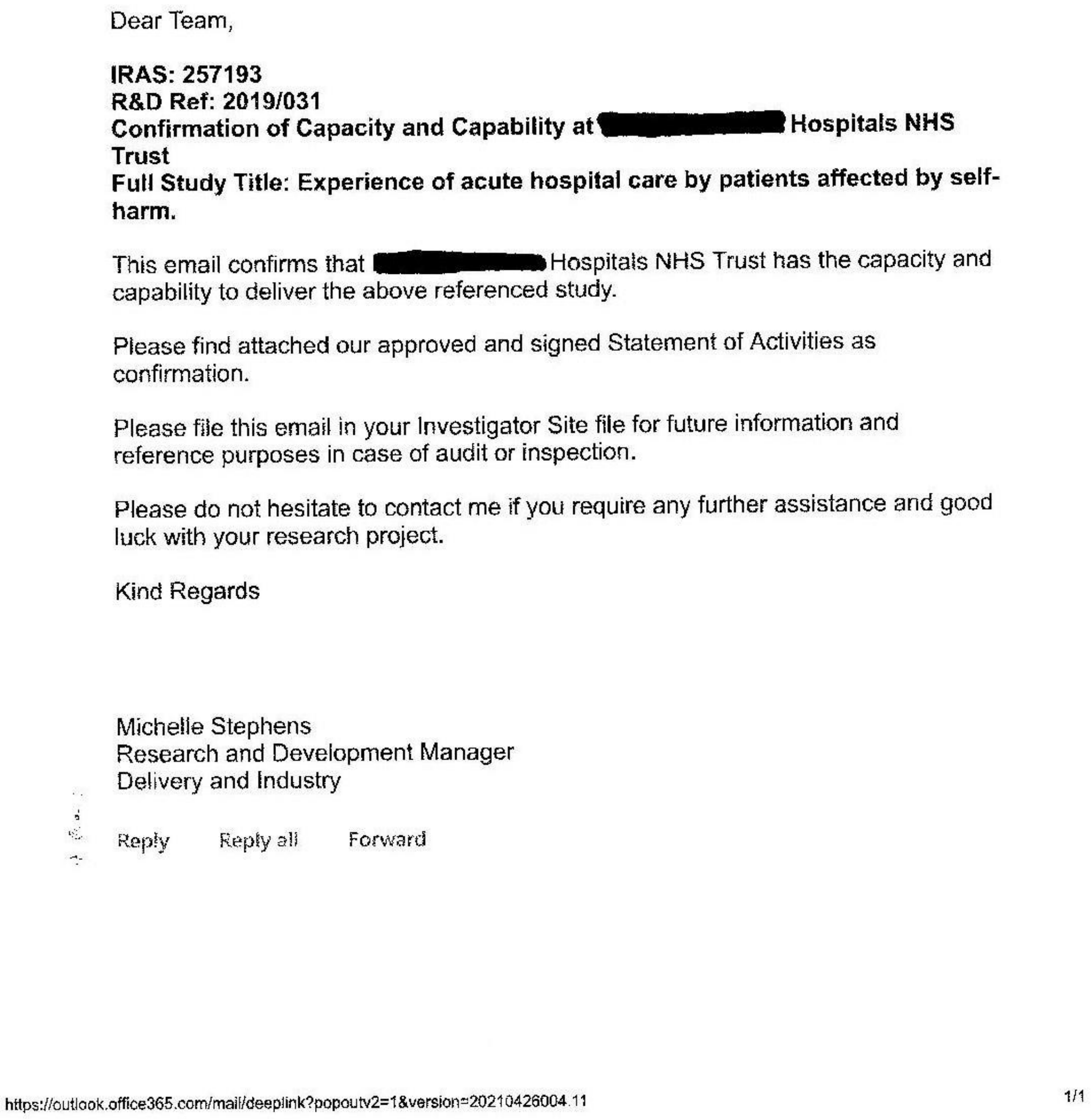
- HRA approval notification, and any amendments made as part of IRAS submission, are provided to Ethics and Integrity Unit (EthicsInfo@uclan.ac.uk).
- the project is carried out in line with the information provided in the forms you have submitted
- you regularly re-consider the ethical issues that may be raised in generating and analysing your data
- any proposed amendments/changes to the project are raised with, and approved, by Committee
- you notify EthicsInfo@uclan.ac.uk if the end date changes or the project does not start
- serious adverse events that occur from the project are reported to Committee
- a closure report is submitted to complete the ethics governance procedures (Existing paperwork can be used for this purposes e.g. funder's end of grant report; abstract for student award or NRES final report. If none of these are available use e-Ethics Closure Report Proforma).

Yours sincerely

Simon Alford
Deputy Vice-Chair
STEMH Ethics Committee

* for research degree students this will be the final lapse date

2.4 Confirmation of Capacity and Capability



Dear Team,

IRAS: 257193
R&D Ref: 2019/031
Confirmation of Capacity and Capability at [redacted] Hospitals NHS Trust
Full Study Title: Experience of acute hospital care by patients affected by self-harm.

This email confirms that [redacted] Hospitals NHS Trust has the capacity and capability to deliver the above referenced study.

Please find attached our approved and signed Statement of Activities as confirmation.

Please file this email in your Investigator Site file for future information and reference purposes in case of audit or inspection.

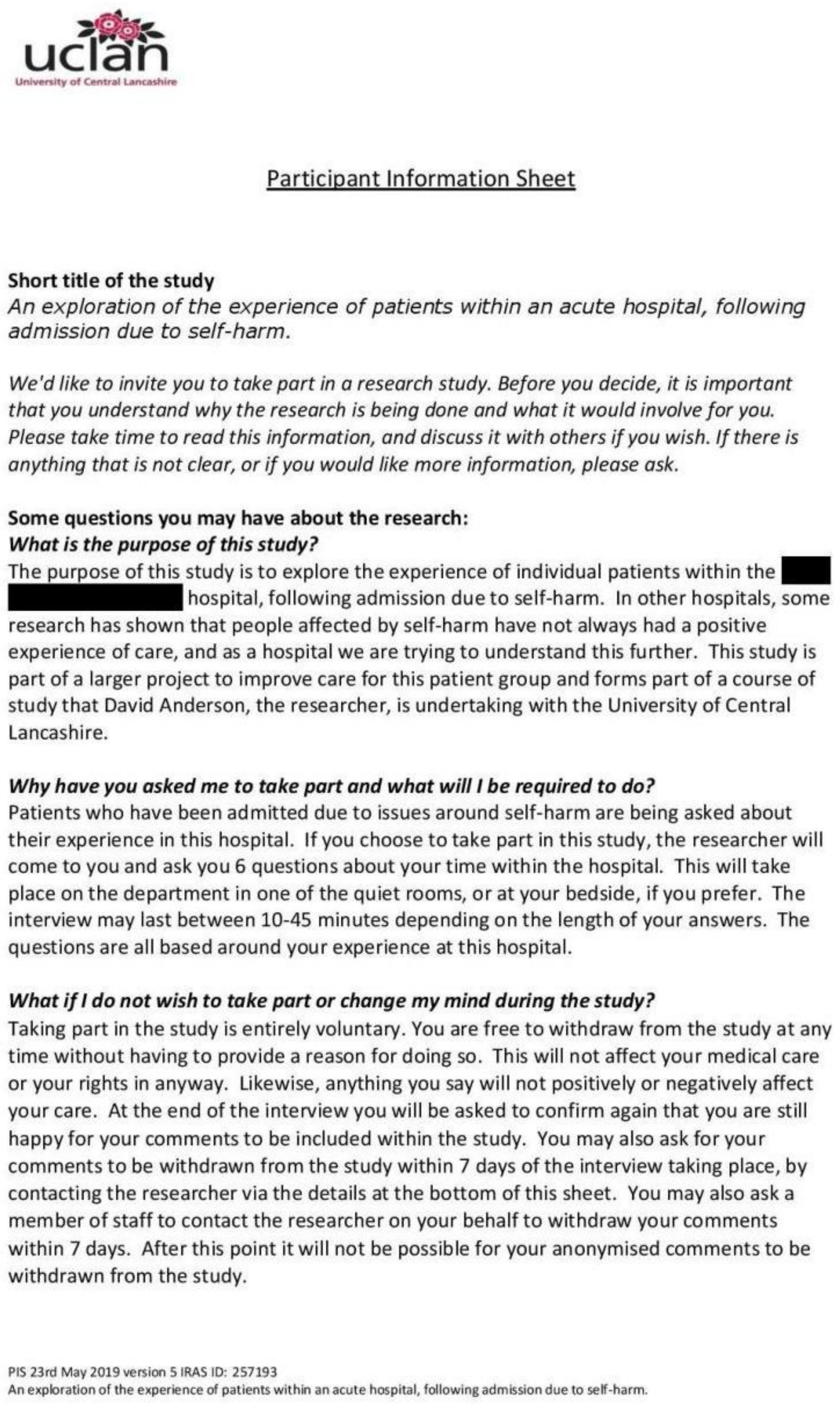
Please do not hesitate to contact me if you require any further assistance and good luck with your research project.

