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EMPIRICAL STUDIES

Being in want of control: Experiences of being on the road to, and making, a suicide attempt

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Abstract
Attempted suicide is a risk factor for future suicidal behaviour, but understanding suicidality from the perspective of people who have experienced attempted suicide is limited. The aim of the study was to explore the lived experience of being suicidal and having made a suicide attempt, in order to identify possible implications for health care professionals. Semi-structured individual interviews were held with 10 persons shortly after they attempted suicide and were analysed through qualitative content analysis. The participants' experience of being suicidal and of having attempted suicide could be described as "*Being on the road towards suicidal action*", which culminated in an experience of either chaos or turned off emotions, "*Making sense of the suicide attempt*", and "*Opening the door to possible life lines*". An overall theme, "*Being in want of control*", captured their all-embracing lack of sense of control and was seen in relation to different aspects of oneself, overall life-situation, the immediate suicide attempt situation and in the outlook on the future. Being in want of control may be a relevant and general feature of being suicidal. People who have attempted suicide need more adequate help to break vicious circles before they reach a point of no return and enter an acute suicidal state of mind. Patients' experience-based knowledge is highly important to listen to and use clinically as well as theoretically when constructing suicide prevention programs.

Key words: *Suicide attempt, sense of control, being suicidal, patients' experiences*

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Suicide attempts are tragic and painful events for the individual, significant others and to society. Attempted suicide is also one of the most powerful predictors of future suicidal behaviour, including death by suicide (Leon, Friedman, Sweeney, Brown, & Mann, 1990; Mann et al., 2005; Retterstøl & Mehlum, 2001). Evidence-based successful strategies to prevent repetition of suicide attempts are still limited (Brown et al., 2005; Hawton et al., 1999; Mann et al., 2005; Moscicki, 2001; Wasserman et al., 2012), and the knowledge about the experience of attempting suicide is still very limited. Increased knowledge about suicidality is essential to improve treatment and care of persons who have attempted suicide, as well as prevention of future suicidal behaviour.

The need for studies focusing on the patients' experiences of suicidality has been pointed out (Hjelmeland & Knizek, 2010; Jobes et al., 2004), but the number of studies aimed at understanding the experience of the suicidal process is still limited. Michel and Valach (2001) interviewed people who had attempted suicide and found that they seldom explained their behaviour with a single cause but rather related their suicide attempt to failures in life projects of importance for their sense of self. Further, a majority of the patients described a state of mind before the suicide attempt, which was characterised by an altered state of consciousness, automatism and, often, analgesia. Older peoples' experience of having attempted suicide has been studied by Kjølseth and Ekeberg (1997) and

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Crocker and Clare (2006). The former found that a common theme in the life stories was growing up under difficult conditions with little emotional support, a poorly developed basic trust and a self-esteem, which was dependent on one's capability to work and to give. Without this capability the informants felt worthless, perceived life as unbearable and attempted suicide. Crocker et al. (2006) reported the themes "struggle" (experiencing life as a struggle before and after the attempt, and in relation to growing older), "control" (trying to maintain control over life before the attempt, and following it either failing or succeeding to regain control) and "visibility" (feeling invisible or disconnected from others and trying to fight against this before the attempt and either becoming more or less connected afterwards).

Everall (2000) described the experiences of young adults who had attempted suicide through the aspects of family experiences, adolescent interactions, self-destructive behaviours, depression and perception of control. The suicide attempt was viewed from the perspective of a continuous process that encompassed the individual world view and experiences rather than isolated events. Female teenagers in Nicaragua who had attempted suicide perceived the causes of their behaviour to be multiple and psycho-social in nature (Herrera et al., 2006). Biong and Ravndal (2007) interviewed young men with substance abuse and suicidal behaviour and understood their suicidality as a communicative activity about pain and hope and described a movement between viewing death as an escape from pain and feeling hope of a life. A review of qualitative studies concerning how people live with or get over being suicidal (Lakeman & FitzGerald, 2008) identified five themes: the experience of suffering, struggle, connection, turning points and of coping and concluded that suicidality often involved existential struggles and that suicide may be seen both as a failure and as a means of coping. In all, studies point to a diversity of aspects of becoming and being suicidal.

Although it is important to study the experiences of sub-groups such as older and younger people, it is equally important to study the broader experience among people who have made a suicide attempt in order to identify more general features of the experience of being suicidal and attempting suicide. Further, exploring their thoughts about what might have stopped them from attempting suicide, or might do so in the future, could give rise to points of improvement of secondary suicide prevention.

