Unburdening Suffering: responses of psychiatrists to patients' suicide deaths

Anne-Grethe Talseth and Fredricka Gilje

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The research questions was: 'How do psychiatrists describe their responses to patients' suicidal deaths in the light of a published model of consolation?' The textual data ($n = 5$) was a subset of a larger ($n = 19$) study. Thematic analysis showed a main theme, 'unburdening grief', and six themes. Embedded in the results is a story about suffering that reveals that, through ethical reflectiveness, a meaning of suffering can be recreated that unburdens grief and opens up new understandings with and among disciplines. This can help to prepare health professionals to respond to people who suffer because of suicidal death.

Introduction

Psychiatrists commonly encounter patient suicide.[1] They have an important role in preventing suicide[2–6] and in the aftermath of a patient's suicidal death.[7–10] After a patient's suicidal death, they can make a significant contribution[7–10] to a health team by passing on lessons learned from caring for suicidal patients,[8] maintaining standards of practice[8] and promoting personal and professional growth.[11] It is important that psychiatrists monitor their reactions to suicidal death because failure to do so may significantly impact on their mental health and professional functioning.[8]

A literature search of electronic databases (CINAHL, PsycINFO, PubMed and Sociological Abstracts) revealed that psychiatrists' reactions to patients' suicidal deaths were infrequently discussed and researched. This is quite remarkable because suicidal death evokes various reactions from therapists, including psychiatrists, whose responses have been noted to be similar to other therapists.[12] These responses include considerable anxiety, most often experienced as shock, sadness, anger, guilt, doubt about competence,[13] stress, grief, depression and loss.[14] Results have also shown that their responses were 'severe' or 'strong', had a major effect on their development as physicians,[3] and impacted on both their professional and personal lives.[14] Responses

Address for correspondence: Anne-Grethe Talseth, Associate Professor, Tromsø University College, Faculty of Health Sciences, MH-bygget, Breivika, 9293 Tromsø, Norway. Tel: + 47 776 60656; Telefax: + 47 776 60612; E-mail: Anne.G.Talseth@hitos.no

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of psychiatrists to patients' suicidal deaths are seldom addressed in published research, even though a suicidal death is one of the most stressful events in a psychiatrist's professional life.[15,16]

We had noted that physicians and some psychiatrists related to suicidal patients in terms of 'power to' and 'power over'.[17] 'Power to' meant striving to be open, meeting patients' needs, confirming patients and accepting suicide as a human reaction, yet worrying about patients. 'Power over' meant searching for an explanation for the suicidal risk, avoiding patients, distancing self from feelings of mortality and vulnerability, worrying about personal professional reputation and feeling guilty. Results have shown that it is important for physicians to confront their own mortality, and their feelings of fear, vulnerability and fallibility, in order to be able to relate to and confirm suicidal patients.

We had also noted in our previous research on nurses that consolation was an important theme in ethically difficult intensive care patient situations[16,18] and in caring for suicidal psychiatric patients.[19–21] A study of physicians revealed four themes ('presence', 'be in contact', 'confirmation' and 'restoration') related to the meaning of consolation; asserted that consolation is of importance in medical practice; and encouraged further research on consolation.[22] We wondered if consolation could be embedded in texts about psychiatrists' experiences with patients' suicidal deaths. We believed that describing psychiatrists' responses to patients' suicidal death may heighten awareness of the ethical concerns that impact on professional practice. We therefore became interested in exploring textual data for responses of psychiatrists to patients' suicidal death in the light of a model of consolation.[23]

The consolation model[23] is based on a hermeneutic interpretation of interviews with 19 professionals from health care, social work and religious affiliations. These interviews focused on the experience of being consoled and mediating consolation. According to the model, consolation occurs when the sufferer and the mediator become ready for consolation. Becoming ready means that the sufferer can express suffering and the mediator dares to listen without judging. Being in communion occurs when sufferer and mediator share an affective state that opens up for the sufferer to transcend suffering and experience meaning despite darkness. Consolation can be viewed as a 'homecoming', which indicates a transition from 'not being at home' to 'being at home'.

