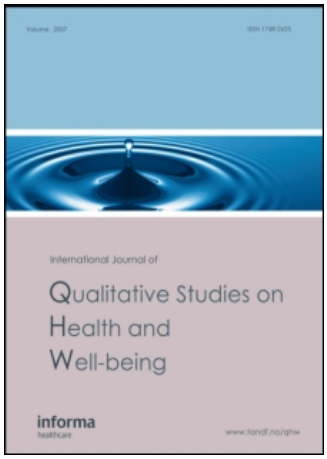

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Young men's experiences of living with substance abuse and suicidal behaviour: Between death as an escape from pain and the hope of a life

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Abstract
The aim of the study was to illuminate the experiences of suicidal behaviour in young Norwegian men with long-term substance abuse and to interpret their narratives with regard to meaning. Data were collected using open-ended, in-depth interviews. A phenomenological hermeneutic approach, inspired by the philosophy of Ricoeur, was used to analyse the data. The naïve reading involved awareness of the perceived sense of pain and hope in the participants. In the structural analysis, three themes were identified: (1) the meaning of relating, (2) the meaning of reflecting and (3) the meaning of acting. A comprehensive understanding of data indicated that the meaning of living with suicidal behaviour could be understood as a movement between different positions of wanting death as an escape from pain and hope for a better life. Our conclusion is that suicidal behaviour in men with substance abuse is a communicative activity about the individual's lived experience of pain and hope. How the participants experienced and constructed masculinity influenced the suicidal behaviour. To reduce pain and create hope by being seen and confirmed in social relationships, and being helped to verbalize existential thoughts and openly discuss possible solutions, are of importance.

Key words: *Public health, substance abuse, suicidal behaviour, men, hermeneutics*

Introduction

Within contemporary suicidology, suicide is viewed as a behaviour, not a disease (Cantor, 2000). Durkheim (1897/2001) emphasized a person's relationship to his or her society when explaining suicidality. Nowadays the relationship with significant others is also highlighted. From a psychological perspective, Shneidman (1985) takes account of the "ten commonalities" of suicide, focusing on the individual and interpersonal dimensions of such behaviour, emphasizing the emotional needs and psychological pain of the subject, "the psychache" in Shneidman's term (1993). From his findings by retrospective psychological autopsies, he argues that suicidal behaviour is an interpersonal event, displaying communication of intention, often to alleviate the mental pain, i.e. emotional pain, psychological pain and psychache, in the mind (Orbach, 2003). Further, the intent might be to force a significant other to express love and affection towards the suicidal individual, though occasionally the person may be seeking rejection. Although the communicative aspects of suicidal behaviour have been implied in psychologically based suicide research (Shneidman, 1985), little has been written on the communicative dimension of the act from the subject's perspective (Lester, 2001). Generally, it should also be noted that far more research has been conducted on suicidal behaviour and alcohol abuse than on suicide and substance abuse (Lester, 2000).

In spite of major research efforts to describe risk factors, develop treatment approaches and implement prevention strategies, suicidal behaviour, i.e. suicidal ideation, suicide attempts and completed suicide (Beskow, Eriksson & Nikku, 1999), continue to be an important public health problem. The World Health Organization (2007) has estimated that 1,000,000 people worldwide die from suicide each year. Attempted suicide has an even higher prevalence in many countries, but exact figures are lacking mainly because epidemiological research on attempted suicide has only recently used standardized

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procedures (Kerkhof, 2000), and there are still controversies in the nomenclature and classification within suicidology (Silverman, 2006). Further, it has been estimated that six people (i.e. family, friends or colleagues) suffer intense grief from every death from suicide and remain to cope with loss (Clark & Goldney, 2000). Considering that the process of adjustment to the loss of a close relationship can be as long as several years, the collective morbidity resulting from suicide deaths adds public health challenges to different parts of health and social services and their practitioners (Talseth, Gilje & Norberg, 2001; Mitchell, Kim, Prigerson & Mortimer, 2005).

Traditionally, suicide has increased with age, and this still generally remains the case (Bille-Brahe, 2001). However, the most significant recent trends have been increased suicide rates in young males, i.e. 15–34 year-olds in many countries and suicide rates are consistently higher for males, with the exception of China (Cantor, 2000; Phillips, Li & Zhang, 2002). In the United States, men were found to be four times more likely than are women to commit suicide (Sakinovsky & Leenaars, 1997). Higher prevalence of substance abuse may be a potential reason for the increased suicidal mortality in young males in European countries during the 1980s and 1990s (Mittendorfer-Rutz, 2006).

Repeated suicide attempts presents one of the most predominant risk factors for completed suicide for both sexes and in all ages, followed by depression (Hawton, Simkin & Fagg, 1997; Moscicki, 2001; Ekeberg, 2006; Fortune, Stewart, Yadav & Hawton, 2007). Furthermore, a history of suicide attempt by self-poisoning appears to be an indicator of a high risk for completed suicide throughout the entire adult lifetime (Friedman, Friedman & Ramirez, 1973; Suominen, Isometsä, Suokas et al., 2004). From the UK, Hawton (2005) presents an explanatory model of attempted suicide in young adults, including the interaction between mental disorders (depression and substance abuse), chronic and acute stress (family problems), and the social environment (deliberate self-harm in friends or family). Factors that may inhibit development of suicidal thoughts into self-harm include social support and personal beliefs against self-harm and suicide.

In Scandinavia, suicide is also one of the major causes of death for young men (Nordic Council of Ministers, 2006). This may reflect cultural and gender-specific differences and risk factors such as sex-roles (Qin, Mortensen, Agerbo, Westergaard-Nielsen & Eriksson, 2000; Wunderlich, Bronisch, Wittchen & Carter, 2001; Möller-Leimkühler, 2003; Webster Rudmin, Ferrada-Noli & Skolbekken, 2003). More individual pathways, like depression, might contribute to alcohol and substance abuse, or a state of depression can be developed from such abuse (Beskow, 1979; Kilmartin, 2005; Kolves, Varnik, Tooding & Wasserman, 2006; Winkler, Pjrek & Kasper, 2006). How men with depression and suicidal behaviour use, or not use, mental health services might also be related to cultural norms (Emslie, Ridge, Ziebland & Hunt, 2006; Strike, Rhodes, Bergmans & Links, 2006).

The concepts of substance use disorder, substance abuse and drug misuse (Widiger & Smith, 1994; Helzer, van den Brink & Guth, 2006) are, in contrast to drug addiction and drug dependence, (Goodman, 1990; Miele, Tilly, First & Frances, 1990) not easily defined and the borderline between them is not always distinguishable. They might cover states from problematic use to established abuse and dependence. Research in the field of suicidal prevention towards persons using psychoactive substances might for that reason be somewhat hampered by the absence of clear definitions (Mino, Bousquet & Broers, 1999). An external perspective on these phenomena within a positivistic paradigm, represented by for example the biomedical diagnostic and statistical manual (DSM), is based on observable and measurable criteria. In the present study, the personal significance of using alcohol and illicit drugs is unique to every person. An inner perspective, the individual's own experience, should for that reason use descriptions that are grounded in direct experiences. We will use the term substance abuse to refer to the wide range of subjective experiences that stem from the intake of alcohol and illicit drugs by the participants.

Substance abuse and male gender is considered as risk factors for suicide (Suominen, Isometsä, Haukka & Lönnqvist, 2004). In the National Comorbidity Survey from the USA (Kessler, Borges & Walters, 1999), lifetime prevalence of substance abuse is estimated at some 5% for men. For a number of reasons male substance abusers might be considered difficult to interrogate about aspects of suicidal behaviour. First, there is the difficulty in differentiating accidental overdoses from intended suicide attempts. Secondly, the social disintegration following a long career of what is often regarded as an antisocial behaviour by others creates difficulties in obtaining the kind of representative sample needed in order to generalize (Johnsson & Fridell, 1997). It is further difficult to determine the impact substance abuse as a single factor has on suicide in men, as it is comorbid with affective illness (Isometsä et al., 1995; Benedetti et al., 2007). Past substance abuse more than tripled the risk of future suicidal acts in men with a major depressive episode, (Oquendo et al., 2007). The characteristics of substance abuse associated with suicide risk in men

further includes heavy use, increased severity of (polydrug) abuse and aggressive behaviour (Harris & Barraclough, 1997; Beautrais, 2002; Miller, 2006). According to the norms of masculinity, such phenomena could help explain male vulnerability (Möller-Leimkühler, 2003; Liu & Iwamoto, 2007). Furthermore, killing one-self might be culturally viewed as a masculine act also by male substance abusers in the western world as traditional gender roles may still be relevant (Linehan, 1973; Canetto, 1993).