Aim

The aim of the study was to explore the lived experience of being suicidal and having made a suicide attempt to identify potential implications for health care professionals concerning how to meet, care for and treat people who have made a suicide attempt and help them not to attempt suicide again.

Specific research questions:

- How do people who have made a suicide attempt describe their situation, feelings and thoughts before and during the process of decision?
- How do people experience the act of attempting suicide?
- What are their own thoughts about the reasons behind their actions and about possible preventive factors?

Materials and methods

The design of the study was exploratory and descriptive and based on interviews with 10 individuals who had attempted suicide.[1] The complexity of human experiences, especially concerning sensitive matters such as having made a suicide attempt, calls for methods that truly explore the lived experience. By listening to patients' voices and their stories, it becomes possible to come closer to life as people live it, rather than as we conceptualise, categorise or theorise about it. In this way we increase the possibility of gaining a deeper understanding of the nature or meaning of what it means to survive a suicide attempt (Van Manen, 2001).

Context

Psychiatric services in Sweden have undergone major reforms during the last decades with the goal of de-institutionalisation, in-patient admissions are now fewer and shorter; the number of in-patient care days/year has decreased from more than 6 million in 1987 to about 1.5 million in 2000 (Kullberg, 2003) in the population of about 9 million inhabitants. In many parts of Sweden, out-patient facilities have been under high pressure, with the consequence of patients having to wait several weeks for their first follow-up meeting after discharge from a psychiatric ward.

The study was conducted at a University hospital in Southern Sweden, which had one psychiatric emergency unit, seven inpatient psychiatric wards and six outpatient services. At this hospital about 50% of all patients who came to medical care after a suicide attempt were admitted to psychiatric

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in-patient treatment following attempted suicide (Niméus, 2000).

Informant recruitment process and ethical aspects

Ten persons who had attempted suicide and were receiving psychiatric in-patient care were included in the study. Criteria for inclusion were: (1) having made a suicide attempt[1] that led to the current admission to psychiatric in-patient treatment, (2) being able emotionally (not so acutely ill/vulnerable that one was unlikely to be able to participate in an interview) and cognitively (not suffering from e.g., dementia) to participate in the study, (3) being at least 18 years old, (4) being able to understand and speak Swedish, (5) that the interview could be conducted within 3 weeks after the attempt and (6) that the patient gave informed, written consent to participate in the study. During the interview period, informants who met the inclusion criteria were recruited consecutively.

The patients were identified by the senior psychiatrist at the psychiatric ward, who verified that inclusion criteria 1–4 were met. If they were, the patient was provided with oral and written information about the study. Four patients refused to participate. At the time of the interview oral information was repeated, and informants were given the possibility to ask questions about the study and their participation. It was stressed that the informants had the right to withdraw from the study at any point, without consequences for their continued care. It was also explained that the interviewer did not work at the ward nor had any other connections to it, and that the information they gave would not be passed on to their caregivers unless the informant should wish so. The patients were offered to contact the interviewer afterwards, in case they had questions or wished to withdraw from the study. None of the 10 informants who agreed to be interviewed dropped out of the study. The rationale for interviewing the patients under in-patient treatment was mainly ethical; in case the interview should evoke anxiety or dysphoria, it was important that the informants had immediate access to support.

Patients for whom more than 3 weeks had passed after the suicide attempt were not included in the study, as experiences from clinical work show that it is easier to more open talk about the event in the near future. Interviews were not scheduled during the first days after the suicide attempt due to both ethical and practical reasons.

The study received approval by the Research Ethics Committee of the Medical Faculty at the University of Lund (2003-12-17 LU 1001-03).

Sample

The sample consisted of five women and five men aged 20–61 years. All but one had made one or more suicide attempt before (Table I).

Interviews

The interviews were conducted at respective psychiatric ward after a median time of 6 days after the suicide attempt (range 3–17 days). The interviews were semi-structured, following an interview guide, developed on the basis of relevant literature, discussions with experts in the research area and on the researchers' clinical experience. The interviews addressed the following aspects: (1) the experiences during the day of the suicide attempt, (2) their experiences and thoughts concerning causes, trigger factors, motives/intentions for the suicide attempt and their reasoning during the decision-making process, (3) whether anything could have prevented the suicide attempt (4) experiences of the care after the suicide attempt, (5) their present thoughts and feelings towards the future. The main aspects were introduced by use of open-ended questions. The

Table I. Characteristics of the informants.