Consolation has various nuances of meaning. Some philosophies can even console.[24] Both Greek and Roman philosophies describe consolation as a kind of homecoming; the soul comes home to itself.[23] Based on these philosophical perspectives, several empirical studies on consolation in health care have described consolation as a shift in perspective from states of tragedy, the unchangeable past, to states of fragility, future possibilities[25] and homecoming.[26,27] Moreover, from an ethical perspective, consolation can be understood as '... entering the sphere of communion, the in-between, by transcending the self and getting in touch with love, joy, beauty and goodness in life that is in contact with the sacred dimension of being' (p. 74).[28] In the Norwegian language 'consolation' is synonymous with the terms 'comfort' and 'solace'. In the English language, general usage of the term 'consolation' suggests 'making someone feel better' or 'giving comfort'.

The research question for this study was, 'How do psychiatrists' describe their responses to patients' suicidal deaths in the light of a published model of consolation?' The aim was to describe these responses based on textual data. Our intent was to grasp

a way of understanding responses to a patient's suicidal death. The original study[17] was approved by the Ethics Committee of the Fifth Health Region, University of Tromsø, Tromsø, Norway, in 1997. In 2002, this same ethics committee approved further in-depth analysis of the data that were the basis for this study.

Method

A qualitative descriptive study was conducted.

Sample

The sample was a subset ($n = 5$) of texts from a larger ($n = 19$) study.[17] The textual data came from narrative interviews with five psychiatrists employed at a psychiatric hospital in Norway. There were four men and one woman. They ranged in age from 41 to 49 years and had 5–12 years of experience in psychiatry. All consented to participate voluntarily.

Data collection

The data were based on the texts of interviews lasting 1–2 hours conducted by the first author. The interviews focused on an experience of treating a 'suicidal patient'. 'Suicidal patient' was defined as a patient with 'suicidal thoughts, suicidal attempt/action, or suicidal death'. In the interviews, questions were posed that clarified, explored and focused on elaborating the narrative. All five participants narrated accounts of their experience with a patient's suicidal death. The narrative interviews were transcribed verbatim into Norwegian text. Validation of the original texts involved the first author listening to the audio-recorded text several times while reading the transcribed texts. Anonymity of participants was protected by means of a coding system. The texts of these five narratives comprised the data for this study.

Data analysis

Data analysis was influenced by the authors' pre-understandings and the hermeneutic literature. Both authors have extensive experience in psychiatric nursing and nursing education. They are of different nationalities. The first author is bilingual with English as a second language. The second author is English speaking and somewhat familiar with the Norwegian language.

The data analysis proceeded through several phases. The first author selected one of the texts for a detailed analysis based on its richness and descriptiveness related to the aim of this study. The selected text, 20 pages in length, was obtained from a two-hour interview and transcribed into Norwegian. Together the authors translated the text into English and thematically[29] analyzed the English version of this text through a process of condensation–abstraction using a detailed approach.[30]

Next, the first author used the detailed analysis to guide the isolation of themes in the other four Norwegian texts. This proceeded using a selective approach.[30] This involved isolating, or selecting, descriptions related to the subthemes and themes from the detailed analysis, while scrutinizing the texts for similarities and variations that

validated or invalidated the detailed analysis. All texts revealed insightful reflections explicating dramatic responses to a patient's suicidal death.

The analysis continued through a process of condensation–abstraction.[23,28] The four texts were divided into meaning units consisting of words, phrases or sentences related to the aim of the study. The meaning units were condensed and abstracted into key descriptions of each unit. These key descriptions were then reflected on and scrutinized for prominent relationships, including commonalties as well as regular patterns and variations. The condensed meaning units were abstracted based on similarities of these relationships, and subthemes were constructed for each text and labeled, influenced by the model on consolation. The subthemes were clustered according to their description of the process or phase of consolation and were then grouped together to form themes. Both authors reflected in depth on these themes over time, resulting in conceptual clarification of the themes and identification of a major theme.