Kind Regards

Michelle Stephens
Research and Development Manager
Delivery and Industry

https://outlook.office365.com/mail/deeplink?popoutv2=1&version=20210426004.11 1/1

Appendix 3: Participant information sheet and consent form



uclan
University of Central Lancashire

Participant Information Sheet

Short title of the study
An exploration of the experience of patients within an acute hospital, following admission due to self-harm.

We'd like to invite you to take part in a research study. Before you decide, it is important that you understand why the research is being done and what it would involve for you. Please take time to read this information, and discuss it with others if you wish. If there is anything that is not clear, or if you would like more information, please ask.

Some questions you may have about the research:
What is the purpose of this study?
The purpose of this study is to explore the experience of individual patients within the [redacted] hospital, following admission due to self-harm. In other hospitals, some research has shown that people affected by self-harm have not always had a positive experience of care, and as a hospital we are trying to understand this further. This study is part of a larger project to improve care for this patient group and forms part of a course of study that David Anderson, the researcher, is undertaking with the University of Central Lancashire.

Why have you asked me to take part and what will I be required to do?
Patients who have been admitted due to issues around self-harm are being asked about their experience in this hospital. If you choose to take part in this study, the researcher will come to you and ask you 6 questions about your time within the hospital. This will take place on the department in one of the quiet rooms, or at your bedside, if you prefer. The interview may last between 10-45 minutes depending on the length of your answers. The questions are all based around your experience at this hospital.

What if I do not wish to take part or change my mind during the study?
Taking part in the study is entirely voluntary. You are free to withdraw from the study at any time without having to provide a reason for doing so. This will not affect your medical care or your rights in anyway. Likewise, anything you say will not positively or negatively affect your care. At the end of the interview you will be asked to confirm again that you are still happy for your comments to be included within the study. You may also ask for your comments to be withdrawn from the study within 7 days of the interview taking place, by contacting the researcher via the details at the bottom of this sheet. You may also ask a member of staff to contact the researcher on your behalf to withdraw your comments within 7 days. After this point it will not be possible for your anonymised comments to be withdrawn from the study.

What should I consider?
Before taking part you should consider if you feel well enough to take part in the interview.

How are my views recorded?
The interview will be recorded on a small digital Dictaphone and then immediately after the interview has ended, transferred to the secure hospital computer system which is protected by passwords and other security measures. The original interview on the Dictaphone will then be deleted. Alternatively, if you prefer, the researcher can take written notes of your comments and then immediately after the interview has ended, these notes will be scanned and uploaded to the secure hospital computer system which is protected by passwords and other security measures. The original notes will then be securely destroyed.

Will any personal details be recorded or kept?
Any details that you give during the interview that may help identify you will also be edited and erased immediately after the interview has ended. An electronic copy of the consent form will be kept by the researcher and a paper copy placed in your hospital notes.

What happens to the data?
The interviews will be transcribed and kept on the secure hospital system which can be accessed by the research student and his supervisors. Brief anonymous written quotations will be used to produce research papers for academic journals, included in a piece of study for the University of Central Lancashire and also shared with the Hospital Trust and wider interested parties, including publications. Brief anonymous quotes, voiced by actors, may also be used for training purposes.

How long will the data be kept?
Interview transcripts will be deleted before 2029, 5 years after the completion of the research project. All audio files will be delated within 3 months of the interviews taking place.

Are there any situations when you will have to break anonymity (tell someone that I said something)?
The only time we may have to inform a member of staff that you personally have said something is:
1) If there is a serious risk to yourself or someone else.
2) If you identify a serious failing in the care the hospital has given you and this needs to be investigated.
3) If required to by law.

Are there any benefits to taking part?
Some research indicates that for patients affected by self-harm, sharing their experiences and emotions can increase a sense of wellbeing and reduce negative feelings.
It is also hoped that by understanding more about the experiences of patients, this information may be used to improve the services and support that we offer to people in the future.

Are there any risks to taking part?

It is possible that by talking about your experience in hospital you may become upset. At the end of the interview the researcher will ask if you would like further support from staff regarding the issues raised during the interview. If you seem to become upset during the interview the researcher may ask if you wish to continue, or the researcher may decide to end the interview and offer you support.

Who has reviewed the study?

All research in the NHS is looked at by an independent group of people, called a Research Ethics Committee, to protect participants' interests. This study has been reviewed and approved by 19/LO/0844 Research Ethics Committee.

How do I give my consent?

If you wish to take part in this study, you will be asked to initial and sign a consent form. You will also be given a copy of the consent form and this participant information sheet to keep.

How can I find out more information or see the results of the study?

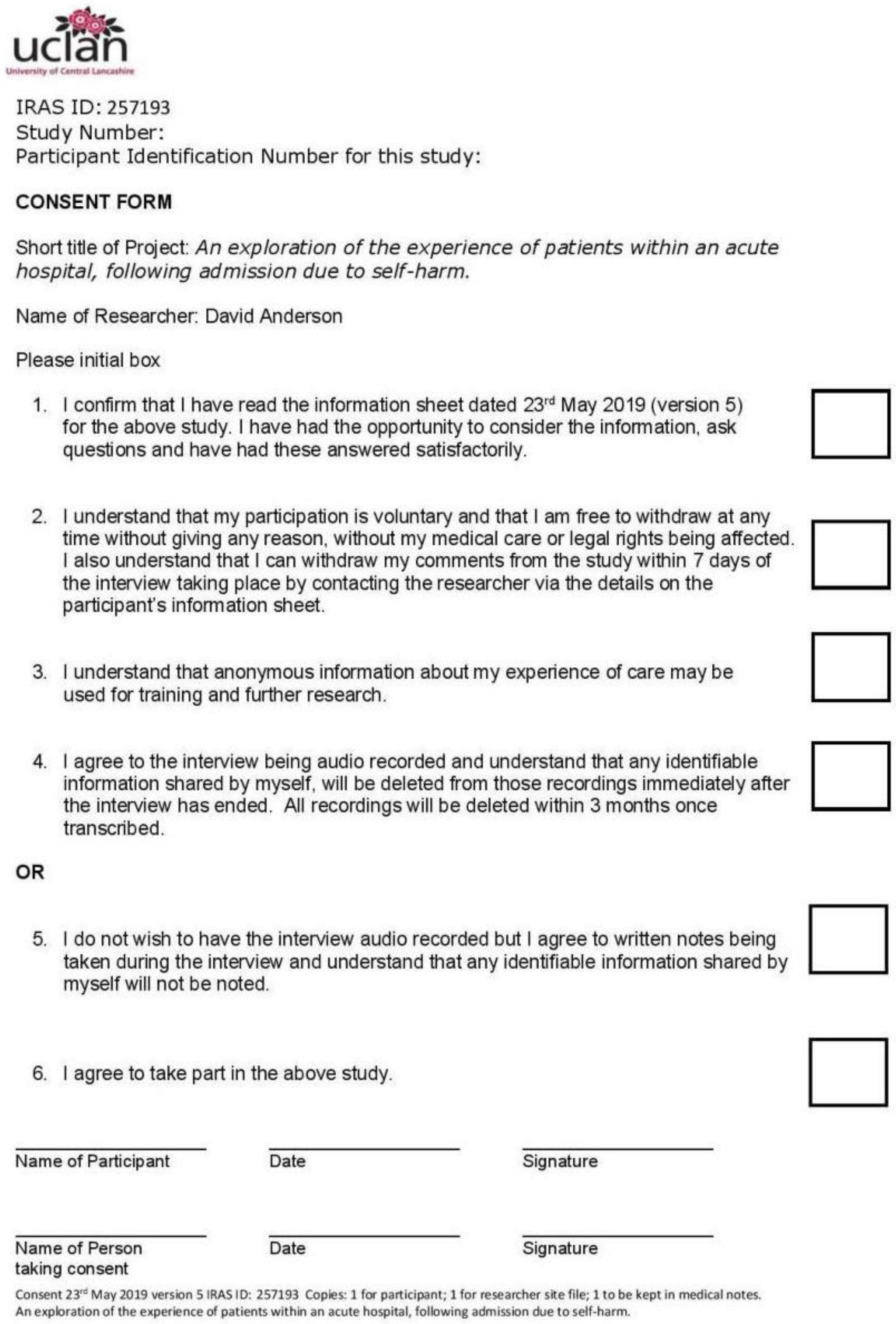
Please contact David Anderson, the researcher, directly on 01254 733632 from outside the hospital, or 83632 from the internal phones if you have any questions or would like to see a summary of the findings after the research is completed. Alternatively, email: David.Anderson@elht.nhs.uk or ask the ward staff to arrange for him to visit you during your stay in hospital.