Characteristics	$n = 10$
Men/women	5/5
Age, range (median)	20–61 years (41 years)
Married, cohab/single	6/4
Occupational status	
Employed	2
Student	2
Parental leave	1
Long-term sick leave or disability pension	4
Unemployed	1
Physical illness	
Recovering from brain tumour	1
Clinical psychiatric diagnoses (ICD-10)	
Depression (major/NOS[a])	5
Bipolar mood disorder	3
Personality disorder (EI[b]/NOS[a])	3
Chronic alcoholism	1
Current prescription of psychotropic drugs	9
Previous suicide attempts	
None	1
1–3	5
5 or more	4
Contact with psychiatric services	
<1 year	1
4–10 years	4
>10 years	5

[a]NOS = not otherwise specified; [b]EI = emotionally instable (= borderline).

informants were interviewed on one occasion each, and the interviews lasted between 45 and 110 min (mean 85 min). The first author carried out the interviews that were tape-recorded and transcribed verbatim, also by the first author. Throughout the interviewing process, transcripts were read by the second author in order to assert a satisfactory quality of the interviewer's interviewing technique and approach towards the informants. The interview guide was also discussed after the first two interviews and was found to be satisfactory. Data saturation was discussed after each of the last three interviews.

Analysis

The interview text was analysed by means of qualitative content analysis as described by Berg (2001). The analysis focused on the manifest content, that is, the visible, surface content of the texts as well as on the latent content, that is, the underlying or implicit meaning of the texts.

Analysis of manifest content is focused on description but involves interpretation. These interpretations are, however, of lesser depth and lower level of abstraction as compared to interpretations made of latent content (Burnard, 1995). Berg (2001) suggests that the two should be combined whenever possible, which in this study meant that the analysis focused on description (answering the question what) and the underlying meaning (answering the question how) simultaneously.

In the first step of analysis, the text was read several times and as open-mindedly as possible in order to gain an overall impression and apprehend essential features of the text, as described by Sandelowski (1995). This reading was made independently by the first, second and third authors who thereafter discussed their impressions of the text and decided on the focus for further analysis. In the second step, meaning units that were related to the aim of the study and the research questions were identified. The meaning units were thereafter condensed and labelled with codes capturing the content as well as the meaning mediated in the texts. This step was made by the first, second and third authors independently who thereafter came together to discuss their coding. In the third step, codes with similar meaning were grouped and labelled as subcategories and categories, embracing the sub-categories in a constant movement between the texts, the codes and the interpretation of the underlying meaning, thus constantly challenging the interpretation of data. This step was made in discussion between the first, the second and the third authors. The fourth author read parts of the interviews and agreed on the categorisation. In the fourth and last step, the researchers reflected on and discussed the findings by taking the research questions and their pre-understanding into account and decided on an overall theme embracing the experience of being suicidal and having made a suicide attempt.

The first and fourth authors had a pre-understanding of the phenomenon of suicidality originating from previous suicide research and in the case of the fourth author also from many years of clinical work as a social worker and psychotherapist. The second author had research experience within the field of medical ethics and, being a theologian, had an existential philosophical frame of reference. The third author, besides clinical and research experience in psychiatric care, had profound experience in qualitative research methodology.

Findings

Being in want of control

The experience of being suicidal and making a suicide attempt could be understood in the overall theme *Being in want of control*. This theme has a double meaning of not being in control as well as wishing to regain control. Statements expressing a want of control were present throughout the different aspects of being suicidal addressed in the interviews; concerning the perceived long-term background of the suicide attempt, throughout the suicidal process and not least in the acute suicidal situation. Expressions of being in want of control were also present in the outlook on the future. The wish for, and necessity of, taking control was a central feature of the text concerning what might prevent suicide attempts.

In the informants' narrations, the experience of *being in want of control* was prevailing and was seen in relation to their (1) thoughts, (2) emotions, (3) actions, (4) life situation as well as their (5) future. Descriptions of inability to direct and regulate (1) thoughts, such as inability to think logically and in more than one direction, thoughts being automatically produced by a mental illness or state of mind, and thoughts that could not be escaped from, were present in the informants' narrations. This could include obsessive thoughts of suicide and was sometimes expressed in metaphors such as *tunnel vision* or *wearing blinders*.