Results

Thematic analysis resulted in 189 meaning units, 189 condensed meaning units, 27 subthemes, 6 themes, and 1 main theme. The main theme is 'unburdening grief'. Table 1 presents an example of the condensation–abstraction process for the theme 'inner dialoguing with self through knowing, reflecting, remembering, sensing, valuing, reasoning, judging and discerning'.

The first theme is 'being professionally responsible in the midst of vulnerability'. This theme was abstracted from four subthemes, namely 'encountering suffering, sufferer and significant others when professionally responsible', 'balancing professional responsibilities and boundaries of self and others in the midst of vulnerability', 'being present to significant others when vulnerable' and 'reflecting on being professionally responsible and vulnerable when meeting the limits of suffering'. These subthemes were abstracted from 32 condensed meaning units. An example from a text follows.

> As soon as I entered the room I could feel the atmosphere – it felt very heavy, a lot of anxiety and confusion. I was confronted with this ... and I was really reflecting ... I was very convinced that we had to be really careful, follow up and really keep an eye on him. I do not know when I really felt this way, but it was before the patient said anything. I also saw how restless he was and how worried the family was when I heard them tell their story ... I was not restless on the outside, but I was on the inside, which helped me to understand how serious this was. It is very difficult to know when my own feelings signal how the other person is feeling ... Where do you draw the line between my feelings and the patient's feelings?

The second theme is 'becoming open to self and others fosters readiness to open up'. This theme surfaced from four subthemes. These were 'struggling to relate to and understand suffering', 'being emotionally touched by the vulnerability of the suffer and significant others', 'being empathic with sufferers' and 'revealing self therapeutically and being very firm and confident fosters sufferer's readiness to open up'. These subthemes were abstracted from 22 condensed meaning units. An example from the text follows.

Table 1 Example of the condensation–abstraction process (8 of the 12 subthemes from the first theme): meaning units, condensed meaning units, subthemes, theme

Meaning units	Condensed meaning units	Subthemes	Theme
I think people are allowed to take their life if they absolutely want to ... In this case, we have to protect them from doing it ... When the patient himself does not have insight about what is good and not good for him, then we must [protect him].	Thinking about evaluating the sufferer's volition	Knowing professionally	Inner dialoguing with self through knowing, reflecting, remembering, sensing, valuing, reasoning, judging and discerning
I know ... the family relationship. The family was terribly frightened that he would commit suicide and so sure that he would.	Reflecting on family's feelings of being terribly frightened	Reflecting deeply on one's own and significant others' feelings and experiences	
I ... know the family through dialogue with the daughter, the wife and the history. I felt close to the family. The patient was close to the family. I did not have as good contact with the patient ... it was distant in many ways.	Re-awakening the family's despair emerges from knowing the family and their history through past dialogue and feeling close to them	Remembering being connected to sufferer's significant others	
The patient didn't say anything about [suicide] ... he did not confirm it ... he had problems saying anything; it seemed the story was real.	Meeting a patient who is voiceless about his story, which seems real	Sensing vulnerability, impending tragedy and voicelessness	
... I was relating to him, being a decent person who cares. Even though you cannot do so much, you are a human being who cares. You really do not want them to commit suicide ... It is about sympathy and empathy. You ... have to be engaged ... be involved with how it is with the patient and at the same time to not lose control.	Being a decent person who cares, is engaged and empathic and not losing control is important	Valuing professional competence and connectedness with the patient as a human being	
It was so hard after he died – everything was seen in this light ... He had had better thoughts, talked especially about his son and the importance of continued living.	Trying to make sense of the lack of congruence between sufferer's thoughts and actions	Reasoning about suffering	