In Norway, Rossow and Lauritzen (1999) reported that among 2051 men and women with substance abuse living in treatment facilities, 45% of the men had experienced life-threatening overdoses, i.e. in need of other people's intervention to survive. Thirty per cent had on one or more occasions attempted to end their own life through self-induced overdose. A statistically significant relationship was established between the frequency of overdoses (more than three) and the desire to die. Furthermore, the incidence and prevalence of overdose deaths in Oslo during the 1990s have been among the highest in Europe, especially for males (Reinås et al., 2002).

It thus seems necessary to acquire more gender-based knowledge in order to understand this phenomenon better, and to enhance tailor-made local interventions and preventive measures for this population. As suicidal behaviour may be seen as the outcome of the complex interaction of biological, genetic, interpersonal and sociological variables (Hawton & van Heeringen, 2000; Darke & Ross, 2002), Scandinavian public health documents and suicide prevention programmes have stressed the need to complement medical-epidemiological studies of suicide with humanistic perspectives (Sundhedsstyrelsen, 1998; Helsedepartementet, 2003; Socialstyrelsen, 2005).

Suicidal behaviour seriously affects the health and well-being of individuals and significant others but is still mainly studied in a positivistic and deductive manner. In this article, as a multi-professional research team from the fields of nursing and sociology, we use a micro-sociological in-depth perspective, researching a small number of individuals at high-risk for suicide. Within the frame of social constructionism (Burr, 1995) we claim an epistemological possibility to improve and deepen our knowledge and understanding of the meaning of suicidal behaviour. Hence, in our study we take a hermeneutic and phenomenological paradigm as our point of departure, focusing the meaning-making activity and lived experiences of some young men who have attempted suicide (Cutcliffe, Joyce & Cummins, 2004). A holistic understanding of the phenomenon of suicidal behaviour, embedded in an integrated whole, calls for research based on interpretation of the inner-perspective of the subjects in question (Beskow, 2005; Hammerlin, 2005, Mehlum, 2005). The aim of the study, therefore, was to illuminate and interpret the lived experience of the suicidal behaviour of some young Norwegian men suffering from long-term substance abuse. The research question was formulated as how meaning is constructed in the narratives of suicidal behaviour.

Method

Epistemological consideration and design

Public health research needs qualitative research methods to find meaning behind the numbers (Karlberg, Hallberg & Sarvimäki, 2002). To search for the meaning of suicidal behaviour from a phenomenological perspective means to refrain from making judgement about the facts and to be open to what the text contains. This kind of understanding forms the reference to Heidegger's (1992) being in the world, i.e. man being related both to an exterior and inner world in time and space (Ashworth, 2006; Sarvimäki, 2006). Drawing on the tradition of phenomenology, Ricoeur's interpretation theory (1976, pp. 71–80) holds the notion that gaining knowledge and understanding about lived experiences cannot pass directly from one person to another, but is to be constructed through the hierarchical interpretation of text (Ricoeur, 1976, pp. 1–16). Such an interpretation integrates explanation and understanding in a dialectic movement rooted in the properties of the text. This movement, the hermeneutic circle, is described as a process, involving first an intuitive guessing of the meaning of the whole, followed by an explanation of the parts and then again a move to a comprehensive understanding of the whole of the text (Ricoeur, 1976, p. 74). We found such a phenomenological hermeneutic approach useful when we wanted to analyse and understand how the meaning of suicidal behaviour was constructed in personal narratives.

Narrative theory holds that the most basic way to create meaning out of human experiences is to narrate them and to listen to others (Polkinghorne, 1988). This is especially so if the narrative is about life events which have involved a disruption between ideal and reality, the self and society (Riessman, 1993). We regard suicidal behaviour as such a disruptive activity. Therefore, we assessed a narrative design as an appropriate and useful method when wanting inductively to analyse and understand how the meaning of a social phenomenon was constructed in biographical accounts (Mishler, 1986;

Wengraf, 2001; Willén, 2002). If our interpreted understanding in the end affects people's perceptions of experiencing substance abuse and suicidal behaviour, we might have been successful in integrating both the horizon of the narrator and the readers of this report. Such scientifically based knowledge may prove important if it contributes to new perceptions and the development of the services offered to substance abusing men, especially when they face existential challenges.

Participants

A purposeful sampling strategy was used to identify potential participants. Based on epidemiological data regarding premature death related to the combination of substance abuse and suicidal behaviour, several substance abuse treatment centres were asked for permission and help to recruit possible male participants between 20 and 40 years of age. To ensure that participants would be able to reflect and articulate themselves on the subject matter, one inclusion criterion was that participants were not currently under the influence of illegal substances. They should also have reported a previous suicidal intent. After a recruitment process of some months, four men, Per, Ola, Vidar and Knut (fictional names), aged between 32 and 40, agreed to participate.

The four men were born and raised in different parts of Norway. Their substance abuse had an early onset with alcohol, ultimately developing into poly-drug dependency and daily injections of heroin from their late teens or the beginning of early adulthood. All had experienced great difficulties in their parents' relationships, and in their own relationships as adults. One of the men was in a long-term relationship at the time he was interviewed, and two had children. Both were in contact with their children. Two had a formal education. All were in vocational training, and on social benefit with their income from social security. They had stayed at the actual treatment centre for a period of some months up to two years, following previous outpatient or in-patient treatment. For Per, Vidar and Knut the suicidal behaviour had its onset between the ages from 17 to 20. Ola experienced his first suicidal attempt at the age of 29. For three of the participants the last suicide attempt had occurred within the last two to four years, while one had attempted only about a month before the interview.

Data collection

The interviews took place where the participants wanted, most often at the institutions where they were living, and during a stable period. The interviews were unstructured by asking them to associate freely on the basis of one opening question: "Can you please tell me the story of how you became addicted to drugs and, in connection with this, if possible also tell me about your experiences of trying to commit suicide". The interviews took the form of a conversation, i.e. the interviewer did not act like an expert, and in line with Denzin and Lincoln (2003), encouraged the participants to narrate as freely as possible. The interviewer asked questions aimed at further narration, such as "What happened next?", "Can you remember any more details" or "How do you reflect on this?" Active, respectful and sensitive listening is a prerequisite for creating a context for narration (Alma & Smaling, 2006).

The interviews lasted between one and two hours, and they were tape-recorded before being transcribed verbatim by the first author. Associations and experiences from both the dialogue and the non-verbal communication that took place during the interview were noted in order to ensure that these initial impressions could also help with later interpretations. The Regional Committee for Medical Research Ethics approved the study (Dnr. 379-03143). The participants were provided with both written and verbal information before agreeing to participate. In cooperation with the treatment centres, individual psychosocial follow-up was planned and offered after the interview if needed.

Data analysis

In the Nordic countries, an empirical method for entering the hermeneutic circle inspired by Ricoeur's (1976) philosophy has been developed and applied by nurse researchers and philosophers (Lindseth, Marhaug, Norberg & Udén, 1994; Talseth, Lindseth, Jacobsson & Norberg, 1997; Lindseth & Norberg, 2004; Gilje, Talseth & Norberg, 2005). This method emphasizes the dialectic movement between understanding and explanation, and between the text as a whole and its parts, in order to get at the meaning of the studied phenomenon. It consists of three different, but interwoven, steps: naïve reading, structural analysis and comprehensive understanding.

Step 1. Naïve reading is regarded as a first conjecture of the text. Lindseth and Norberg (2004) emphasize that it guides and provides the direction of the following structural analysis. In the naïve reading, each transcribed interview was repeatedly read by the researchers with an open mind. This means keeping a phenomenological attitude and dispensing what might be taken for granted in order to grasp the intuitive sense of the meaning of

the text as a whole. The focus was on the men's experiences of substance abuse and suicidal behaviour in everyday life.