An inability to control one's (2) emotions was recurrently described as a general pattern in the informants' life stories and as an experience in the acute suicidal situation. This included the inability to predict, understand and regulate one's emotions. The informants described this lack of control as

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painful and scary, and that it had contributed to why they attempted suicide.

In the text there were also statements conveying the sense of not having been in control of (3) one's actions. This concerned the suicide attempt action as well as other actions (deliberate self-harm, food habit and alcohol habit, etc.). The loss of control over one's actions in the suicide attempt situation was for example described as:

> It was like, the first five or six pills I took were difficult to take, but when I'd swallowed them, it just felt like "This is so easy". So then it just so happened that I took more. [. . .] I took almost the rest of all pills in the house.

A loss of control was also described by the informants in relation to their (4) total life situation prior to the suicide attempt; a situation that was recurrently described as chaotic and filled with unsolvable problems, which contributed to a sense of spiralling downwards and out of control. The insecurity and lack of control regarding the present life situation also coloured the outlook on the (5) future. This included feeling unable to trust oneself not to attempt suicide again and a prevailing sense of being unable to handle various sorts of life problems, and could be seen as expressions of a sense of not being in control over one's future.

The experience of being suicidal and having made a suicide attempt embraced the following categories: *Being on the road towards suicidal action*, *Making sense of the suicide attempt* and *Opening the door to possible life lines* with internal variation seen as sub-categories (Table II).

Table II. The experience of being suicidal and making a suicide attempt.

Being in want of control	
Categories	Sub-categories
Being on the road towards suicidal action	*To be or not to be? – The road to deciding* *To pass the point of no return*
Making sense of the suicide attempt	*Being stuck in vicious circles* *The only way out of endless suffering* *Being exhausted and unable to think straight*
Opening the door to possible life-lines	*Finding alternative solutions* *Seeking and receiving adequate help*

Being on the road towards suicidal action

Being on the road towards suicidal action refers to the experiences of suicidality from the first thought of suicide until the point where the informants attempted suicide. The category included the sub-categories *To be or not to be—the road to deciding* and *To pass the point of no return.*

To be or not to be?—The road to deciding. The informants described the decision to attempt suicide as being preceded by an inner debate about whether to go on living or to die—to be or not to be. This inner debate could last from minutes to decades, and in terms of intensity it varied from near absence of conscious suicidal thoughts to obsessing about suicide. There was, however, some recurrent descriptions of the suicidal ideation prior to the suicide attempt. One such description was *weighing pros against cons* of committing suicide. The most recurrent argument against committing suicide was that it would hurt one's significant others. Pro-suicide arguments were mostly about getting relief from one's own suffering. The process of weighing pros against cons was sometimes described to generate such a high level of anxiety that getting away from these thoughts became an additional motive for attempting suicide. It was described that it was easier to find reasons to stay alive in the early stages of the suicidal process. As time went by and the vicious circle of unsolvable problems continued to tear at one's mental and physical energy, focus was shifted more and more towards one's own suffering, whereas the counter-suicide arguments (i.e., that it would hurt loved ones) seemed to lose in weightiness. One's impact on significant others' lives could with time also turn into a pro-suicide argument:

> The only thing that spoke against suicide was that I'd hurt my family. The things that spoke for suicide were so many more, for instance then that my family would be better off without me, since my influence on their lives was negative. (Man, 47 years)

The road to decision also included *justification of suicide*. Besides the typical form of justification that others would be better off without one, other justifications present for committing suicide were labelled *cannot go on just for the sake of others*, *no other solution* and *suicide is brave*. However, concerning the view of suicide as a brave action, the contradicting view was also present, stating that suicide is a cowardly escape or simply wrong. Justifications made on the road to decision thus concerned

significant others, the belief that there was no other solution and moral issues:

> 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 to not live at all (Woman, 20 years).

The degree of planning varied between the informants: Some had decided to commit suicide months ago, which in some cases was followed by preparations such as saving pills. Others had decided very quickly with little planning. When asking more closely about the decision-making process, it turned out that also those who stated the act had been planning for a long time and in fact had not decided *when* to do it until just before the attempt. This decision was described as impulsive, in the sense that it was made without much preceding contemplation at the time and that it was made very shortly before the attempt (hours–minutes). Only one informant set a date in advance and stuck to that plan, and he decided two days before.