Table 1 (*Continued*)

Meaning units	Condensed meaning units	Subthemes	Theme
I thought 'What . . . is going on with us [self and colleagues]?' It was so difficult the day after he was admitted because he had been so restless for a long time. How could this change happen so quickly? I blame myself harshly. I did and I still do. I blame myself that I could think he could change and be better so quickly. This does not happen so fast . . . I was so naïve, it was awful.	Evaluating and blaming self harshly over time	Judging self	
It was very difficult for the patient to talk . . . very difficult for him to be a patient in the hospital – he really did not want that. That was why he was really restless. He admitted he had a suicide plan, understood why the family was very worried about him, and knew he was not psychotic.	Interpreting the sufferer's thoughts and words about suicide, family worries, being hospitalized, reasons for restlessness, and not being psychotic	Discerning the patient's safety	

> I was very affected by the family's feelings . . . I used myself as a tool . . . I managed to get the patient to sit down. It was a big deal for him to do this . . . I figured out how to get him to sit down. The patient had gone to and fro – turned on the water, drank, back and forth. So I was very strict and authoritative. He had to sit down, he had to talk to me . . . I had to figure out how he really was . . . and he had to tell me . . . I really think it calmed him down. He managed to become so calm that he formulated some thoughts and said something.

The third theme is 'inner dialoguing with self through knowing, reflecting, remembering, sensing, valuing, reasoning, judging and discerning'. This theme was abstracted from 12 subthemes, namely, 'knowing professionally', 'knowing self ', 'knowing sufferer and suffering', 'reflecting on professional responsibilities, what is known and not known and what has been learned about the limits of suffering', 'reflecting deeply on one's own and significant others' feelings and experience', 'reflecting on discerning reality', 'remembering relating to sufferer's significant others', 'sensing vulnerability, impending tragedy and voicelessness', 'valuing professional competence and relatedness to the patient as a human being', 'reasoning about suffering', 'judging self' and 'discerning the patient's safety'. These subthemes were abstracted from 97 condensed meaning units. An excerpt from a text reflecting inner dialogue through valuing follows.

> If you . . . aren't really being a fair . . . and honest human being, the patient will experience you negatively. When we talk about the meaning of going on living, I have to have a lot of empathy and understanding and, at the same time, I am very direct, not harsh, so that I do not provoke people to do it [suicide]. We meet them where they really are – at their reason for wanting to die by suicide. You have to meet them so they do not feel we minimize [their life situation] . . .

An excerpt follows that shows inner dialoguing through judging.

> I thought what . . . is going on with [self and colleagues]? It was so difficult the day after he was admitted because he had been so restless for a long time. I wondered how this could change so quickly. I blamed myself harshly. I did and I still do. I blame myself that I could think he could change and be better so quickly. How could I be so naïve . . . It was awful . . .

The following is an excerpt about inner dialoguing through relatedness.

> Well, I know a lot about the family relationship . . . I know [the family] was terribly frightened that he would commit suicide. They were sure he would do it.

The fourth theme is 'outer dialoguing with sufferer and others through therapeutic communication and collaboration'. This theme evolved from two subthemes, namely 'communicating therapeutically with sufferer and significant others' and 'collaborating with others'. These were abstracted from 19 condensed meaning units. An example follows.

> I was right that he had a plan to commit suicide. It was difficult for him to think about suicide so he walked around and became restless. I was very direct with him. I directly asked if he had suicidal thoughts, what he would use the gun for, and also asked if he thought about using it on himself. He hesitantly said, 'Yes'.

The fifth theme, 'being true to self', emerged from three subthemes. These were 'revealing personal and professional integrity', 'participating in the suffering of grief with significant others with courage' and 'revealing meaning of suffering through

relating to colleagues and metaphor'. These three subthemes were formulated from 13 condensed meaning units. A text conveyed:

> You know, when I talked to [the patient] the first time, I was so convinced we had to hospitalize him the day he came. It was strange. And then I was so convinced we could discharge him the next day. It was difficult to evaluate.