What if I want to complain about this research?

Please contact: Customer Relations Team, [redacted] [redacted]. From outside the hospital telephone: [redacted] [redacted] from the internal phones, or email: ………………………………. You can also contact the University Officer for Ethics at OfficerforEthics@uclan.ac.uk

Who is the sponsor for the research?

The University of Central Lancashire is the sponsor for this study based in the United Kingdom. We will be using information from you in order to undertake this study and will act as the data controller for this study. This means that we are responsible for looking after your information and using it properly. Individuals from the University of Central Lancashire and regulatory organisations may look at your medical and research records to check the accuracy of the research study. The University of Central Lancashire will keep identifiable information about you for 5 years after the study has finished until 31st July 2029. Your rights to access, change or move your information are limited, as we need to manage your information in specific ways in order for the research to be reliable and accurate. To safeguard your rights, we will use the minimum personally-identifiable information possible. You can find out more about how we use your information Ethics & Integrity Unit, Research Services, UCLan, Foster Building, Preston, PR1 2HE. 01772 892735. IRASSponsor@uclan.ac.uk



IRAS ID: 257193
Study Number:
Participant Identification Number for this study:

CONSENT FORM

Short title of Project: *An exploration of the experience of patients within an acute hospital, following admission due to self-harm.*

Name of Researcher: David Anderson

Please initial box

1. I confirm that I have read the information sheet dated 23rd May 2019 (version 5) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected. I also understand that I can withdraw my comments from the study within 7 days of the interview taking place by contacting the researcher via the details on the participant's information sheet. ☐
3. I understand that anonymous information about my experience of care may be used for training and further research. ☐
4. I agree to the interview being audio recorded and understand that any identifiable information shared by myself, will be deleted from those recordings immediately after the interview has ended. All recordings will be deleted within 3 months once transcribed. ☐

OR

5. I do not wish to have the interview audio recorded but I agree to written notes being taken during the interview and understand that any identifiable information shared by myself will not be noted. ☐
6. I agree to take part in the above study. ☐

Name of Participant	Date	Signature
Name of Person taking consent	Date	Signature

Consent 23rd May 2019 version 5 IRAS ID: 257193 Copies: 1 for participant; 1 for researcher site file; 1 to be kept in medical notes.
An exploration of the experience of patients within an acute hospital, following admission due to self-harm.

Appendix 4: Medical pathway following intentional paracetamol overdose

4.1 Introduction

To place the research in context and to enable the reader to connect further with the lived experience of the interviewees, the medical pathway that was followed by the participants is outlined below. The use of images is intended to enhance connection. The images were however, taken at a variety of hospital sites to ensure anonymity, but were chosen as they closely reflect the various environments encountered by the participants within this study.

4.2 The arrival

Image 4. Outside A&E.

7 of the 16 participants arrive at the A&E department via transport from family and friends. They book in at the reception desk themselves, giving details of the reason for their attendance. The participants are directed to the A&E waiting area, until being triaged by a member of nursing staff in the assessment room, adjacent to the waiting area.

Image 5. Emergency Ambulance.

9 of the 16 participants arrive by emergency ambulance and enter the A&E department via the ambulance corridor. They are then, ideally, taken into one of two Rapid Assessment Rooms within the department. If these rooms are already occupied, as is frequently the case, the participants remain with the ambulance crew in their care. They join a line of patients in a corridor waiting for assessment. This wait ranged from a few minutes to over an hour. Those participants considered extremely poorly, upon arrival, are taken to Resus, for immediate emergency treatment.

4.3 Initial assessment

Image 6. Assessment room in A&E.

Within the assessment room, the participants are all cannulated and have their bloods taken, which are then sent to pathology for analysis. A brief history of the participants is recorded by an A&E nurse, covering the following areas (Crouch *et al.* 2017):

What drugs or chemicals have they taken?

What time the drugs were taken and the amount, and whether they were ingested, injected, or inhaled?

Has the participant vomited since taking the overdose?

What other medications is the participant currently taking?

Does the participant have any known allergies?

Does the participant have any other medical conditions?

Does the participant have any previous history of depression, mental illness, or attempted suicide?

Does the participant still feel as if they wish to end their life?

4.4 Blood test results

Image 7. A&E corridor.

Following their paracetamol overdose, during the first few hours most of the participants are conscious and display few symptoms, apart from vomiting, nausea, and malaise. Advance symptoms of jaundice and elevated liver function tests normally appear after 2-3 days (Crouch *et al.* 2017). For some participants, treatment is started immediately if they are: displaying signs of jaundice, hepatic tenderness, if the overdose had been staggered over an hour, or if the time of the ingestion is unknown but within the last 24 hours. Otherwise, if the blood results can be acted upon within 8 hours of the overdose ingestion, the participant is placed on the corridor in A&E or within a cubicle, or asked to sit in the main waiting area, until the blood results are received (Crouch *et al.* 2017). Participants considered at high risk of suicide are placed within the view of the staff, on the corridor or in a cubicle, opposite the nurses' station.

4.5 Treatment in A&E

Image 8. Overdose treatment tray in A&E.

For all the participants, the blood test results indicate that treatment is required to prevent liver damage and liver failure. Therefore, three infusions of differing strength of acetylcysteine are administered. The first of these lasts 1 hour and is given in the A&E department. The second and third infusion lasts 4 hours and 16 hours, respectively. This is also given in the A&E department or on the Admission Ward once a bed has become available. Overall, due to problems with cannulas, line blockages and the need for further blood tests, treatment takes over 30 hours; all the participants therefore waiting in A&E in a cubicle or on the corridor, for an admission bed. Waits in A&E, for a few of the participants exceed 12 hours.

4.6 Transfer to assessment ward

Image 9. Medical Assessment Ward.

The hospital has a 42-bed Admission Ward and a second 41-bed Admission Ward. All participants are assigned a bed purely on availability; neither ward has areas for certain groups of patients, such as those affected by mental health problems. On the Admission Ward the acetylcysteine treatment continues. None of the participants are considered at high suicidal risk and therefore are not placed under 1:1 Heath Care Assistant observation. The decision to place patients under 1:1 observation is also influenced however, by other pressures within the ward. The two wards have a total of 8 Health Care Assistants for 83 patients during the night shift.

4.7 Completion of treatment and mental health assessment

Image 10. Hospital clock.

Once the third infusion is completed, bloods are taken and tested again to assess liver, kidney, and clotting function. If further treatment is required, another 16-hour infusion of acetylcysteine is given. When the blood tests results are acceptable however, the patient is referred to the Mental Health Team for assessment. In theory, this assessment should be requested when the medical staff consider the patient is fit for assessment, however in reality mental health services only agree to visit the participant once all medical treatment is complete (Cross, *et al.* 2017). From the point of request for mental health assessment being made, participants wait up to 24 hours for this to occur.

4.8 Participation in research

Image 11. Admission Ward quiet room.

Interviews for the study are conducted on the Admission Wards, while participants are continuing treatment or waiting for assessment from the Mental Health Team.