To pass the point of no return. The final step from thought to suicidal action thus took place quite hap hazardously and was either triggered by a defined event or by an inexplicable impulse from within: "It simply felt like it was time". Most informants described that when they did take their final step from thought to suicidal action they had passed a critical *point of no return*, beyond which they neither wanted to nor felt they could seek help:

> When I come to the point where I make that decision, seeking help is not an option. I cannot do that on my own. [...] When I feel that bad I don't want the help. [...] In the suicidal phase, right before I make an attempt, no one can help me. Before that and afterwards, on the other hand, I can be helped. (Man, 32 years)

Being past the point of no return was described in terms of being in an altered state of mind of which two main types were described: Either a state of *chaos*, that is, confusion, panic and despair, or a state of *tunnel vision and turned off emotions*. Those who experienced chaos were mainly those who also described a short suicidal process. Further, these informants described that they were not able to take into account any consequences of their actions, for themselves nor for their significant others, meaning that thinking about significant others could not inhibit the suicide attempt;

> It was chaotic. [...] I have no idea of what time it was then. [...] I was completely freaked out. All shaky. I couldn't... It was total chaos. [...] I panicked. (Man, 44 years)

The other type of acute suicidal state of mind, *tunnel vision and turned off emotions*, was described in terms of suicide being the only thought and wish in one's mind and that one's actions were directed by a strong decisiveness coupled with emotional numbness. This state of mind left no room for concern for significant others. The belief that it would have been impossible for anyone to talk them out of attempting suicide when they were this state was expressed. The experience that it almost felt as if it was not oneself who had performed the act was also described:

> I never thought you'd have such a... one-track mind when you try to take your life. I thought you'd think more than once, like think about others and so on. You don't. [...]In that situation you can't see anything else, you just see straight ahead. [...] I simply said calmly to myself: '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.[...] It's horrible—I think that even if my husband had walked in on me when I was about to take the pills and said that: 'No, don't do it, you can't do that', I would simply have said that 'You can't tell me what to do or not. It's my life, and I decide over it.'. (Woman, 55 years)

Making sense of the suicide attempt

Making sense of the suicide attempt refers to how the informants afterwards tried to explain why they had attempted suicide. This was seen as *Being stuck in vicious circles, The only way out of endless suffering* and *Being exhausted and unable to think straight.*

Being stuck in vicious circles. Explanations of why the suicide attempt had occurred were generally complex and recurrently described in terms of being stuck in vicious circles. Such vicious circles typically consisted of several difficulties (e.g., being unemployed, depressed, unable to sleep and in conflict with significant others) that could not be resolved and that negatively affected each other. All informants pointed at more than one single perceived cause of their suicide attempt. To some informants there was one main factor (typically a psychiatric disorder), which was perceived as the very root of suicidality: "It's the disease that makes

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it happen" (Woman, 39 years). Other informants did not single out any factor as more important than the rest.

The only way out of endless suffering. Experiencing an endless suffering was a recurrent feature in the explanations of why the suicide attempt had occurred. Descriptions of the suffering included feeling sad, anxious, scared, empty, lonely, rejected, weak and worthless as well as experiences of failure, meaninglessness, disappointment and hopelessness. In general, one had suffered for a long time (months–years) before one attempted suicide, and the perception that the suffering would continue endlessly was recurrently expressed. In spite of the strong wish to die at the time of the suicide attempt, death *per se* was not described as the most important goal by the informants; instead the wish to get away from suffering was described as the main objective of attempting suicide:

> Right then it's the only solution you can see. Before that, you've tried so many ways of dealing with your situation. It's not like you have a problem on Monday and attempt suicide on Friday. (Woman, 39 years)

> It's not about succeeding to die. That's not the primary thing. That's to... somehow... get on... from what you can't get out of. (Man, 30 years)

Viewing the suicide attempt as a way of communicating something was sparsely described in the text and concerned a hope to get help and a wish to get revenge. When present, the purpose of communicating something was not described as the sole or most important purpose of attempting suicide.

Being exhausted and unable to think straight. Struggling with the various difficulties of life and trying to endure one's own suffering was described to tear at one's mental and physical energy until one felt exhausted. Feeling exhausted, in turn, was described to negatively affect one's mood, ability to handle interpersonal conflicts, ability to handle everyday responsibilities such as work and children, ability to "think straight" and ability to resist suicidal impulses. The inability to think straight was further given as an explanation to the "crooked logic", which lay behind the justifications that were made prior to the suicide attempt, such as "My family will be better off without me".