Step 2. Lindseth and Norberg (2004) point out that several kinds of structural analyses can be used to explain the text by identifying and formulating themes. As we collected and analyzed biographical narrative material, Labov's (1982) definition of a personal narrative guided our process of identifying the narrative content of the text. Labov (1982) claims that a fully developed personal narrative consists of six parts; (1) abstract (core narrative); (2) orientation (who, where, when); (3) complicating action (what happened); (4) evaluation (the effect on the narrator); 5) resolution (what impact did it have); and finally (6) coda (bringing the story back to the here-and-now).

Twenty-six core narratives on suicidal behaviour, fulfilling Labov's (1982) definition, were identified in the text. They were reflected on against the background of the naïve understanding and then set in relation to each other and sorted into six subthemes according to their content. The concepts we used to describe these parts were expressed in everyday language. Assisted by the co-author the sub-themes were reflected on, examined and interpreted into higher-level content of meaning forming three themes. This was done by going back and forth between the naïve understanding, the core narratives and the sub-themes until all were captured and formulated in different themes. A theme was defined as a thread of similar meaning that penetrated one or several sub-themes.

Step 3. The process of interpreting the text as a whole means that we again tried to come close to the text and to re-contextualize it (Lindseth & Norberg, 2004). In order to keep a clear stance between our findings and the discussion, we chose not to include illuminating literature as part of this step. Through reflecting on the three themes in relation to the research question and the authors' prior understanding, we formulated the main theme of the study. This represented a comprehensive understanding, or the main interpretation, of the meaning of the studied phenomenon.

Findings

The main theme of the study was conceptualized as between death as an escape from pain and the hope of a life, connecting the men's pain and hope formed by the relation to self and others, existential thoughts and bodily experiences, ultimately affecting their decision-making process of living or dying (see Figure 1). The findings are explained in the following.

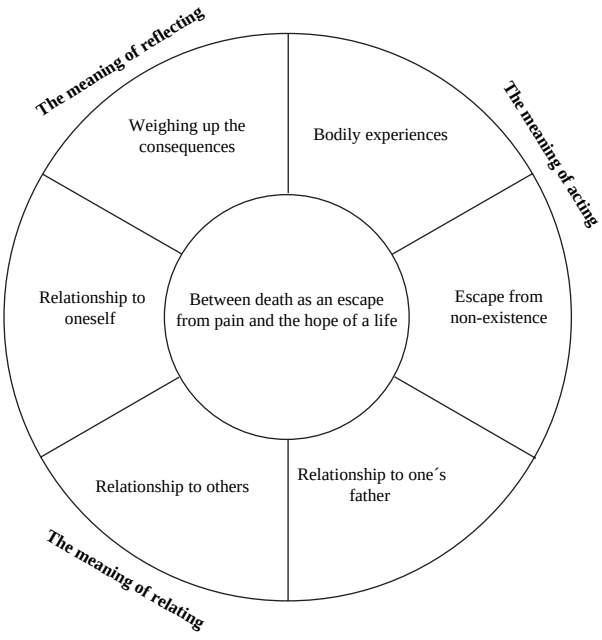

Figure 1. Model showing the main theme in relation to the tree themes (outside the circles) and the six sub-themes (outer circle).

Naïve reading

Per, Ola, Vidar and Knut started to narrate about life prior to their debut with drugs as boys and then about the process up to the point when the situation got out of control and they became addicted in their adolescence. The following narration was on suicidal ideation and attempts, described as an activity embedded in their previous life experiences merged with the current situation.

At the core of the descriptions were the participants' perceptions of pain. Pain was experienced in a number of ways and took different shapes over time. Some pain was related to consequences of the deteriorating substance abuse. Other pain was like an experience of being bound and rejected without seeing any alternatives to the present life. Pain could take the form of experiencing a boiling inside of arrested feelings or as a dark emptiness. Homelessness, stigmatization and lack of material resources created other sorts of pain.

In the first place, the participants tried to escape pain by substance abuse. This was experienced as an aid for achieving well-being by alleviating the pain in the first place. However, after some time the aid became part of their problematic situation and established physical and mental dependency developing gradually over time. Their state of mind changed and they experienced feelings of hopelessness, loneliness and shame as the situation got worse. The escalation of pain led the young men to contemplate alternatives to their current situation, as life became perceived as unbearable. Suicidal

ideation, and planning, varying in intention and duration, was central in these reflections. Living with acting out suicide attempts was often experienced as seeking escape from a painful life more than a wish to die. To be rescued from dying could sometimes be experienced as a turning point in one way or another, and followed by a reduction of substance abuse or active seeking for help.

If such a personal initiative of reduction of substance abuse and help seeking was seen and supported by family, friends or professionals this was experienced as hope. Hope, as well as pain, was also experienced in different ways over time. At the beginning of their substance abuse, hope was described as keeping control over the abuse and at the same time engaging in ordinary social life. As the addiction developed, hope was more experienced as managing different bodily and social consequences and symptoms of withdrawal. Having faith in a better future, despite a situation of feeling pulled between conflicting forces whether to continue to exist or to take one's life, created hope in times of serious distress.

Preliminary understanding of the young men living with substance abuse and suicidal behaviour involved on the one hand awareness of their sense of pain pushing for the ultimate action and, alternatively, still hoping to find a meaningful life. The sense of pain and hope seemed to fluctuate over time related to different internal and external experiences.

Structural analysis

In the initial part of the structural analysis, the 26 core narratives on suicidal behaviour were condensed into six sub-themes. Three of them, *relationship to oneself*, *relationship to others*, *relationship to one's father*, referred to the social relationships domain. One, *weighing up the consequences*, concerned existential reflections, and two, *escape from non-existence* and *bodily experiences*, focused on the body as the centre for actions. Furthermore, subjective meaning was constructed across the above sub-themes, and ultimately condensed into three themes involving *the meaning of (a) relating, (b) reflecting*, and, *(c) acting*.

In the following, the presentation of the findings will be structured according to the meanings assigned to the six sub-themes, and thus be held as interpretive filter through which subjective experience is conveyed. All participants narrated about how they had experienced different relationships, engaged in existential reflections and actions over time, but for practical reasons we chose the most relevant excerpts to explain the themes.

The meaning of relating

The constructed meaning of relating concerned the social relationship domain. The nature of the relationships often gave rise to negative and painful feelings, such as seeing oneself as unworthy, hopeless and lonely, with feeling guilt and shame in connection with others, as well as anger directed at oneself and others. Patterns of relationships in childhood and adolescence pointed to similarities in the participants' experience of physical and/or emotional abuse and neglect by the father. For two of the participants, the relationship to a later physically absent or dead father also worked both as a rejection and as a dream. Such family relationships at an early age were perceived as a source of low self-esteem in the young boys. A continual negative relationship to the self seemed to influence both their earlier and current troubles, and created emotional problems for the participants in their daily lives, as Per illustrated it:

> Since I was quite small I was told (by his father) that 'you won't amount to anything'. Even now, when I encounter new situations, his words come back to me: 'you won't manage that, you can't do that' (using father's tone and emphasis).

The narrator expressed here and in the following lines how he felt inept in his own grown-up intimate relationships with his wife and child, and felt incapable of feeling and expressing love the way he may have wanted

> "Life with my wife on an everyday basis was hard, I felt I wasn't capable of loving her ... and it was difficult with the child. I didn't have many positive feelings and I was very passive."

Perceived helplessness and passivity related to past and present experiences led to the breakdown of his marriage and changed his relationship with his daughter in a negative way. In this situation suicidal ideation rapidly emerged in Per "I have to end this kind of life", which was soon followed by an impulsive suicide attempt by intoxication of prescribed medication. When he was telling this story, he showed signs of being emotionally affected. Painful feelings of abandonment by his father and loss from his broken relationships caught him up again.