Appendix 5: Data table

Pseudonym name	Length of interview	Method of recording	Location of interview on ward
Alex	32 minutes	Notes	Quiet Room
Charlotte	20 minutes	Audio	Bedside on bay
Elizabeth	22 minutes	Notes	Bedside on bay
Ellie	21 minutes	Notes	Bedside on bay
Harriett	15 minutes	Notes	Quiet room
Jasmine	35 minutes	Notes	Quiet room
Katie	25 minutes	Audio	Bedside – side room
Lauren	50 minutes	Notes	Bedside – side room
Mark	41 minutes	Notes	Bedside – side room
Mollie	45 minutes	Notes	Bedside bay
Noah	44 minutes	Audio	Bedside bay
Namoi	20 minutes	Audio	Bedside – side room
Olivia	22 minutes	Audio	Bedside bay
Simon	51 minutes	Notes	Bedside side room
Sophia	35 minutes	Audio	Bedside side room
Trevor	40 minutes	Notes	Bedside bay

In total 19 potential participants, having met the inclusion criteria, were invited to participate in the research. 2 individuals declined, 17 accepted. One interview was terminated after 6 minutes by the researcher as the individual wanted to speak exclusively about the reason for his suicide behaviour, support was therefore given separately to enable this. All data from this interview was immediately deleted and excluded from the study. In total therefore, 16 participants were interviewed as outlined in the table above, 4 males and 12 females. All participants had taken a paracetamol overdose within the past 24 hours, at least with some intent to end their life.

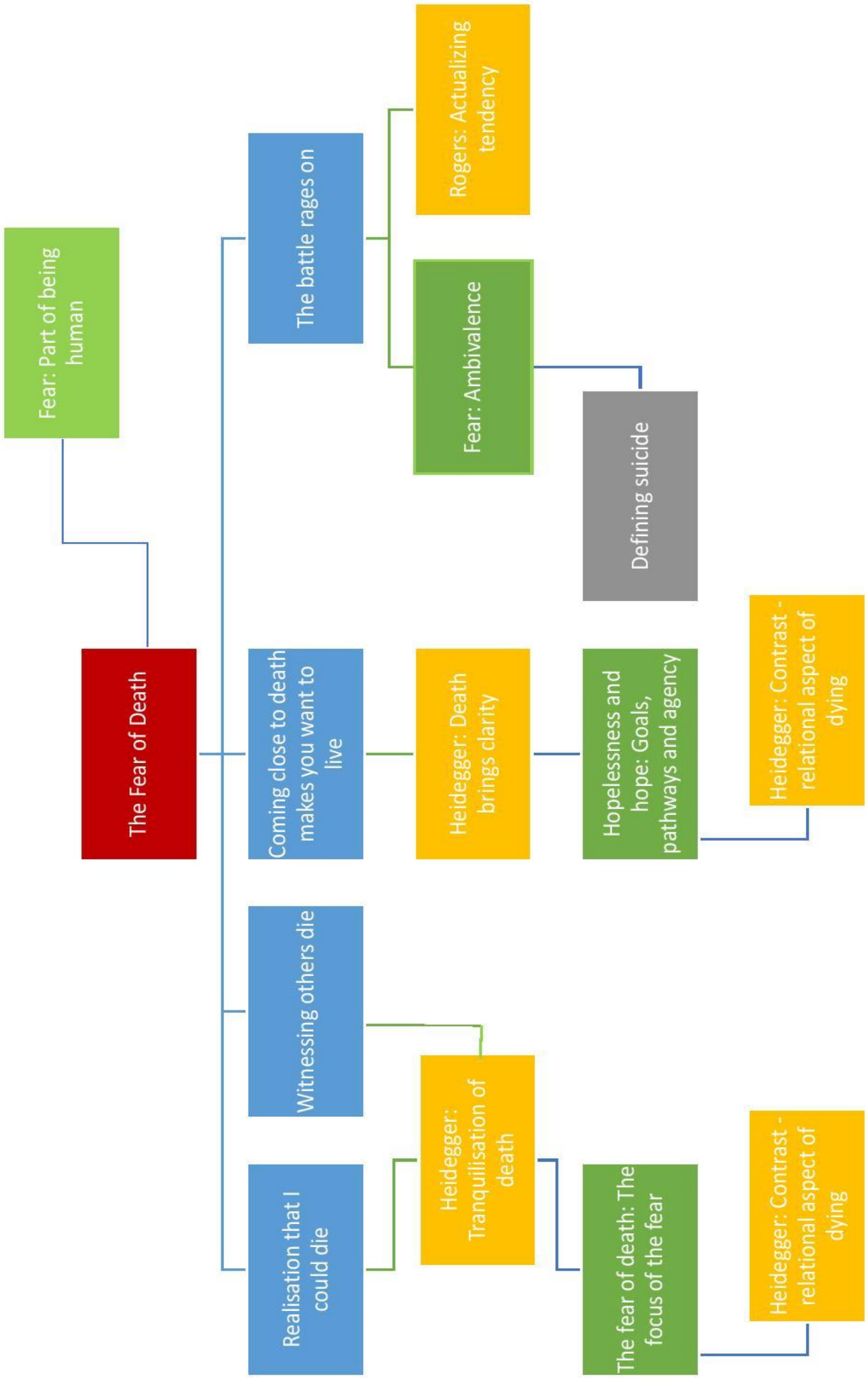
Appendix 6: Transcription symbols

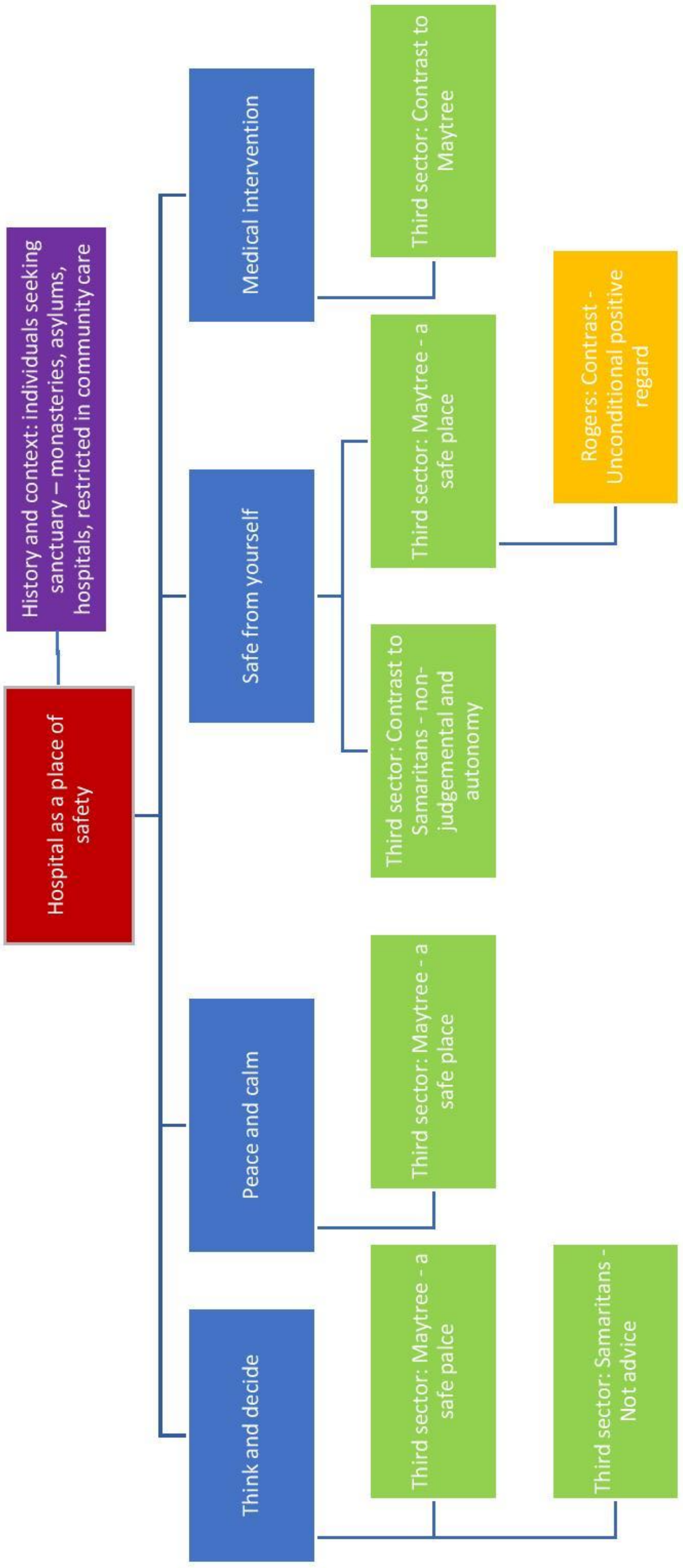
Adapted from Silverman (2011, p.465).