Opening the door to possible life-lines

Opening the door to possible life lines refers to how the informants, at the time of the interview, described different things that might have stopped them from attempting suicide, or might do so in the future. Two sub-categories were identified: *Finding alternative solutions* and *Seeking and receiving adequate help.*

Finding alternative solutions. Finding alternative solutions refers to preventing the suicidal process from ever starting or to stop it in its early stages by creating and maintaining positive life circumstances, and by learning to better solve problems that have arisen. The informants typically stressed that they themselves had to contribute a great deal in order to prevent future suicide attempts, and in order to do this they believed they needed to obtain new skills concerning problem-solving and help-seeking:

> I was so stupid as to take a too long Christmas break [from work rehabilitation]. As a consequence I had difficulties going back. I stayed at home, and it turned into a depression instead. [...] I think that if I had not made such a long break from work rehab, I would still be doing that today. (Woman, 58 years)

Seeking and receiving adequate help. Getting adequate help was recurrently described as a possible life-line, and the need for the patients themselves to get better at seeking help as well as a need for improvements of the help offered was underlined. There was a wish for better accessibility, and this particularly concerned the possibility to get in touch with someone you know. Reluctance to seek help at the psychiatric emergency unit because this seemed scary and difficult was described. However, other informants argued that accessibility was not a problem, and that they had not sought help because of their own inability to do so and/or scepticism towards the help offered by psychiatric services.

Another improvement of professional help suggested as a possible life line concerned after-care, including more and better psychological treatment as well as help with social problems such as economic difficulties and unemployment. It was generally believed that after the point of no return nothing could have stopped them, except for if someone had discovered them and made them stop, and in accordance with this it was stressed that the time of seeking and receiving help was crucial—it has to happen before it is too late.

Significant others were in general described as important reasons for living, and sometimes as valuable sources of love and support, but in the text concerning what might have prevented them from attempting suicide significant others were very sparsely mentioned;

> If I have a stable ground to stand on [economically] and I can get more help, or help in a different way, at the same time as I motivate myself to work harder with my situation, there is a possibility that things might get better. Or that it won't happen again. (Man, 47 years)

Discussion

Main findings in relation to previous research and possible clinical implications

That being in want of control is a key issue in the experience of being suicidal is supported by other interview studies with people who have made a suicide attempt (Crocker et al., 2006; Everall, 2000; Michel & Valach, 2001; Sinclair & Green, 2005.) Further, it seems likely that being in want of control is a general feature of the suicidal process, since this theme recurs in different studies of varying age groups (young patients — Everall, 2000; elderly — Crocker et al., 2006; mixed age groups — Michel & Valach, 2001; Sinclair & Green, 2005, and the present study). It thus seems important that caregivers listen to and acknowledge patients' experiences of being in want of control and provide opportunities for patients to reflect upon these, as such experiences are likely to be scary and damaging to the trust in oneself and one's sense of capability to handle future difficulties. Helping people who have attempted suicide to strengthen their sense of control and mastery seems crucial to turn their sense of powerlessness into hope for and belief in a future that is manageable and worth living. That strengthening the sense of control is crucial for people in order to move on from being suicidal is supported by the findings of Sinclair and Green (2005), who interviewed patients who had attempted suicide but then not reattempted. Also, having a father who exerts control without affection has been found to be an independent risk factor for repeating attempted suicide among adolescents (Groholt, Ekeberg, & Harlodsen, 2006).

A sense of control can be achieved by being able to handle difficulties, but also by being able to predict and understand something, such as one's emotions. The meaning of control is naturally influenced by culture, and perhaps people in the western world, with its idealisation of autonomy and independence, are particularly vulnerable to experiences of being in want of control. It is further important to note that, from an ethical perspective, there is a conflict between personal autonomy and the societal responsibility to prevent suicide. In order to take care of the individuals in an optimal way, health care professionals should be aware of this conflict.