Another similar pattern in the participant's core narratives was that it was possible to find substitutes for lack of close relationships in for instance nature or religion. When Per found God he experienced a turning point in which hope got the upper hand through providing a feeling that he was not completely on his own. This experience of having a

nurturing relationship gave him a new platform from which he could see his complicated relationship with his father in a new way. This change of perspective allowed him to forgive his father and to reduce his anger towards him. This letting go of the past opened new ways of perceiving his situation and he felt more constructive towards his future. One result of this was that he also managed to develop a new relationship with his daughter. Some more positive accounts of experiences of relationships in adolescence appeared as well. Following daily routines, such as school, sports and being with peers created a safe space and a feeling of belonging. When experiencing relationships as adults, nature, faith or relationships to their own children, seemed to have had a protective effect in their difficult everyday life through a feeling of closeness. Belonging and closeness filled their sense of emptiness and created a different relationship to the self, reflecting a more hopeful position in life: "In nature and in sport I have felt safe and that I could be myself. Looking back, nature and football have been very important for me" (Vidar).

The meaning of reflecting

The constructed meaning of reflecting concerned how reflections on life and death, freedom and responsibility were experienced by the participants over time. All had experienced serious lack of communication within the family, which aroused different reflections based on feelings of loneliness or anger. Sometimes they, like Vidar, had to take responsibility in situations where others failed. From the age of 7–8 years old, and for several years after, Vidar often had to separate his mother and father when they fought:

> I have always felt alone with this. My parents have never wanted to talk about it afterwards. Sort of something we didn't talk about. They were too embarrassed. . . . I have never sorted it out, never managed to get it out in the open.

As the oldest son, the narrator may have felt both trapped and forced into an adult role, in order to protect his mother and his siblings from a violent and periodically drunk father. Having to take on this role had painful consequences for him by interjecting negative feelings, followed by his perception of his father as a non-existing person. Left with an offending or a non-existing father, with reduced social and practical guidance and care, seem to have caused confusion in the participants related to gender roles and expectations of responsibilities within the family. This perceived confusion became part of demands that were greater than the participants could manage, creating serious reflections on how they could be freed from this sort of problem. Getting away did not necessarily mean reflections about seeking death, though death, also in one's thoughts, could seem like a release, as Vidar exemplified:

> I wanted to die many times, but I never considered suicide (at that time). I thought that it must be a release to be dead, Sometimes I was so tired of living that taking dope was a way of getting away from living. Dying was a solution. School work went really badly, I more or less dropped out and had a void in my life . . . then I often had those thoughts . . . then . . . I thought about suicide.

Vidar seemed to be preoccupied with a wish to be released from living. Taking dope and having death as a possibility was constructed like a sort of freedom from this deadlocked life. His reflections on death escalated when he did not manage his schoolwork and felt a void in life. This may indicate that he had ideas of being responsible himself of ending up outside a normal social activity that he and those around him had expectations of. The metaphor "dropped out" could indicate that there were internal circumstances that influenced his declining schoolwork, in contrast to if he had "been dropped" and by that had projected the responsibility outside himself.

Knut had some more positive accounts on experiences of reflecting:

> I have used a lot of music with lyrics that make sense to me. I use music actively, listening. It is possible to build something. I think that is very important to stress.

The narrator's perspective illustrated how more hopeful reflections can occur through directing one's consciousness to other people's life experiences and messages. Such a focused perception could be used constructively to seek alternative actions in a daily life of distress.

The meaning of acting

The constructed meaning of acting concerned which actions were presented in the narratives. Choosing between different actions means the process leading to which one action was given priority over another. Some actions were based on feelings embedded in the participants' experiences of social relationships, others on reflections of life and death, freedom or responsibility. Choices of action were also described as being based on physical and mental experiences of

pain or hope, which had significance for suicidal planning or attempts, as Per recalled:

> I had no place to live and I felt so bad. I had then planned that if I didn't get anywhere to spend the night or a place to live, I would just put an end to it all. I had pain in my leg. I had no money for drugs. I couldn't cope with any more, I was at rock bottom. Luckily I came into (naming a specific low-threshold institution). Getting in there saved my life.

Per's decision for action was mainly made on the background of present painful physical bodily experiences, and was related to his own assessment of whether his perceived pain could be made better, or at least relieved, in the short term. Seeking for, and receiving, relief influenced his choice to continue to live. In this account he used the metaphor "I was at rock bottom" to express how his situation was perceived at that time. This may indicate an existence from which he wanted actively to escape. Still, his decision-making was susceptible.

For Ola, his experience of loss after his parents' divorce, followed by his father's premature death, had serious consequences for his actions:

> I was very upset when he was gone. It was the first time I tried to take an overdose, I was quite a long way down then ... didn't manage to seek help, didn't manage to talk about it ... went round and boiled ... tried to escape by doping myself, didn't manage to do things the way I wanted.

In his state of grief, acting out intoxicating himself seemed to be a short-term solution of self-medication. The emotional problems were perceived as being so overwhelming, that death was assessed as a solution he tried to achieve by a suicide attempt. The metaphor "went around and boiled" may indicate that Ola felt he was in a process so full of stored, pent-up energy that he could either burst and become a real failure, or else use this energy to achieve what he really wanted, to manage his situation. The point of his planned suicidal behaviour seemed to be an action directed to try to reduce the temperature that the unmanageable feelings inside him created.

All participants experienced how decision-making and actions could fluctuate and turn. Being met in a subject-subject relationship, for example by health care professionals, was experienced as a suicide-preventive factor of hope, as Vidar illustrated:

> He (his general practitioner) understood, the first person who understood that part of my drug addiction was self-medication. It was the first time I got help for drug-addiction. He believed in me and listened to me. That meant a lot and was one of the reasons why I managed to go on.

Attitudes, courtesy and the practical approach of health personnel were experienced as a life-saving turning point of reducing pain and creating hope, influencing Vidar's motivation and later decision-making and actions.

Comprehensive understanding

The structural analysis revealed that the participants lived experiences of pain and hope could be understood as a movement between different positions of whether to continue to exist or to end one's life. Which of these positions one currently highlighted depended on the perception of being seen and confirmed in social relationships, the possibilities of verbal communication of existential thoughts and one's assessment of possible actions.

Pain was experienced as containing intense feelings of being isolated in relation to oneself and to others. Combined with physical and social experiences related to consequences of deteriorating substance abuse, pain affected the participants' thoughts and decision-making processes. When pain got the upper hand, leaving the person without being able to perceive any future relief or help, escaping pain was acted out and expressed through impulsive or planned suicide attempts. Hope was experienced as different types of turning points, and in this state of mind participants felt more invigorated and optimistic. Feelings of belonging and self-worth, when engaging in subject-to-subject relationships to others, seemed to be of utmost importance for survival. Relationship to nature and faith in God brought about a focus outside the participants that expanded their vision of life in times of distress. Access to psychosocial care when needed could also signalize that a better life might be possible. Given that the people around them managed to look behind the participants' often-destructive situations, the process towards a wish to continue to exist was susceptible.

The comprehensive understanding, integrating the naïve reading, structural analysis and the authors' professional experiences and theoretical pre-understanding, was formulated as the main theme of the study *between death as an escape from pain and the hope of a life*. Being between death as an escape from pain and the hope of a life meant to engage in often-negative relationships and existential reflections in a society in transition. Having this

position in life meant holding different possibilities open for acting out this way of existing.

Discussion

Findings

From the inside perspective of some men with long-term substance abuse and suicidal behaviour, the study illuminates how their lived experiences can be hermeneutically interpreted and given meaning. The findings show that the participants alternate between different positions of whether to continue to exist or end one's life in a complex pattern of feelings, thoughts and actions. The meaning of their lived experiences was embedded in complex social processes over time, also described by Maris, Berman and Silverman (2000), and as part of this, their suicidal process seemed to be susceptible. In order to prevent suicide among young men with substance abuse problems, we suggest it should be regarded as a major task for social and health professionals to look for possibilities to identify and facilitate turning points, as they come in different forms. An open attitude in professionals is required, that is not acting as experts on behalf of the individuals' experiences, but keeping an explorative stance towards the person's meaning-making systems. Reducing a person into a descriptive diagnosis or to a single-dimensional case, might hinder an opportunity to identify turning points and infuse hope.