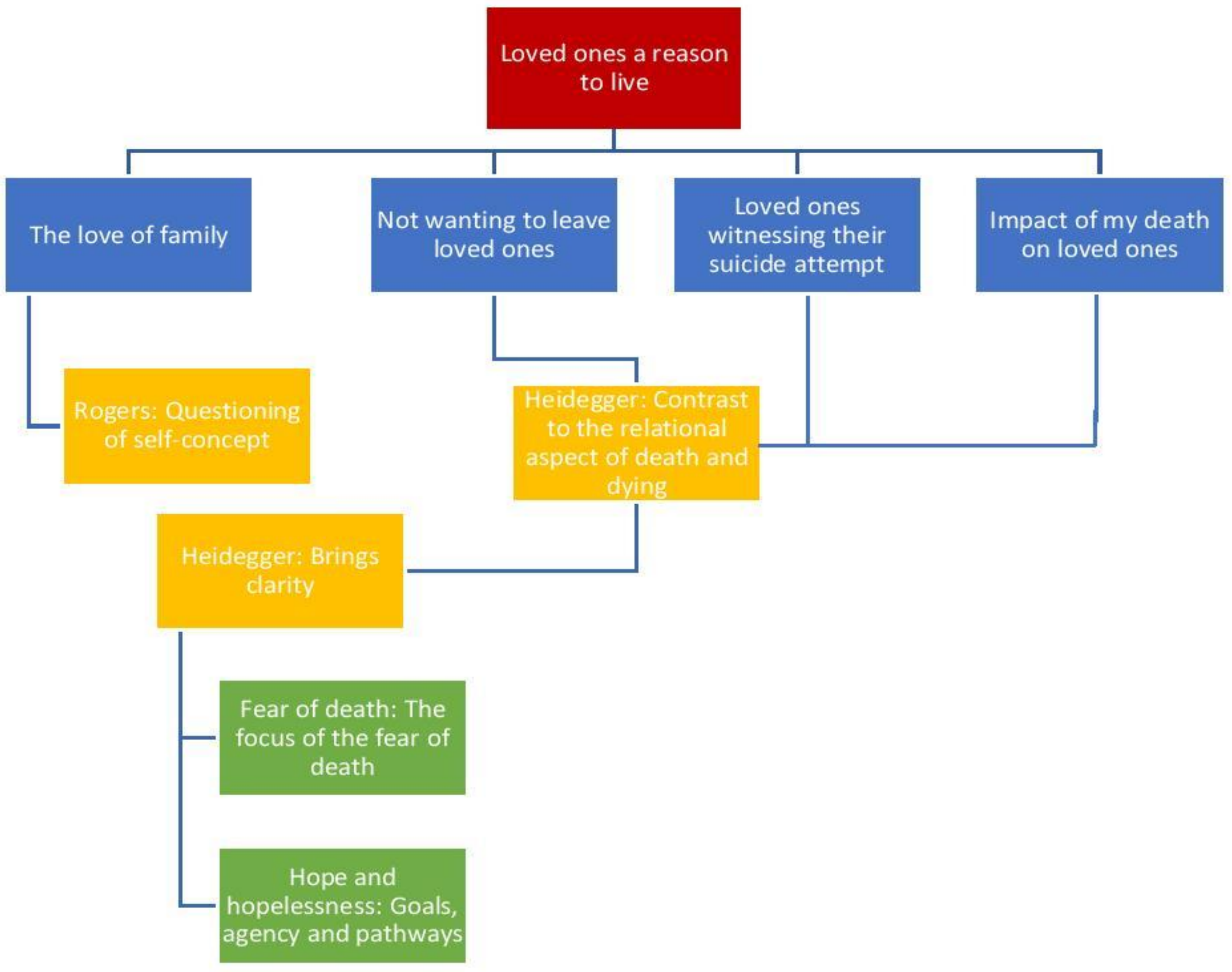
(3)	Number in parentheses indicates elapsed time of silence in seconds.
(.)	A dot in parentheses indicates a tiny gap, less than a second.
(( ))	Double parentheses contain interviewer's descriptions rather than transcriptions.
____	Underscoring indicates some form of stress, via pitch and/or amplitude.