This study points at a number of possible ways to help strengthen the sense of control among people who have attempted suicide. For example, adequate treatment of psychiatric symptoms such as depression, anxiety and alcohol abuse or dependence and filling basic needs of adequate sleep and food-intake are prerequisites for people to function in a way where they can feel in control of themselves and their life-situation. This is in line with the findings of Sinclair and Green (2005), who found that abstaining from alcohol and receiving adequate treatment of depression was important for people who had made a suicide attempt in order not to re-attempt. The present study underscores the need for better treatment of sleeping problems, as poor sleep contributed greatly to the exhaustion and inability to think straight. Also, improving impulse control would probably strengthen a person's sense of control and decrease the risk of suicide attempts. But this does not seem to be enough. In order to restore a sense of control and ability to deal with life without attempting suicide the informants in the present study ask for a better understanding of themselves, for learning new skills to solve problems and seek help, and for more help with social and economic problems. To meet these needs it seems important to provide more resources for psychotherapeutic treatment, for an intensified after-care and for multi-professional efforts such as better collaboration between psychiatric and social services.

The findings of our study suggest that the acute suicidal situation can be understood *either* as a complete loss of control (by those experiencing chaos) *or* as an attempt to regain control (by those experiencing tunnel vision and turned off emotions). This duality of possible meanings of suicide is in line with the conclusion of the review by Lakeman and FitzGerald (2008), in which suicide may be seen as both a failure and a means of coping.

The experience of being past the point of no return meant being in an acute suicidal state of mind — *chaos* or *tunnel vision and turned off emotions* — where one feels one cannot be reached with help. The existence of an acute suicidal state of mind is in line with previous models of suicidality, such as "the presuicidal syndrome" (Ringel, 1976) and "the suicidal mode" (Rudd, 2000). However, the existence of two different acute suicidal states, as an expression of trying to regain control or losing

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control, found in our study, has to our knowledge not previously been found, although each type of experience is in line with findings of different studies. Schnyder et al. (1999) found that people who had attempted suicide often had felt panic in the immediate suicide attempt situation, whereas other studies have described automatisms and feelings of numbness immediately prior to and during self-injury (e.g., Michel & Valach, 2001). The acute suicidal states of chaos or tunnel vision and turned off emotions thus seem highly relevant to recognise for all professionals working with persons who may be suicidal. The findings of this study indicate that warning signs could be when a person with suicide ideation expresses a view of endless suffering and shows signs of exhaustion and desperation, or if a person who has expressed severe suffering and the view of being stuck in his or her problems suddenly and inexplicably seem perfectly calm. This is of course difficult to recognise for a health care professional who meets a person for the first time, which implies that personal relationships and continuity may be better than large, centralised emergency units in the prevention of suicidal acts.

The findings of our study showed that people who are in an acute suicidal state of mind are unwilling or unable to seek help. Hence, it is highly important to strengthen each individual who has attempted suicide, so that he or she is able to recognise early signs and in the future can seek help before it is too late. This could be an important way of improving his or her sense of control.

Also, psychiatric services need to be open for providing help in the earlier stages of the road towards suicidal action. Especially when there is a lack of in-patient spaces or long waiting times for out-patient contacts, there is a risk that "the bar is set too high" in terms of how suicidal a patient must be in order to be qualified for acute help, that is, that patients have to be so suicidal that they in fact are likely to have passed the point of no return where they no longer can or want to seek help.

The informants' descriptions of their state of mind prior to attempted suicide thus seem highly relevant to recognise for all professionals working with people, who may be suicidal, but also to meet patients in this experience afterwards with understanding, and to support them to reflect on it.

Our findings further showed that impulsiveness was found to play a central role on the road to suicidal action: The final step from suicidal ideation to suicidal action was described as impulsive, irrespective of the degree of planning. The central role of impulsiveness in suicidal acts is supported by previous studies (Dougherty et al., 2004; Mann et al., 1999). In the clinical situation it seems that clinicians often try to discriminate between impulsive acts on the one hand and well-planned, non-impulsive acts on the other hand. However, it seems that it does not have to be one way or the other, but rather that also well-planned acts with a long-lasting wish to die can be impulsive in the final step to action. It seems important to note when assessing the risk of suicidal acts. Also, improving impulse control would probably strengthen a person's sense of control.

Further, the finding that the main motivation behind attempted suicide was to get relief from suffering is worth underscoring as it is known from clinical experience and research that so-called manipulative motives such as seeking attention or revenge often are assumed by health care professionals but, as shown in this and other studies, that such motives seldom are experienced as relevant by patients who have attempted suicide (Skogman & Öjehagen, 2003). In order to be able to adequately meet these patients and take their despair seriously, and not judge them beforehand, there is a need for increased knowledge and understanding about the patients' situation among health care staff.