Shneidman (1993) and Orbach (2003) argues that suicide has to do with thresholds for enduring psychological pain. Suicide might then occur when mental pain is deemed by the person to be unbearable. However, the concept of pain generally reflects a broader understanding with at least three major components: the sensory component, the emotional response and social interactions (Sällfors, 2003). Thus, the perceived escalation of psychological and other pain, leading the young men to contemplate alternatives to their current situation, might be viewed as a global suffering that had to be alleviated by different means. Suffering, contradictory to present definitions of pain, adds an existential dimension to the experience. Hence, the suffering experienced by the participants can be understood as a struggle with life itself, against experiences of alienation and death to their body, soul and spirit, and in which their pain was contained (Eriksson, 1992, 1997; Wiklund, Lindholm & Lindström, 2002). In the present study, pain refer to the range of physical, psychological, social and existential experiences leading over time to a sense of loss of meaning in life.

Our findings suggest that substance abuse and suicidal behaviour can be viewed as goal-oriented activities with the intention of communicating to society the participants' different states of being (Qvortrup, 1999; Hammerlin, 2006). In the first place, experienced as self-medication, substance abuse might be a communicative act about the individual's often-painful emotional relationship to himself. However, emotional and relational pain also developed in the participants from processes that took place in interplay with others (Bille-Brahe, 2001). Such pain led to suicidal ideation, planning or attempts that communicated serious difficulties in the emotional relationship between the individual and others.

The study shows how emotional and relational pain in young men may originate from the feelings of having been abandoned by their father. In the light of the significance other men have for men within a Western hegemonic masculine society (Connell, 2005), this lack of culturally important acknowledgment seems to have been especially traumatic. This experience had serious consequences for them, which they communicated by life-threatening behaviour. The literature provides little evidence for how contextual masculinity, i.e. striving for power and dominance, independency and autonomy in our part of the world, corresponds with suicidal behaviour (Canetto, 1995; Möller-Leimkühler, 2003; Webster Rudmin et al., 2003). This might need further research. External factors, such as unemployment and low income, have been identified as major gendered risk factors for men in a Western society (Qin, Agerbo & M2ortensen, 2003). We experienced that when men are given the opportunity to speak for themselves, internal and relational factors become highly evident.

The young men in our study had lost someone; that is their father, who they might have ambivalently loved and hated. An alternative understanding of the sociological theory of Connell (2005) could be based on object relation theory (Agrawal, Hauser, Miller & Penn, 2003). This would possibly pay attention to the communication of aggression in the participants' suicide attempts. Introjecting their father may have evoked painful aggressive feelings towards him. Unconsciously these feelings could be directed as actions towards themselves (Kienhorst & van Heeringen, 2001; Thorvik, 2005). However, from the way the participants told about their emotions and relationship with regard to their fathers, their experiences seemed to have remained in their consciousness, suggesting that a sociological understanding might be more relevant than a psychodynamic one.

Our study does not support the findings of Hjelmeland, Knizek and Nordvik (2002), who

suggests that people engaging in non-fatal suicide behaviour should not receive different treatment or follow-up according to their gender. According to Hjelmeland et al. (2002), the reason for this is that both sexes display more or less the same list of problems. We consider that if the young men represented in the present study are not helped to evaluate unpleasant events with their father figure or to examine the impact of gender; that is socially constructed sex-role expectations; this might leave them with life-threatening rational and irrational negative emotions, thoughts and actions.

Physical and social pain related to the deteriorating process of substance abuse provoked suicidal ideations, planning and attempts in the participants. Communicating hope by seeking help to alleviate such pain leaves social and health care practitioners with several windows of opportunity to intervene. A gendered and holistic based care should, according to Cutcliffe et al. (2004), also account for an inner perspective, helping to grasp and verbalize emotions, thoughts and actions (Karoliussen & Smebye, 1981; Peplau, 1989; Hedelin, 2000).

Hope was experienced and communicated by the participants in a number of different ways. Despite their painful life experiences, they seemed to express hope when trying to hold on to a conversational domain, as either an inner monologue or a dialogue with others. By attending to a phenomenological, committed and a non-judgemental attitude, professionals have the possibility to enhance life-saving hope in times of hopelessness. This might moderate a potential need to commit suicide as a means of securing the last word toward others (Bille-Brahe, 2001; Platt, Davis, Sharpe & O'May, 2005). Dufault and Martocchio (1985) emphasize that hope, as a multidimensional dynamic life force changing over time, has implications for feelings, thoughts and actions. The complexity and magnitude of the problems confronting the participants from an early age seemed to influence their problem-solving abilities negatively and at times leave them with hopelessness. Trying to cope with the sense of hopelessness by substance abuse eventually led to increased vulnerability and became a part of their later suicidal behaviour (Nielsen et al., 1996; Plutchik, 2000; Kolves et al., 2006). However, as part of their hope, the coping mechanisms they developed involved not only substance abuse as self-medication, but also body awareness, and actions to maintain culturally accepted everyday activities, relationship to nature and faith in God.

Method

There is no suicidal behaviour that is not experienced and perceived by a person. By arguing that there is no objectivity independent of a person's consciousness and his interpretation of his lived experience, we have worked under the assumption that the verbal stories constructed by the participants are trustworthy (Barbosa da Silva & Wahlberg, 1994). Hence, our following interpretation is not established truth, but verisimilitude (Bruner, 1986). In the present study, we have presented some of many possibilities of experiencing substance abuse and suicidal behaviour. When researching ontologically subjective phenomena, qualitative methods can be argued to be epistemologically objective and scientifically robust by being intersubjectively communicated and tested (Barbosa da Silva & Wahlberg, 1994). The use of narrative inquiries invites participants to speak about the perceived world in their own words, and phenomenological hermeneutic analysis of these perceptions can provide valid knowledge about the world, i.e. lived experiences in a broader historical, social, and cultural context (Singer, Scott, Wilson, Easton & Weeks, 2001; McQueen & Henwood, 2002).

The sample of this study is biased as it consists of participants who have been chosen from specific treatment centres and who have been asked to participate. They may have felt more or less motivated to share their experiences. The participants had resources to manage to cooperate with the social service over a long period, and to apply for their present residential status. Having had hope in the positive effects of treatment, and ultimately being able to prepare themselves for interviewing, this elite-bias (Sandelowski, 1986) gave rich descriptions. Whether their descriptions are in concordance with life experiences of other substance abusing men cannot be said, as the method is not meant to grasp the truth about the phenomenon, but to explore and probe (Bateson, 2000).

Being relatively inexperienced with this kind of interviewing, the first author's ability to initiate, signalize and follow up both verbal and non-verbal communication may have influenced how and what the participants told. Telling and listening to existential and traumatic life-events is not easy, and may create conscious and unconscious resistance and defences in both parts. On several occasions the participants and the interviewer were emotionally touched by what was told, leading to silence, shift of theme or difficulties in forming narrative-pointed follow-up questions. When reading the transcribed text, the interviewer's impact on how the stories were

told was obvious, as the stories sometimes developed into non-narrative directions. To keep an open and reflective attitude and facilitate a "you-me" relationship, this was seldom interrupted by the interviewer. The challenge was to get back to narrative-pointed questions. However, the transcribed text gave the impression of rich descriptions of the phenomenon under study, and thus the content was assessed as being researchable for the team. We then decided to keep the sample at four participants. The results we have presented, therefore, are influenced by the method, i.e. the sample, and how the empirical work was prepared, collected, transcribed and interpreted. The principles and consequences of sampling, and the process of interviewing, transcribing and interpretation, as well as the effect of the investigators on a study, are all closely related to different aspects of validity (Kvale, 1997). Using a narrative approach means validating by the coherence within the study and the theoretical contextualization (Riessman, 1993). Ricoeur (1976) argues further that an interpretation is only one of several possible ones, and that other researchers may have analysed the data differently.