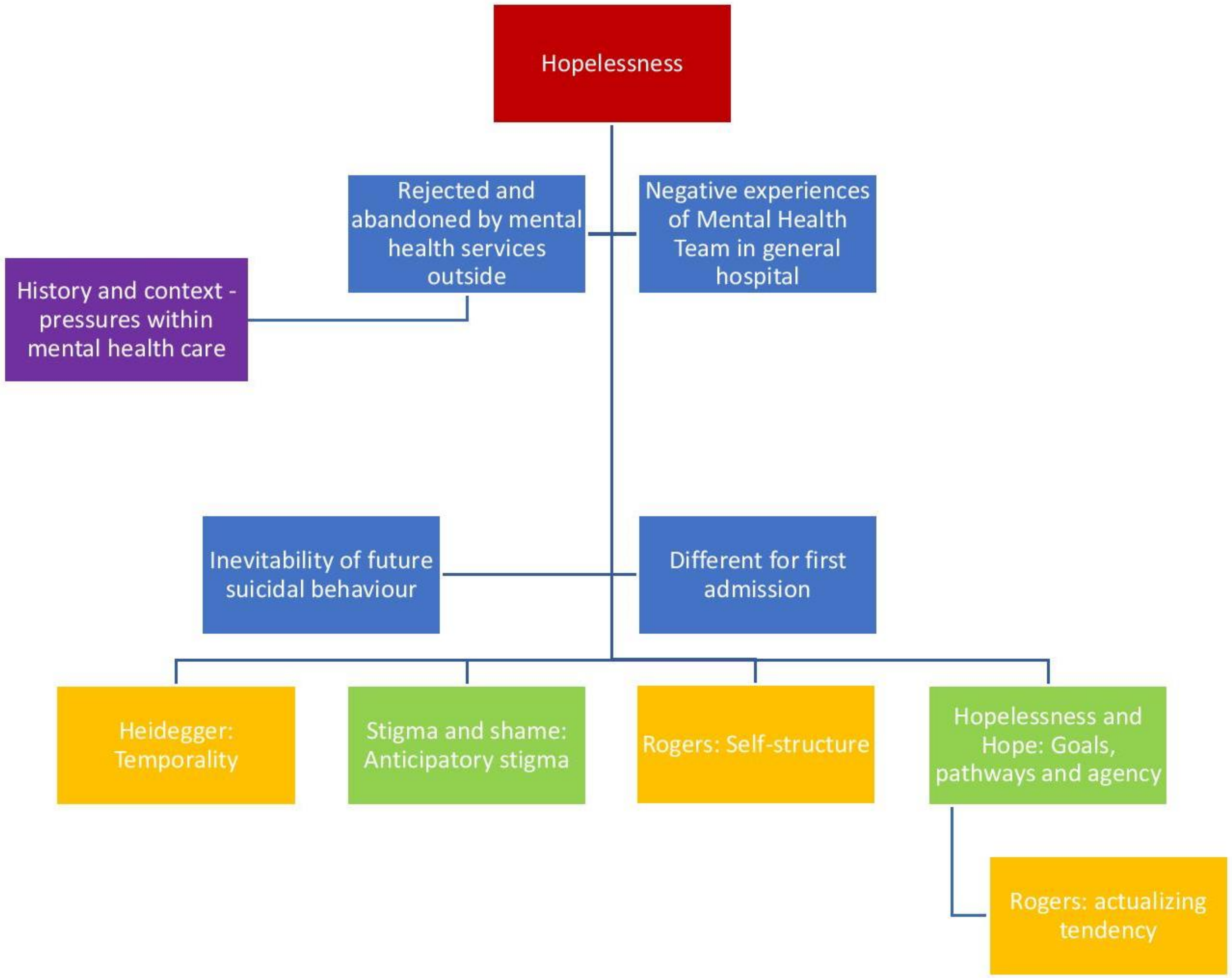
Appendix 7: Mind maps

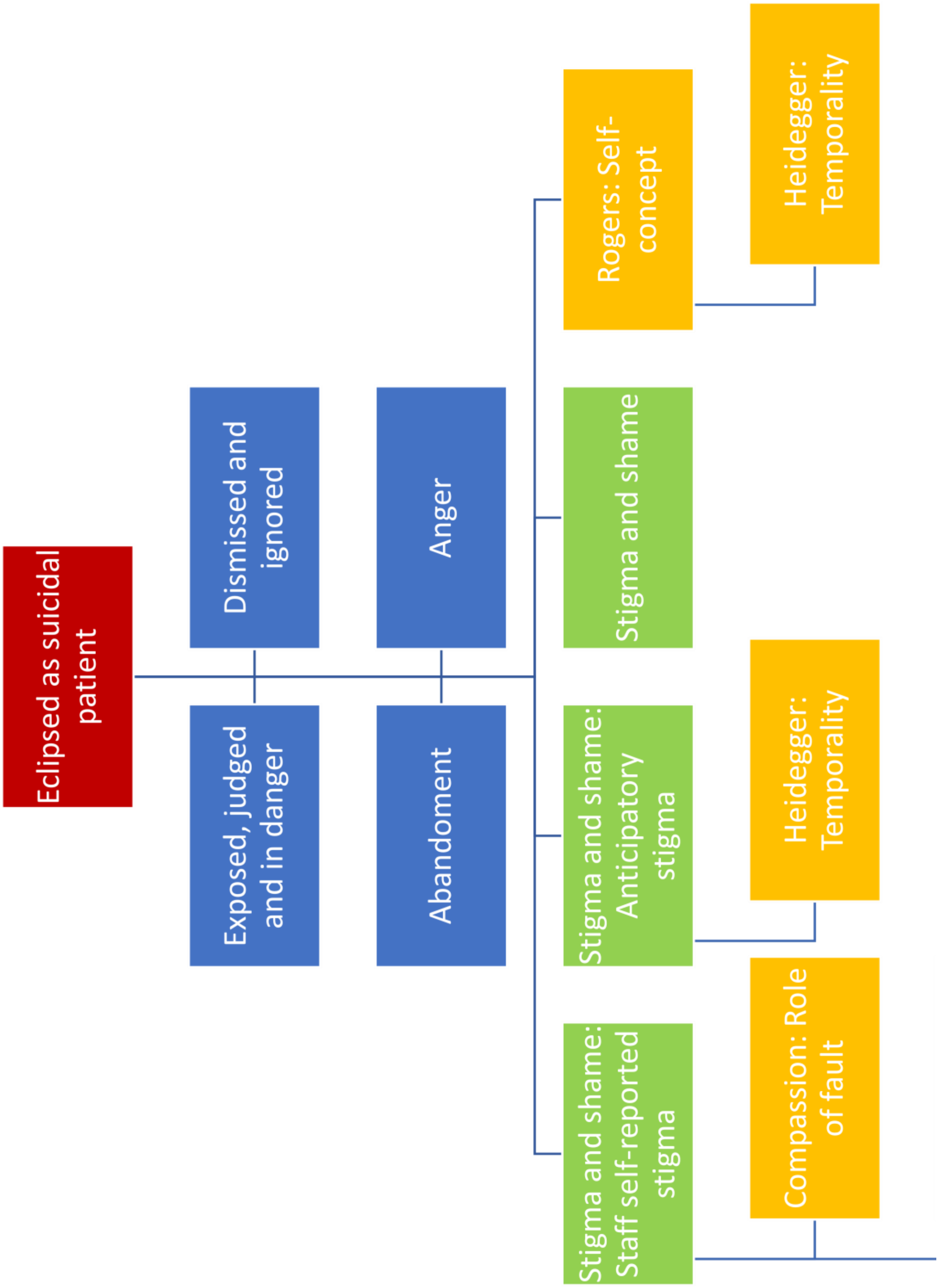
Key: Purple: Historical context. Grey: Definition. Red: Principal theme. Blue: Sub theme. Yellow: Analysis. Green: Discussion.




History and context: individuals seeking sanctuary – monasteries, asylums, hospitals, restricted in community care
Hospital as a place of safety
Think and decide
Peace and calm
Safe from yourself
Medical intervention
Third sector: Maytree - a safe palce
Third sector: Samaritans - Not advice
Third sector: Maytree - a safe place
Third sector: Contrast to Samaritans - non-judgemental and autonomy
Third sector: Maytree - a safe place
Rogers: Contrast - Unconditional positive regard
Third sector: Contrast to Maytree


Loved ones a reason to live
The love of family
Not wanting to leave loved ones
Loved ones witnessing their suicide attempt
Impact of my death on loved ones
Rogers: Questioning of self-concept
Heidegger: Contrast to the relational aspect of death and dying
Heidegger: Brings clarity
Fear of death: The focus of the fear of death
Hope and hopelessness: Goals, agency and pathways


Hopelessness
Rejected and abandoned by mental health services outside
Negative experiences of Mental Health Team in general hospital
History and context - pressures within mental health care
Inevitability of future suicidal behaviour
Different for first admission
Heidegger: Temporality
Stigma and shame: Anticipatory stigma
Rogers: Self-structure
Hopelessness and Hope: Goals, pathways and agency
Rogers: actualizing tendency


Eclipsed as suicidal patient
Exposed, judged and in danger
Dismissed and ignored
Abandonment
Anger
Stigma and shame: Staff self-reported stigma
Stigma and shame: Anticipatory stigma
Stigma and shame
Rogers: Self-concept
Compassion: Role of fault
Heidegger: Temporality
Heidegger: Temporality


Human Relationships
Surprising experience
Undeserving of staff's time
Stigma and shame: Anticipatory stigma
Rogers: Self structure and conditions of worth
Rogers: Self structure and conditions of worth
Stigma and shame: Anticipatory stigma
Heidegger: Temporality
Heidegger: Temporality
Heidegger: Temporality
Heidegger: Temporality
Human Kindness
Non judgmental
Rogers: Congruence
Hope
Third sector: Samaritans
Rogers: Unconditional positive regard
Third sector: Maytree
Third sector: Contrast to Samaritans
Third sector: Maytree
Place of saftey - UPR limited
Patient-staff relationships: Relationships and skills
Third sector: Samaritans: not advice or expertise but a caring presence
Third sector: Maytree befriending and kindnesss
Relationship between patient and staff: relationship within therapy
Context of patient-staff relationships

Appendix 8: The role of the third sector – Maytree and the Samaritans

8.1 Introduction

Although A&E departments have in many areas of the country become the default place of support for individuals experiencing suicidal crisis, many charities are also actively involved in caring for individuals at suicide risk, including members of the National Suicide Alliance. Indeed, the third sector plays a leading role in informing government policy around suicide prevention, with charities being involved in the National Suicide Prevention Strategy Advisory Group (Department of Health and Social Care, 2019). Accordingly, as part of this research I sought to explore the principal findings of this research in relation to the approach of two charities that care for individuals experiencing a suicidal crisis. First, in relation to the Maytree Centre, a relatively small organisation that offers respite care to those 'in suicidal crisis' (Centre for Public Impact, 2019, para.23), and secondly, perhaps the most famous suicide prevention charity, the Samaritans, and its helpline. The Maytree Centre was chosen as it is unique in being 'Britain's only non-medical sanctuary for the suicidal' (Maytree, 2019b, 00:41). Secondly, the Samaritans helpline was chosen due to its worldwide prominence in offering support to individuals with suicidal thoughts. Accordingly, the impact of these two charities is briefly noted within this Chapter, followed by a discussion of their approach and values in relation to the findings of this research.