Another text said:

> When I am in despair I find someone I can trust and talk with. I had my chief, and I trusted him.

A further example was:

> [Colleagues] see it is painful for you, but at the same time you can just be there. To really understand what it is like for the patient . . . It is like a surgeon who has to cut and knows where it starts bleeding.

The sixth theme is 'unburdening grief emerges through shifting perspectives'. This surfaced from two subthemes, namely 'unburdening grief surfaces through telling, listening, reading and reflecting' and 'teaching about past experiences of suffering releases own grief and gives meaning'. These were abstracted from six condensed meaning units. An example from one text was:

> I talked about this [patient's suicide] with my chief at the time, and I asked to dialogue with him. He came to me right away. He clearly said I could not have done anything else. First, it was not legal to keep [the patient] hospitalized because his wife had signed him in . . . I really had checked that the family would follow up. I told them they could come back for more care if he became worse. At the time [the patient] had changed. The [chief] meant I should not blame myself at all. I was relieved. This chief psychiatrist had had lots of experience.

Another example was:

> This was . . . a powerful suicide . . . It influenced me very much. I discussed this event in different ways, with colleagues, in meetings and reading literature. I reflected over and over on my emotional reactions to this powerful suicidal death . . . Whenever I lecture about how to meet people who have suicidal thoughts, I connect it to this experience.

The main theme is 'unburdening grief'. Table 2 illustrates the themes and subthemes related to the themes in the model of consolation.[23]

Discussion

The results of this study describe responses of psychiatrists to patients' suicidal deaths as 'unburdening grief'. Viewing these results in the light of a model of consolation[23] brings forth ethical reflectiveness on self in relation to others. Based on the consolation model,[23] a 'sufferer' is one who endures grief, pain or anguish. In this study, a 'sufferer' is referred to in several ways (i.e. as the patient, as the patient's family and as the psychiatrist, all of whom endure grief). The psychiatrist can be viewed as a 'mediator' and the patient can be seen as a 'sufferer'.

The psychiatrist became ready for mediating consolation while 'being professionally responsible in the midst of vulnerability'. This involved encountering the patient (sufferer) and the patient's family (suffering others) as human beings, seeing beyond

Table 2 Themes of the consolation model related to the themes and subthemes revealed by the study

Consolation model	Themes	Subthemes
Becoming ready for consolation	Being professionally responsible in the midst of vulnerability	Encountering suffering, sufferer and significant others when professionally responsible Balancing professional responsibilities and boundaries of self and other in the midst of vulnerability Being present to significant others when vulnerable Reflecting on being professionally responsible and vulnerable when meeting the limits of suffering
	Becoming open to self and others fosters readiness to open up	Struggling to relate to and understand sufferer Being emotionally touched by the vulnerability of the sufferer and significant others Being empathic with sufferers Revealing self therapeutically; being very firm and confident fosters sufferer's readiness to open up
Dialoguing	Inner dialoguing with self through knowing, reflecting, remembering, sensing, valuing, reasoning, judging and discerning	Knowing professionally Knowing self Knowing sufferer and suffering Reflecting on professional responsibilities, what is known and not known, and what has been learned about the limits of suffering Reflecting deeply on own and significant others' feelings and experience Reflecting on discerning reality Remembering relating to sufferer's significant others Sensing vulnerability, impending tragedy and voicelessness Valuing professional competence and relatedness to the patient as a human being Reasoning about suffering Judging self Discerning the sufferer's safety
	Outer dialoguing with sufferer and others through therapeutic communication and collaboration	Communicating therapeutically with sufferer and significant others Collaborating with others

Table 2 (*Continued*)