Based on the assumption of social constructionism (Burr, 1995), the findings of this study should be seen as applicable within a unique situation embedded in a specific context. Thus, the analytical generalization of the findings might count for transferability and guidance to what might occur in another situation (Kvale, 1997, p. 163). This study offers knowledge to professionals about the necessity of having an open attitude towards the individuals' lived experiences and the need of identifying and facilitating turning points. To encounter individuals experiencing substance abuse and suicidal behaviour, and to understand how hope and pain influencing their suicidal ideation, is therefore of major concern within different parts of the health care and social welfare system. Drawing on the ideas of Ricoeur (1991), we argue that the focus should be more on the kind of reflections and actions that the findings of the present study create in the reader when assessing transferability (Wiklund et al., 2002). We suggest that it is the researcher or the clinician who must make the final judgment about whether the thick description we have tried to give in the present study is sufficiently analogous to be used as a precedent for cases he or she is engaged in. However, the empirical findings of the present study indicate, that in comparable contexts, pain and hope in young men experiencing substance abuse and suicidal behaviour might be understood as "whatever the experiencing person says it is and existing whenever he says it does" (McCaffey & Beebe, 1994). The validity of the data presented may have been affected by the fact that only one researcher interviewed and transcribed, although the analysis was done collectively. The validity of the analysis was strengthened through several discussions of the step-wise findings and an ongoing review of the data by the two members of the research team (Granerud & Severinsson, 2006).

Conclusions

The lived experience of young men with substance abuse and suicidal behaviour can be understood as goal-oriented, communicative and meaning-making activities about the individuals' pain and hope. The empirical source of this study indicates that social demands and possibilities informed the ways in which the participants experienced and constructed masculinity, and thus influenced their suicidal behaviour. From a public health perspective, guided by the interest of preventing premature death, it is important for health and social professionals to identify and facilitate turning points. A holistic and phenomenological attitude towards the individual's lived experiences is necessary. As suicidal behaviour in this study seems to be receptive, reducing pain and create hope by being seen and confirmed in social relationships, and being helped to verbalise existential thoughts and openly discuss possible solutions, are of importance.

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References

Agrawal, H. R., Hauser, S. T., Miller, M., & Penn, H. (2003). "My father did this to me!" The psychodynamic treatment of an angry, sad, and violent young man. *Harvard Review of Psychiatry*, *11*(4), 194–209.

Alma, H. H., & Smaling, A. (2006). The meaning of empathy and imagination in health care and health studies. *International Journal of Qualitative Studies on Health and Well-being*, *1*(4), 195–211.

Ashworth, P. D. (2006). Seeing oneself as a carer in the activity of caring: Attending to the lifeworld of a person with Alzheimer's disease. *International Journal of Qualitative Studies on Health and Well-being*, *1*(4), 212–225.

Barbosa da Silva, A., & Wahlberg, V. (1994). Vetenskapsteoretisk grund för kvalitativ metod (The scientific basis for qualitative methods). In B. Starrin, & P. Svensson (Eds.), *Kvalitativ metod och vetenskapsteori* (pp. 41–70). Lund: Studentlitteratur.

Bateson, G. (2000). *Steps to an ecology of mind*. Chicago: University of Chicago Press.

Beautrais, A. L. (2002). Gender issues in youth suicidal behaviour. *Emergency Medicine*, *14*, 35–42.

Benedetti, A., Fagiolini, A., Casamassima, F., Mian, M. S., Adamovit, A., Musetti, L., et al. (2007). Gender differences in bipolar disorder type 1: A 48-week prospective follow-up of 72 patients treated in an Italian tertiary care center. *Journal of Nervous and Mental Disease*, *195*(1), 93–96.

Beskow, J. (1979). *Suicide and mental disorder in Swedish men*. Copenhagen: Munksgaard.

Beskow, J., Eriksson, B. E., & Nikku, N. (1999). *Självmordsbeteende som språk (Suicidal behaviour as language)*. Stockholm: Forskningsrådsnämden.

Beskow, J. (2005). Suicidalitet som språk (Suicide as language). In H. Herrestad, & L. Mehlum (Eds.), *Uutholdelige liv. Om selvmord, eutanasi og behandling av døende (Unbearable lives. Suicide, euthanasia and treatment of terminally-ill people)* (pp. 43–59). Oslo: Gyldendal akademisk.

Bille-Brahe, U. (2001). The suicidal process and society. In K. van Heeringen (Ed.), *Understanding suicidal behaviour: The suicidal process approach to research, treatment and prevention* (pp. 182–210). Chichester: John Wiley.

Bruner, J. S. (1986). *Actual minds, possible worlds*. Cambridge: Harvard University Press.

Burr, V. (1995). *An introduction to social constructionism*. London: Routledge.

Canetto, S. S. (1993). She died for love and he for glory: Gender myths of suicidal behaviour. *Omega*, *26*(1), 1–17.

Canetto, S. S. (1995). Men who survive a suicidal act. In D. F. Sabo, & D. F. Gordon (Eds.), *Men's health and illness: Gender, power, and the body* (pp. 292–304). Thousand Oaks: Sage Publications.

Cantor, C. H. (2000). Suicide in the western world. In K. van Heeringen, K. Hawton, & R. Goldney (Eds.), *The international handbook of suicide and attempted suicide* (pp. 9–28). Chichester: Wiley.

Clark, S. E., & Goldney, R. D. (2000). The impact of suicide on relatives and friends. In K. van Heeringen, K. Hawton, & R. Goldney (Eds.), *The international handbook of suicide and attempted suicide* (pp. 467–484). Chichester: Wiley.

Connell, R. W. (2005). *Masculinities*. Cambridge: Polity Press.

Cutcliffe, J. R., Joyce, A., & Cummins, M. (2004). Building a case for understanding the lived experiences of males who attempt suicide in Alberta, Canada. *Journal of Psychiatric and Mental Health Nursing*, *11*(3), 305–312.

Darke, S., & Ross, J. (2002). Suicide among heroin users: Rates, risk factors and methods. *Addiction*, *97*(11), 1383–1394.

Denzin, N. K., & Lincoln, Y. S. (2003). *Collecting and interpreting qualitative materials*. Thousand Oaks: Sage.

Dufault, K., & Martocchio, B. C. (1985). Symposium on compassionate care and the dying experience. Hope: Its spheres and dimensions. *The Nursing Clinics of North America*, *20*(2), 379–391.

Durkheim, E. (1897/2001). *Selvmordet: En sosiologisk undersokelse (Suicide: A sociological inquiry)*. Oslo: Gyldendal.

Ekeberg, Ø. (2006). Akutt selvpåført forgiftning: Risikofaktorer, klinisk vurdering og oppfølging (Acute self-inflicted poisoning: Risk factors, clinical assessment and follow-up). *Impuls. Tidsskrift for psykologi*, *60*(1), 53–60.

Emslie, C., Ridge, C., Ziebland, S., & Hunt, K. (2006). Men's accounts of depression: Reconstructing or resisting hegemonic masculinity? *Social Science and Medicine*, *62*(9), 2246–2257.

Eriksson, K. (1992). The alleviation of suffering-the idea of caring. *Scandinavian Journal of Caring Sciences*, *6*(2), 119–123.

Eriksson, K. (1997). Understanding the world of the patient, the suffering human being: The new clinical paradigm from nursing to caring. *Scandinavian Journal of Caring Sciences*, *3*(1), 8–13.

Fortune, S., Stewart, A., Yadav, V., & Hawton, K. (2007). Suicide in adolescents: Using life charts to understand the suicidal process. *Journal of Affective Disorders*, *100*(1–3), 199–210.

Friedman, R. C., Friedman, J. G., & Ramirez, T. (1973). The heroin overdose as a method of attempted suicide. *Addiction*, *68*(2), 137–143.

Gilje, F., Talseth, A. G., & Norberg, A. (2005). Psychiatric nurses' response to suicidal psychiatric in-patients: Struggling with self and sufferer. *Journal of Psychiatric and Mental Health Nursing*, *12*(5), 519–526.

Goodman, A. (1990). Addiction: Definition and implications. *Addiction*, *85*(11), 1403–1408.

Granerud, A., & Severinsson, E. (2006). The struggle for social integration in the community–the experiences of people with mental health problems. *Journal of Psychiatric and Mental Health Nursing*, *13*(3), 288–293.