The views of people who have attempted suicide on what might prevent suicide attempts have to our knowledge not been explored before. Many of the possible life-lines mentioned by the informants (working with problem-solving skills, help-seeking behaviour, focusing on the problems viewed as most important by the patient, high access to a therapist you know) are included as methods and goals in therapies, which have been shown to reduce the number of re-attempts —dialectical behavioural therapy (DBT; Linehan, Armstrong, Suarez, Allmon, & Heard, 1991, Linehan et al., 2006) and a form of cognitive therapy especially targeting suicidal behaviour (Brown et al., 2005). It is possible that some re-attempts could be prevented if more patients were offered psychotherapeutic treatment with these features.

Methodological considerations

Because interviews were chosen as a method, patients with the most severe psychiatric symptoms and/or cognitive impairment such as dementia and patients who could not speak Swedish could not be included. When interpreting the findings it is important to note that the experiences of these persons may differ from the participants' experiences. This is also the case with those who complete suicide. The informants provided sample variation concerning degree of planning and suicidal intent, occurrence of previous attempts, method used for the current attempt, psychiatric diagnosis, age and sex. It should

be noted that all informants but one had made previous suicide attempts and had been in contact with psychiatric services for many years. It may thus be that the variation in experiences of attempted suicide and the views on possible preventive factors are even greater than pictured in the present paper.

There is a risk that the informants withheld criticism against psychiatric services as the interviewer, even if being a student at the time, was a representative of health care professionals (Kvale & Brinkmann, 2008). This risk was, however, reduced by the fact that the interviewer was not working clinically where the interviews were conducted and that her role as a researcher was made clear to the informants. Before the interviews the informants were informed that their feelings, views and experiences were important in the process of improving treatment and care of people in their situation. The impression from the interviews as well as the texts was also that the informants felt free to speak their mind. To increase the trustworthiness of the data, and in turn of the findings, the interviews were continuously listened to and read as text by the second author, who provided feedback in order to support the development of interviewer skills (Grane-heim & Lundman, 2004). The interviewer had a pre-understanding of suicidality being a medical student and suicide researcher, which, during the phase of analysis, was taken into account and reflected upon together with the other authors who had different pre-understandings. The authors' pre-understandings have thus most certainly influenced the collection and analysis of data, in line with the concept reflexivity (Malterud, 2001), meaning that the perspective or position of the researcher always shapes the research. Malterud (2001) states: "Preconceptions are not the same as bias, unless the researcher fails to mention them" (p. 484). The use of qualitative content analysis can further be criticised. The method has on the one hand has been described to be devoid of theoretical base and to liberally draw meaningful inferences about the relationships and impacts implied in a study, but is has on the other hand been described to be useful when the purpose of the method is to gain information from study participants, without imposing preconceived categories or theoretical perspectives but based on participants' unique perspectives and grounded in the actual data (Hsieh & Shannon, 2005).

The ethical principle of not to harm was conducted by taking into consideration that the interview might give rise to painful thoughts. This risk was given attention to during the interview by providing the informants with possibility to talk to someone at the ward after the interview was carried out. The principle of autonomy was respected by informing the informants about their voluntary participation and that they could withdraw from the study without explanation.

It is also important to point out that the patients could benefit from the interviews. Several informants stated that it felt good to talk about their experiences and being listened to. It may thus be that the interviews had beneficial and perhaps some therapeutic effects.

Conclusions

We conclude that being in want of control is a relevant and general feature of being suicidal and that people who have attempted suicide need more adequate help to restore the sense of control. In order to restore a sense of control it seems important to help patients breaking the vicious circles before they reach a point of no return and enter an acute suicidal state of mind. We can also conclude that patients' own experience-based knowledge is highly important to listen to and use clinically in each meeting with a potentially suicidal person, as well as theoretically when constructing suicide prevention programs. The question of how professionals view and collaborate with the person's own experience-based knowledge —whether it is accepted and valued by health care professionals—may need further attention.

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Note

1. A suicide attempt was defined as "a situation in which a person has performed an actually or seemingly life-threatening behaviour with the intent of jeopardising his life, or to give the appearance of such intent, but which has not resulted in death" (Beck et al., 1972).

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