Consolation model	Themes	Subthemes
Being in communion	Being true to self	Revealing personal and professional integrity Participating in the suffering of grief with significant others with courage Revealing meaning of suffering through relating to colleagues and metaphor
Shifting perspective	Unburdening grief through shifting perspectives	Unburdening grief surfaces through telling, listening, reading and reflecting Teaching about past experiences of suffering releases own grief and gives meaning

the stigma of suicide, feeling 'emotionally touched' by the suffering and realizing that understanding required understanding the sufferer and suffering others. When meeting the sufferer and suffering others, the psychiatrists perceived the situation as a gestalt through suddenly sensing vulnerability (e.g. the 'heavy atmosphere'). Sensing the 'heavy atmosphere' evoked ethical concern for self and sufferer. Through ethical reflectiveness and being trustworthy, the psychiatrists revealed their self to the sufferer and suffering others.

'Becoming open to self and others fosters readiness to open up' occurred as the psychiatrists related professionally to the suffering and suffering others, and struggled to relate to the sufferer. The psychiatrists were firm and confident. They insisted that the sufferer sit down and talk about suicidal thoughts and plans. As the psychiatrists actively listened and empathically responded to the sufferer's voicelessness rather than verbalizations, and calmness rather than restlessness, the sufferer began to open up, uncovering anguish.

'Inner dialoguing with self through knowing, reflecting, remembering, sensing, valuing, reasoning, judging and discerning' emerged as the psychiatrists reflected on and evaluated the status of the patient's suffering and safety. This was a kind of deep ethical deliberation with self that involved anticipatory loss (i.e. being on the threshold of grief). They then decided they were 'satisfied' with the sufferer's response as well as the support and encouragement of the suffering others.

When the psychiatrist heard about the sufferer's suicidal death they were shocked. Their initial response was that this was 'so awful', they were so 'naïve'. This seemed to activate their conscience. They 'blamed' themselves 'harshly' and thought they 'should have been more careful and not swayed by their emotions in the situation'. These words convey a feeling of guilt, self-doubt and grief. They described this as 'catastrophic'. Hearing about the death was 'an awful, dreadful experience' because they had related professionally to the suffering others. In a way, they were alienated from their identity, in darkness and in exile.[25] An example of ethical reflectiveness on the suffering of self and others was: 'When I am in despair I find someone I trust to talk with . . . It is like the patient who threatened suicide; he had to trust somebody to feel relieved . . .' The psychiatrists struggled even more with grief by judging themselves harshly and striving to balance boundaries. This struggle was apparent in several texts that showed distance from self by shifting narration in first person pronouns to third person pronouns.

'Outer dialoguing with sufferer and others through therapeutic communication and collaboration' involved interactions with colleagues, significant others and patients. Prior to the patient's death, the psychiatrists discerned the sufferer's safety by communicating therapeutically, persistently and directly questioning, in a firm yet kind way, about suicidal thoughts and plans, and informing relatives about maintaining safety at home. Collaboration with colleagues meant discussing, listening to advice, relating to and feeling supported by colleagues. It also involved engaging in a no-harm contract with the patient and relatives.

The psychiatrists struggled further with their inner and outer dialogue. For example, one text described a psychiatrist's dialogue with a supervisor about the patient's suicidal death. The supervisor responded with statistical information about suicide, which brought momentary relief. However, after reflecting on the feelings of the suffering others and his own ethical stance concerning professional responsibilities and relationships with significant others, he continued to struggle. The text implied a

sense of captivity and wishfulness – ethical imagination – about what could have been. For example, 'One could have escaped this. I think about it now. If I had known [the patient] better, perhaps this would not have happened.' This seems to refer to the psychiatrists' re-visioning the past to open up to relating to the patient. It also seems to convey their expectation to have prevented the suicide.[2–6] All that had been possible was now impossible because of the patient's suicide death. The results show that most texts focused on the mediator's inner dialogue – reasoning, thoughts, feelings, values, convictions, reflections and recollections. This inner dialogue reveals ethical reflectiveness, similar to the inner dialogue of senses, imagination, reason and intelligence in the midst of suffering.[25]