8.2 The Maytree respite centre

8.2.1 Introduction

The Maytree Respite Centre was founded in 2002 and offers short term residential respite to individuals in crisis; a terrace house in a suburb of London, offering guests four-night stays at no cost. Recently, the impact of the Maytree respite centre in reducing suicidal risk has become recognised (Centre for Public Impact, 2019). For example, a study conducted by the University of East London (Briggs *et al.* 2012) evidenced that 83% of guests showed a reduction in the level of suicide risk at the end of their stay. Furthermore, ‘the sample interviewed 4-9 months after the stay reported similarly, that they were less suicidal’ (Briggs *et al.* 2012, p.3.). Briggs *et al.* (2012, p.9) also suggested that 28% of guests’ description of their stay at Maytree could be classed as ‘transformational’. Likewise, research conducted by Imperial College London in 2017, evidenced that: ‘80% of guests believe themselves to be at less risk of suicide on the day they leave Maytree than the day they arrived, and 77% reported this decrease remained a week later’ (see Centre for Public Impact, 2019, para.11).

8.2.2 Befriending and kindness

The founding core principle of the Maytree charity is befriending, an approach which is described within its staff training handbook:

> Through offering and establishing a relationship of trust, and through the process of talking, being listened to and being heard without being judged, a distressed person may regain perspective and hope, and be less at risk of suicide (Maytree, 2019a, p.5).

Indeed, individuals who stay at the house are termed guests, rather than patients, and only four guests are permitted to stay at any one time to make ‘sure that there is room for every individual’ (Maytree, 2019b, 01:25); the term 'guests' signifying how individuals are treated and given 'total attention' (Briggs *et al.* 2007, p.141) during their stay, their presence as a person being fully valued. The charity seeks to ensure that all guests experience the same kindness and support that they would offer a friend during their stay. Indeed, as one of the volunteers and assistant co-ordinators at Maytree described: 'We are not doing psychotherapy here, we are just doing befriending' (Moss, 2016, p.1). It is important to acknowledge however, that human contact is offered, but never expected or required (Briggs *et al.* 2007).

The philosophy of befriending and kindness, offered by the staff and volunteers at Maytree, feels very similar to the participants' description of helpful encounters with staff within this study. For example, encounters experienced as human kindness and free of judgement were experienced by participants as positive and helpful. Furthermore, Maytree's belief that positive relationships with staff and volunteers can enable individuals suffering with suicidal thoughts to find a sense of hope, is also reflected within the findings of this study. Significantly, Maytree appears to be able to operate their approach of close relationships to individuals, effectively and safely for staff, volunteers, and guests.

Accordingly, to explore this approach further, an interview with the director of Maytree was conducted. Howarth (2021) suggested that central to offering relationships with guests at Maytree safely, is the training and supervision of staff and volunteers. Everyone undertakes a four-month training programme before selection and once working, is required to attend regular 'reflection' sessions. Within such sessions, volunteers are provided with supervision and encouraged to reflect on their own experiences and needs to enhance self-awareness. Importantly, these reflective supervision sessions are compulsory. In contrast, within the NHS, reflective supervision is not mandatory for most professions (Milne & Reiser, 2020) and in some areas 'threadbare and minimalist' (Bond & Holland, 2010, p.1).

A further distinctive aspect of the care offered at the Maytree Respite Centre, is the time that guests spend with staff and volunteers, especially in contrast to the NHS, where staff's time can be very limited with patients.

8.2.3 Shared lived experience

In contrast to NHS care, all the staff and volunteers working within the Maytree Respite Centre have themselves been impacted by mental health problems or suicidal thoughts, with many volunteers having stayed as guests themselves in the house. Consequently, guests frequently speak of being able to connect with volunteers due to their shared lived experience (Briggs *et al.* 2007). As its director described, although the focus should always remain on the guest and their needs, volunteers can share aspects of their story if it enhances the relationship. Indeed, Howarth (2021) suggested that it is very hard to establish a trusting relationship with someone if they offer nothing of themselves; a relationship is two ways. Indeed, as it was noted in the analysis above, an important aspect of compassion is 'relatedness', and this seems to be powerfully evident within the Maytree's approach. Such an approach certainly reflects the findings of this study, with participants describing how, if staff offered and shared their lived experience, they felt understood and accepted. Equally, however, as noted above, it could be argued that such self-disclosure could be considered unprofessional, crossing professional boundaries (Arnold & Boggs, 2020). Organisations like the Maytree, however, perhaps indicate that it is possible to offer this level of congruence and connection safely, when staff are supported through effective reflective supervision and training.

8.2.4 Being valued

A further contrast to the care found within the NHS, is that within the Maytree Respite Centre, most of the care offered to guests is carried out by volunteers. Indeed, the centre has a total of 141 volunteers, who work alongside the small number of paid staff (Centre for Public Impact, 2019). The organisation suggests that such an approach enables guests to feel valued, as Maytree's director commented: 'Knowing that somebody's rocked up to support them without getting paid for it—there's something quite touching about that' (see Mohammadi, 2015, p.494). Interestingly, such an approach appears to reflect how when staff, within this study, went beyond what they had to do, participants experienced a sense of self-worth; such qualities also reflecting aspects of Roger's notion of unconditional positive regard.

8.2.5 A safe place of peace to reflect

Importantly, the house also seeks to be a place of peace and safety. Items that guests could harm themselves with are locked away, and windows are fitted with safety locks. Each room also has an alarm button, so if at any point during their stay, the individual feels particularly at risk, they can request help. The charity seeks to enable guests to feel safe even when wrestling with feelings of suicide, offering them a space to rest and reflect on their situation and accessibility to staff and volunteers.

Within the historical review of the care of the suicidal, it was noted how throughout the centuries such individuals have sought such places of safety; a place of refuge that was largely lost with the move to community care (Nolan, 1993; 2009). For many of the participants within this study, it was noted that the hospital was valued as a safe place. Not having easy access to items through which they could end their life, and the accessibility of staff, made many participants feel safe and brought reassurance, along with offering a place to reflect; such values, therefore, corresponding to the environment offered by the Maytree Centre. As Murphy (2017, p.119) notes in relation to Maytree's offer to guests: 'In some ways this is an opportunity to have the relief of escape, albeit for a few days only, without actually having to die in the process.'

It should be noted however, that the Maytree Respite Centre is unable to offer something that was deeply valued by many participants within this study – the medical care to save their life. Connected with their strong fear of dying and death, many participants significantly valued the role the hospital staff played in providing treatment for their recent overdose, along with the reassurance of the staff monitoring their physical condition. As a non-medical establishment, such care cannot be offered by Maytree.

8.2.6 Summary

Overall, therefore, the philosophy and approach taken by the Maytree Respite Centre, closely aligns with many positive aspects of the participants' experience of being in hospital following an overdose, as highlighted within this study. Specifically, the expression of kindness and compassion, the presence and availability of staff and volunteers. Such volunteers sought to value them and were willing to share their own lived experience with guests, along with offering the peace and safety of the physical space. Furthermore, the approach taken by the Maytree Respite Centre, suggests that, with supervision and training, it is possible for staff and volunteers to offer befriending relationships with guests safely. Accordingly, as Briggs *et al.* (2007, p.146) notes: 'Maytree simultaneously offers an alternative approach to suicide prevention and a challenge to current assumptions and ways of working.' Importantly, however, the Maytree Centre is unable to offer the medical care and monitoring that many participants within this study sought.

8.3 The Samaritans helpline

8.3.1 Introduction

The Samaritans is a large international organisation, with over 20,000 volunteers in the United Kingdom and the Republic of Ireland. In 2019 the charity responded to 3.3 million calls to its helpline within the United Kingdom and the Republic of Ireland, with 20% of these calls involving individuals expressing suicidal feelings (Samaritans, 2020; 2021). Indeed, Murphy (2017, p.119) suggests that the Samaritans 'probably do more to prevent suicides than any other of our highly regulated medical and evidence-based interventions.' Despite such comments, it should be noted that the efficacies of helplines are difficult to establish, partly due to the brief nature of the anonymous contact (Coveney *et al.* 2012). Research conducted by Coveney *et al.* (2012) however, indicated that 31.8% of users rated the Samaritans helpline as 'excellent' and 39.4% as 'good', in a follow up questionnaire. 'Respondents tended to report feeling less suicidal, alone, afraid, and anxious and more hopeful, supported and wanting to live after contact' (Coveney *et al.* 2012, p.318).