Hammerlin, Y. (2005). En resept på et selvmordsfritt samfunn. Ansatser til en kritisk refleksjon (A prescription for a suicide-free society. The beginning of a critical reflection). In H. Herrestad, & L. Mehlum (Eds.), *Uutholdelige liv. Om selvmord, eutanasi og behandling av døende (Unbearable lives. Suicide, euthanasia and treatment of terminally-ill people)* (pp. 243–262). Oslo: Gyldendal akademisk.

Hammerlin, Y. (2006). Det lidelsesproduserende hverdagslivet (Everyday life that leads to suffering). *Impuls. Tidsskrift for psykologi*, *60*(1), 11–22.

Harris, E. C., & Barraclough, B. (1997). Suicide as an outcome for mental disorders: A meta-analysis. *British Journal of Psychiatry*, *170*, 205–228.

Hawton, K., Simkin, S., & Fagg, J. (1997). Deliberate self-harm in alcohol and drug misusers: Patient characteristics and patterns of clinical care. *Drug and Alcohol Review*, *16*(2), 123–129.

Hawton, K., & van Heeringen, K. (2000). Introduction. In K. van Heeringen, K. Hawton, & R. Goldney (Eds.), *The international handbook of suicide and attempted suicide* (pp. 1–6). Chichester: Wiley.

Hawton, K. (2005). Psychosocial treatments following attempted suicide: Evidence to inform clinical practice. In K. Hawton (Ed.), *Prevention and treatment of suicidal behaviour. From science to practice* (pp. 197–219). New York: Oxford University Press.

Hedelin, B. (2000). Med gemenskap som grund-psykisk hälsa och ohälsa hos äldre människor och psykiatrisköterskans hälsofrämjande arbete (Community as a basis for mental health and ill-health among older people and the psychiatric nurse's health-promoting activities). Göteborg: Nordiska hälsovårdshögskolan.

Heidegger, M. (1992). *Varat och tiden (Existence and being)*. Göteborg: Bokförlaget Daidalos.

Helsedepartementet. (2003). *Resept for et sunnere Norge: Folkehelsepolitikken (A prescription for a healthier Norway)*. Oslo: Helsedepartementet.

Helzer, J. E., van den Brink, W., & Guth, S. E. (2006). Should there be both categorical and dimensional criteria for the substance use disorders in DSM-V? *Addiction*, *101*, 17–22.

Hjelmeland, H., Knizek, B. L., & Nordvik, H. (2002). The communicative aspect of nonfatal suicidal behaviour—are there gender differences? *Crisis: The Journal of Crisis Intervention and Suicide Prevention*, *23*(4), 144–155.

Isometsä, E., Heikkinen, M., Marttunen, M., Heikkinen, M., Aro, H., Kuoppasalmi, K., et al. (1995). Mental disorders in young and middle aged men who commit suicide. *British Medical Journal*, *310*, 1366–1367.

Johnsson, E., & Fridell, M. (1997). Suicide attempts in a cohort of drug abusers: A 5-year follow-up study. *Acta Psychiatrica Scandinavica*, *96*(5), 362–366.

Karlberg, I., Hallberg, L. R.-M., & Sarvimäki, A. (2002). Introduction and aims of the book—health, public health and research on public health. In L. R.-M. Hallberg (Ed.), *Qualitative methods in public health research: Theoretical foundations and practical examples* (pp. 13–38). Lund: Studentlitteratur.

Karoliussen, M., & Smebye, K. L. (1981). *Sykepleie: Fag og prosess (Nursing—Profession and process)*. Oslo: Universitetsforlaget.

Kerkhof, J. F. M. (2000). Attempted suicide: Patterns and trends. In K. van Heeringen, K. Hawton, & R. Goldney (Eds.), *The international handbook of suicide and attempted suicide* (pp. 49–64). Chichester: Wiley.

Kessler, R. C., Borges, G., & Walters, E. E. (1999). Prevalence of and risk factors for lifetime suicide attempts in the national comorbidity survey. *Archives of General Psychiatry*, *56*(7), 617–626.

Kienhorst, I., & van Heeringen, K. (2001). Psychoterapeutic implications of the suicidal process approach. In K. van Heeringen (Ed.), *Understanding suicidal behaviour: The suicidal process approach to research, treatment and prevention* (pp. 273–287). Chichester: Wiley.

Kilmartin, C. (2005). Depression in men: Communication, diagnosis and therapy. *The Journal of Men's Health & Gender*, *2*(1), 95–99.

Kolves, K., Varnik, A., Tooding, L. M., & Wasserman, D. (2006). The role of alcohol in suicide: A case-control psychological autopsy study. *Psychological Medicine*, *36*(7), 923–930.

Kvale, S. (1997). *Det kvalitative forskningsintervju (The qualitative research interview)*. Oslo: Ad notam Gyldendal.

Labov, W. (1982). Speech actions and reactions in personal narrative. In D. Tannen (Ed.), *Analyzing discourse: Text and talk* (pp. 219–247). Washington, DC: Georgetown University Press.

Lester, D. (2000). Alcoholism, substance abuse and suicide. In B. M. Bongar, A. L. Berman, & M. M. Silverman (Eds.), *Comprehensive textbook of suicidology* (pp. 357–375). London: Guilford Press.

Lester, D. (2001). Nonfatal suicidal behavior as a communication. *Crisis: The Journal of Crisis Intervention and Suicide Prevention*, *22*(2), 49–51.

Lindseth, A., Marhaug, V., Norberg, A., & Udén, G. (1994). Registered nurses' and physicians' reflections on their narratives about ethically difficult care episodes. *Journal of Advanced Nursing*, *20*(2), 245–250.

Lindseth, A., & Norberg, A. (2004). A phenomenological hermeneutical method for researching lived experience. *Scandinavian Journal of Caring Sciences*, *18*(2), 145–153.

Linehan, M. M. (1973). Suicide and attempted suicide: Study of perceived sex differences. *Perceptual and Motor Skills*, *37*, 31–34.

Liu, W. M., & Iwamoto, D. K. (2007). Conformity to masculine norms, Asian values, coping strategies, peer group influences and substance use among Asian American men. *Psychology of Men & Masculinity*, *8*(1), 25–39.

Maris, R. W., Berman, A. L., & Silverman, M. M. (2000). Theoretical componement in suicidology. In B. M. Bongar, A. L. Berman, & M. M. Silverman (Eds.), *Comprehensive textbook of suicidology* (pp. 26–61). London: Guilford Press.

McCaffery, M., & Beebe, A. (1994). *Pain: Clinical manual for nursing practice*. London: Mosby.

McQueen, C., & Henwood, K. (2002). Young men in 'crisis': Attending to the language of teenage boys' distress. *Social Science & Medicine*, *55*(9), 1493–1509.

Mehlum, L. (2005). Traumatic stress and suicidal behaviour: An important target for treatment and prevention. In K. Hawton (Ed.), *Prevention and treatment of suicidal behaviour: From science to practice* (pp. 121–138). New York: Oxford University Press.

Miele, G. M., Tilly, S. M., First, M., & Frances, A. (1990). The definition of dependence and behavioural addictions. *Addiction*, *85*(11), 1421–1423.

Miller, P. G. (2006). Dancing with death: The grey area between suicide related behavior, indifference and risk behaviors of heroin users. *Contemporary Drug Problems*, *33*(3), 427–450.

Mino, A., Bousquet, A., & Broers, B. (1999). Substance abuse and drug-related death, suicidal ideation, and suicide: A review. *Crisis: The Journal of Crisis Intervention and Suicide Prevention*, *20*(1), 28–35.

Mishler, E. G. (1986). *Research interviewing: Context and narrative*. Cambridge: Harvard University Press.

Mitchell, A. M., Kim, Y., Prigerson, H. G., & Mortimer, M. K. (2005). Complicated grief and suicidal ideation in adult survivors of suicide. *Suicide & Life-Threatening Behavior*, *35*(5), 498–506.

Mittendorfer-Rutz, E. (2006). Trends of youth suicide in Europe during the 1980s and 1990s—gender differences and implications for prevention. *Journal of Men's Health & Gender*, *3*(3), 250–257.

Moller-Leimkühler, A. M. (2003). The gender gap in suicide and premature death or: Why are men so vulnerable? *European Archives of Psychiatry and Clinical Neuroscience*, *253*(1), 1–8.