'Being true to self' involved 'being in communion with self'. This is reflected in the inner peace one psychiatrist found through remembering and deep reflection. Finding inner peace indicates relatedness to self. For example, the psychiatrists' reflections conveyed self-confidence; they 'could not be frightened of people who are suffering' or they 'could manage their professional responsibility'. This is similar to the results of a study[17] that showed physicians became aware that suicide and death concerned them personally; they recognized their own mortality, fear, anxiety and values. The psychiatrists' inner peace was evident, for example, in becoming convinced of who they were; that is, 'I am a decent person who cares'. This reveals that the psychiatrists experienced 'being in communion with self'. They seemed to be genuinely feeling one with themselves, not pretending to be someone they were not.

Marcel wrote that communion between 'I and Thou' is founded on a prior community, the experience of the lived body as a 'we-reality', togetherness in being.[31] Thus, communion with self is a kind of incarnation, feeling one with one's body and connected to other bodies in an intersubjective nexus. The psychiatrists' communion with self emerged from revealing personal and professional integrity, participating in the experience of suffering and 'not giving up'. This implies ethical reflection that strengthened their relatedness to self in the midst of vulnerability.

The importance of physicians recognizing and meeting vulnerable expressions from a patient as a human being is pointed out by Sørlie,[32] who writes:

> If these expressions are ignored and [physicians] try to preserve their identity on a social level through confirmation from colleagues, they may experience an identity problem ... In such situations, with respect to their identity, it is important for physicians to be persons who respond to the vulnerable expressions of life (p. 50).[32]

Expressions of vulnerability can evoke ethical reflectiveness; they can open up ethical inquiry. When psychiatrists do not dare to respond to the vulnerable expressions in life, they risk forgetting their true identity and being in exile,[25] which obliterates meaning and purpose.

Revealing meaning of suffering through metaphor was apparent in the text: 'It is like a surgeon who knows where to cut and when it begins bleeding.' Courage was revealed metaphorically as 'just being there' in the midst of suffering without being threatened. Language can be unavailable to express suffering; it can be inadequate to console. Excessive grief is often inexpressible; it can be too awful to speak about. Metaphors are frequently used to express grief. Use of metaphors indicates a gap, a rift, in language and meaning. Although subject to interpretation, metaphors remove us from a situation, yet at the same time 'offer us a home in language and understanding' (p. 106).[33] Being at home is consoling. Suffering can be emotional or

mute and wordless.[34] Candib asserts that 'what cannot be said is still experienced' (p. 45).[35] At that point it is important for the physician to be available[35] and connect with the presence of the patient through sensitive and caring communication[36] and consolation.[22] Indeed, this indicates the importance of psychiatrists' monitoring of their own reactions to suicidal deaths because they impact on their ability and possibility of functioning professionally[8] and mediating consolation.

As shown in the results of this study on ethical reflectiveness, psychiatrists place their suffering within a pattern of meaning. This pattern surfaced from 'unburdening grief through shifting perspectives'. The psychiatrists' perspective shifted from self-doubt (alienated self) to self-confidence (true self), from self to suffering others, from tragedy to fragility,[18] from voicelessness to restored voice (telling and retelling the story of suffering). These shifts in perspective helped the psychiatrists to restore relatedness and, as such, they relieved, cast off a burden and brought inner peace.

Shifting perspective from self-doubt to self-confidence occurred as harsh self-judgments changed to courage. Shifting perspective from self to suffering others happened as the psychiatrists heard about the patient's death and, like the patient's family, encountered the 'awful, catastrophic' experience of overwhelming grief. Their own despair was awakened as they lamented deeply, realizing the inconsolable grief of the family. Shifting perspective is also apparent as the psychiatrists realized the problem could not be solved but resolved.[37] This kind of resolution can be viewed as a shift in perspective from tragedy to fragility.[18] When we view a situation that cannot be reversed as fragility instead of tragedy, we are directed to the future. 'Fragility enjoins us to do something, to help, but moreover to foster growth, to allow for accomplishment and to flourish' (p. 369).[18] Accepting fragility becomes a complex endeavor for those who think in terms of 'power over'. According to Fromm,[37] 'power over' is a negative kind of power that risks dehumanizing others. When dehumanized, two ethical perspectives clash – the psychiatrists' action ethics and the patient's relational ethics.