Although not offering a physical environment to support patients, the Samaritans primary aim is to offer an emotional safe space, as Colombus (2021, p.19) notes: 'The most important thing we do as Samaritans is create a safe space for people to talk about anything they want, without any fear or judgement.' The Samaritans (2021) seek to offer callers this opportunity through non-directive, active listening, and a caring presence.

8.3.2 Not about advice or expertise, but a caring presence

To grasp the philosophy which underpins the Samaritans, it is necessary to understand history, and how, early on, lived experience radically and permanently changed the charity's approach. The Samaritans was founded in November 1953 in London, by a vicar called Chad Varah, who sought to offer counselling to his parishioners in person and via a phone line. To aid his work he recruited several volunteers, whose initial role was 'to make me coffee, fetch me sandwiches, and keep the clients from becoming too impatient while waiting for the big event, which was an appointment with me' (Varah, 1992, p.157). Over the first three months however, Varah (1992) came to realise that the number of people coming into the church seeking support was increasing, but the numbers seeing him, were decreasing. Those seeking support were finding what they needed from the volunteers. Varah (1992, p.168) was intrigued:

> I knew for certain that neither religion nor even psychiatry was what the majority of suicidal people needed, but the 'listening therapy' we called 'befriending', performed by a lay person selected for attitude at this.

The selection of the right volunteers became central to Varah's approach, 'seniority counted for nothing' (Varah, 1992, p.169). 'The person you turn to did not need to be someone with qualifications or diplomas, as long as he or she cared' (Varah, 1988, p.40).

Such an approach reflects the thematic review and analysis of this research, including, the importance of relationships with staff, the perception of compassion and kindness, and the questioning of the role of 'skills' in caring for people. Such evidence suggests that individuals find non-judgemental relationships, expressed through genuine human compassion and kindness, more positive than skills or knowledge.

8.3.3 Non-judgemental and autonomy

A further distinctive value of the Samaritans is the belief that adults, if having capacity, have the right to make their own decisions about their life, without judgement, even in relation to their choice to die. Confidentiality is upheld and only broken when 'we are really worried about what you have told us, and we feel you are unable to make decisions' (Samaritans, 2019, para.12). The organization stresses that they hope that through talking to their volunteers, people may no longer want to end their life; this is however a freedom that they respect for adults with capacity.

Such an approach is different for patients in hospital care. Within hospitals, various strategies and procedures seek to prevent individuals from ending their life through suicide. Furthermore, as noted for the participants within this study, the hospital as a place of safety was valued for this reason. Many of the participants within this study wanted to feel safe and protected; they valued the reassurance that they could not end their life through the presence of the staff and their physical surroundings. Importantly, within our analysis of the transcripts through the lens of Roger's, although the qualities reflected within unconditional positive regard were valued, this did not extend to respecting the individual's right to end their own life; the hospital being valued as a place of safety because of that 'safety net'. Accordingly, the findings of this study would suggest that participants did not value their autonomy being respected to the point of being able to end their own life, as with the approach taken by the Samaritans.

8.3.4 Non-disclosure

A further distinctive feature of the Samaritans approach is their policy of volunteer non-disclosure. Their philosophy of active listening requires that all conversations to the helpline should be focused entirely on the caller and never the listener. Therefore, volunteers are advised to avoid sharing any personal opinions, feelings, or experience. As Pollock *et al.* (2010), notes, volunteers are to remain anonymous to callers. Such an approach is believed to offer volunteers a degree of emotional protection, especially when working with callers that may be abusive, manipulative, or sexually inappropriate (Pollock *et al.* 2012). Research by Pollock *et al.* (2012) however, indicates that for both volunteers and callers to the helpline, this policy of non-disclosure can impede the development of rapport and empathy. Indeed, Pollock's *et al.* (2010, p.215) evaluation of the Samaritan's services, noted a common suggestion for improvements by service users was that: 'Volunteers could act a little "more human" and less automated or robotic … the feeling that they were speaking to a "real person".' Similarly, within this study, when staff offered something of themselves to patients, expressed emotions, shared their stories, how mental health issues had impacted them, this was experienced positively by several participants. Staff being perceived as being real or congruent was experienced as helpful.

8.3.5 Summary

In summary, several aspects of the philosophy underpinning the approach offered by the Samaritans, reflect the values experienced as helpful by many of the participants within this study. These include being non-judgemental and the importance of caring attitudes above expertise or skills. Interestingly however, it is possible that the Samaritan's focus on non-disclosure and active listening would seem to limit the ability of callers to perceive such attitudes. Indeed, participants within this study valued staff when perceived as expressing aspects of themselves. Furthermore, although staff being non-judgemental was valued by all participants, within the findings of this study, this did not extent to staff failing to intervene to prevent death through suicide, in contrast to the Samaritan's approach; the hospital being valued, at least at the point of interview, as a place to be saved and to be safe.

8.4 Summary – the role of the third sector

Both the Maytree Respite Centre and the Samaritans play an important role in caring for individuals in crisis, offering either physically and/or emotionally, a space where people feel valued, listened to and experience kindness through relationships with volunteers, many who themselves have been impacted by emotional distress. Many of the qualities expressed by these two organisations reflect those experienced as helpful by participants within this study, as highlighted through our analysis of the transcripts. The organisations differ however in their approach to self-disclosure, which will undoubtedly impact on the individual's perception of congruence, which for many participants in this study was significant within the experience of helpful relationships. Likewise, participants 'fear of death' and wish for 'a safe place', is also reflected in Maytree's approach of physically offering a sanctuary for those in crisis, along with a policy of intervening to prevent suicide; an approach that differs from the Samaritans.

For individuals who have taken an overdose however, and need urgent medical attention, Accident and Emergency departments continue to remain the only point of care available. Certainly, however, acute emergency care can learn from organisations like the Samaritans, and particularly the Maytree Respite Centre, perhaps most significantly, in seeking to recognise the importance of relationships and the role of supervision in supporting staff to offer those relationships safely.

Appendix 9: Covid impact statement

The Covid-19 pandemic impacted on the data collection for this study. Following the transfer viva, it was recommended that a further three interviews be conducted as part of the study, due to the need for further reflexivity. Due to restrictions on research data collection within clinical settings, this was not permitted. Furthermore, due to operational pressures and the hospital admission wards continuing to be Covid cohort wards, it is not envisaged that this situation will change in the next 18 months.

To mitigate against this factor, further reflexivity was undertaken and included within the thesis in relation to the transcripts (Chapter 11). This was further supported through discussions with the supervision team, reviewing a selection of the transcripts together.

Appendix 10: Details of the use of research findings to date

- Presentations as part of the Induction Programme for all Health Care Assistants at East Lancashire Hospitals NHS Trust, ongoing - approximately twelve times a year.
- Presentations as part of training sessions for A&E staff at the Blackpool Victoria Hospital, ongoing - approximately six times a year.
- Presentation to East Lancashire Samaritans training event, December 2019.
- Presentation to Lancashire County Council Suicide Prevention and Self-harm Reduction Strategy Group, December 2019.
- Presentation to Blackburn with Darwen Council, Suicide Prevention Strategy Group, December 2019.
- Presentation to University of Central Lancashire, Advance Nursing Associates and medical students, based at East Lancashire Health Care Trust, annually.
- Presentation to Emma Wadey, Head of Mental Health Nursing at NHS England & NHS Improvement, July 2020.
- Presentation to University of Central Lancashire, MSc Pre-reg Physiotherapy students, annually.

Appendix 11: Plans for future dissemination of research

- Application made to present research findings at a workshop, as part of the *National Suicide Prevention Alliance* conference in January 2022.

- Application made to present findings at NHS England National Safeguarding Committee. Winter 2021.

- Continue to share findings as part of staff training programmes at East Lancashire Health Care Trust and Blackpool Victoria Hospital. Ongoing.

- Submit a journal article of the findings from the literature review of the lived experience of suicidal behaviour from autobiographical accounts. Winter 2021.

- Submit a journal article of the findings of the research, of the lived experience of being in acute NHS emergency care following an overdose with suicide attempt. Spring 2022.

- Seek to enable the findings to be shared as part of the student nurse training at the University of Central Lancashire. Winter 2021.

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