Moscicki, E. K. (2001). Epidemiology of completed and attempted suicide: Toward a framework for prevention. *Clinical Neuroscience Research*, *1*, 310–323.

Nielsen, A. S., Bille-Brahe, U., Hjelmeland, H., Jensen, B., Ostamo, A., Salander-Renberg, E., et al. (1996). Alcohol problems among suicide attempters in the Nordic countries. *Crisis: The Journal of Crisis Intervention and Suicide Prevention*, *17*(4), 157–166.

Nordic Council of Ministers. (2006). *Nordic statistical yearbook 2006*. Copenhagen: Nordic Council of Ministers.

Oquendo, M. A., Bongiovi-Garcia, M. E., Galfalvy, H., Hanga, A., Goldberg, P. H., Pablo, H., et al. (2007). Sex differences in clinical predictors of suicidal acts after major depression: A prospective study. *American Journal of Psychiatry*, *164*(1), 134–141.

Orbach, I. (2003). Mental pain and suicide. *The Israel Journal of Psychiatry and Related Sciences*, *40*(3), 191–201.

Peplau, H. E. (1988). *Interpersonal relations in nursing*. New York: Macmillan Education.

Phillips, M. R., Li, X., & Zhang, Y. (2002/3/9). Suicide rates in china, 1995–99. *Lancet*, *359*(9309), 835–840.

Platt, S., Davis, S., Sharpe, M., & O'May, F. (2005). Contextual effects in suicidal behaviour: Evidence, explanation, and implications. In K. Hawton (Ed.), *Prevention and treatment of suicidal behaviour. From science to practice* (pp. 53–70). New York: Oxford University Press.

Plutchik, R. (2000). Aggression, violence and suicide. In B. M. Bongar, A. L. Berman, & M. M. Silverman (Eds.), *Comprehensive textbook of suicidology* (pp. 407–423). London: Guilford Press.

Polkinghorne, D. E. (1988). *Narrative knowing and the human sciences*. Albany: State University of New York Press.

Qin, P., Mortensen, P. B., Agerbo, E., Westergaard-Nielsen, N., & Eriksson, T. (2000). Gender differences in risk factors for suicide in Denmark. *The British Journal of Psychiatry*, *177*(6), 546–550.

Qin, P., Agerbo, E., & Mortensen, P. B. (2003). Suicide risk in relation to socioeconomic, demographic, psychiatric, and familial factors: A national register-based study of all suicides in Denmark, 1981–1997. *The American Journal of Psychiatry*, *160*(4), 765–772.

Qvortrup, L. (1999). *Selvmordsadfærd, kommunikation og sprogteoretiske perspektiver (Suicidal behaviour, communication and language—theoretical perspectives)*. Stockholm: Forskningsrådsnämnden.

Reinås, K., Waal, H., Buster, M., Harbo, M., Noller, P., Schardt, S., et al. (2002). *Strategic choices for reducing overdose deaths in four European cities*. Oslo: Rusmiddeletaten.

Ricoeur, P. (1976). *Interpretation theory: Discourse and the surplus of meaning*. Fort Worth: Texas Christian University Press.

Ricoeur, P. (1991). *From text to action: Essays in hermeneutics, II*. London: The Athlone Press.

Riessman, C. K. (1993). *Narrative analysis*. London: Sage Publications.

Rossow, I., & Lauritzen, G. (1999). Balancing on the edge of death: Suicide attempts and life-threatening overdoses among drug addicts. *Addiction*, *94*(2), 209–219.

Sakinovsky, I., & Leenaars, A. A. (1997). Suicide in Canada with special reference to the difference between Canada and the United States. *Suicide & Life-Threatening Behavior*, *27*, 112–126.

Sällfors, C. (2003). *Pain: Coping and well-being in children with chronic arthritis: Doctoral dissertation*. Göteborg: Nordic School of Public Health.

Sandelowski, M. (1986). The problem of rigor in qualitative research. *Advances in Nursing Science*, *8*(3), 27–37.

Sarvimäki, A. (2006). Well-being as being well—a Heideggerian look at well-being. *International Journal of Qualitative Studies on Health and Well-being*, *1*(1), 4–10.

Shneidman, E. S. (1985). *Definition of suicide*. New York: Wiley.

Shneidman, E. S. (1993). Suicide as psychache. *The Journal of Nervous and Mental Disease*, *181*(3), 145–147.

Silverman, M. M. (2006). The language of suicidology. *Suicide & Life-Threatening Behavior*, *36*(5), 519–532.

Singer, M., Scott, G., Wilson, S., Easton, D., & Weeks, M. (2001). "War stories": AIDS prevention and the street narratives of drug users. *Qualitative Health Research*, *11*(5), 589–611.

Socialstyrelsen. (2005). *Folkhälsorapport 2005 (Public health report 2005)*. Stockholm: Socialstyrelsen.

Strike, C., Rhodes, A. E., Bergmans, Y., & Links, P. (2006). Fragmented pathways to care. *Crisis: The Journal of Crisis Intervention and Suicide Prevention*, *27*(1), 31–38.

Sundhedsstyrelsen. (1998). *Forslag til handlingsplan til forebyggelse af selvmordsforsøg og selvmord i Danmark (Draft action plan for prevention of attempted suicide in Denmark)*. København: Sundhedsstyrelsen.

Suominen, K., Isometsä, E., Suokas, J., Haukka, J., Achte, K., & Lönnqvist, J. (2004). Completed suicide after a suicide attempt: A 37-year follow-up study. *American Journal of Psychiatry*, *161*(3), 562–563.

Suominen, K., Isometsä, E., Haukka, J., & Lönnqvist, J. (2004). Substance use and male gender as risk factors for deaths and suicide—a 5 year follow-up study after deliberate self-harm. *Social Psychiatry and Psychiatric Epidemiology*, *39*, 720–724.

Talseth, A. G., Lindseth, A., Jacobsson, L., & Norberg, A. (1997). Nurses' narrations about suicidal psychiatric in-patients. *Nordic Journal of Psychiatry*, *51*(5), 359–364.

Talseth, A. G., Gilje, F., & Norberg, A. (2001). Being met–a passageway to hope for relatives of patients at risk of committing suicide: A phenomenological hermeneutic study. *Archives of Psychiatric Nursing*, *15*(6), 249–256.

Thorvik, A. (2005). Å drepe, bli drept og dø. Om psykodynamisk forståelse av suicid (To kill, to be killed and to die. Psychodynamic understanding of suicide). In H. Herrestad, & L. Mehlum (Eds.), *Uutholdelige liv. Om selvmord, eutanasi og behandling av døende* (pp. 60–75). Oslo: Gyldendal akademisk.

Webster Rudmin, F., Ferrada-Noli, M., & Skolbekken, J. A. (2003). Questions of culture, age and gender in the epidemiology of suicide. *Scandinavian Journal of Psychology*, *44*(4), 373–381.

Wengraf, T. (2001). *Qualitative research interviewing: Biographic narrative and semi-structured methods*. London: Sage.

Widiger, T. A., & Smith, G. T. (1994). Substance use disorder: Abuse, dependence and dyscontrol. *Addiction*, *89*(3), 267–282.

Wiklund, L., Lindholm, L., & Lindström, U. A. (2002). Hermeneutics and narration: A way to deal with qualitative data. *Nursing Inquiry*, *9*(2), 114–125.

Willén, H. (2002). Personal narrative research in the context of troubled parenthood. In L. R.-M. Hallberg (Ed.), *Qualitative methods in public health research: Theoretical foundations and practical examples* (pp. 175–200). Lund: Studentlitteratur.

Winkler, D., Pjrek, E., & Kasper, S. (2006). Gender-specific symptoms of depression and anger attacks. *The Journal of Men's Health & Gender*, *3*(1), 19–24.

World Health Organisation. (2007). *Suicide prevention.* Retrieved April 24, 2007, from http://www.who.int/mental_health/prevention/suicide/suicideprevent/en/

Wunderlich, U., Bronisch, T., Wittchen, H., & Carter, R. (2001). Gender differences in adolescents and young adults with suicidal behaviour. *Acta Psychiatrica Scandinavica*, *104*(5), 332–339.