A shift in perspective is noted in creating meaning through the experience of teaching students and colleagues. Lessons can be learned that can benefit other health professionals and contribute to personal and professional growth.[11] The past remained unchanged; however, the psychiatrists' perspective of past experience shifted to passing on the lessons they had learned to medical students and colleagues. Grief did not prevent them from resuming relationships among the living. Rather, in a commemorative way, what 'was' was transformed into what 'could be'. Relating to students seemed to be a way for psychiatrists to enable students to become more human in the midst of suffering and, thus, to help future physicians to help future patients.[38] In this way the memory of the deceased patient served the general good of the living. The psychiatrists unburdened grief through disclosing – telling and retelling – their story through lecturing students and dialoguing with others. Through ethical reflection on self and others they came to a deeper understanding of death, loss, shock and grief of suicide. They also came to a deeper understanding of themselves. Lecturing about this experience stimulated self-reflection and self-awareness (mindfulness), which unburdened grief and mediated consolation for them. When grief was unburdened, their own voice emerged and they related to others, which opened up new perspectives.

Ricoeur[39] writes that telling and retelling our story creates our identity and opens up understanding in a way that differs from talking about statistics and theories. Telling and listening to stories can be emotionally engaging. Out of an affective, rather than a

cognitive, connection, healing insight[25] surfaces, creating meaning. As described in the model, consolation gives meaning.[23]

Verification strategies

In qualitative research, five verification strategies ensure reliability and validity of data.[40] These are: methodological coherence, sampling sufficiency, data collection and analysis, thinking theoretically, and theory development.

Methodological coherence ensures congruence between the research question and components of the method.[40] Limited research on this topic provided a basis for using a descriptive research design. The research question, 'How do psychiatrists' describe their responses to patients' suicidal deaths in the light of a model of consolation?', was addressed through a qualitative descriptive study using thematic analysis.

The small sample ($n = 5$) was a subset of textual data from a previous study[17] based on interviews with physicians experienced in treating suicidal patients. Although sampling sufficiency could be a limitation, these texts described relevant lived experiences. The authors had recognized that texts from the larger study[17] contained rich in-depth descriptions and the findings presented one of several possible interpretations.[41] They noted that all five psychiatrists who participated in the larger study narrated an experience of a patient's suicidal death. This study, then, addressed a more focused examination of textual data from these interviews.

Collecting and analyzing data concurrently involves mutual interaction between what is known and what is not known. The original study was published in 2000. Over time, the context of treating suicidal patients has changed in terms of the duration of hospitalization, which may have impacted on the psychiatrists' responses to patients' suicidal deaths. The textual data is from narratives based on interviewees' reconstructions of what happened,[41] often within a framework about which they later learned.[42] This does not have to be viewed as a problem as long as the textual data were based on psychiatrists' narrations from their own memory. In the act of remembering, the psychiatrists activated an embodied impression of a situation. Moreover, the detailed and select thematic analysis approaches were useful ways to manage textual data that involved two languages.

Thematic analysis of the data emerged from our sensitive reading and re-reading, and reflecting and re-reflecting on rich textual data. Both authors have experience in interpretive research methods. Our backgrounds influenced as well as facilitated the interpretive process as we contrasted and compared themes, subthemes and meaning units. Throughout the analysis process we read the text repeatedly and asked questions of the text, which were pursued, developed and tested against other interpretations.[41] This process gave an in-depth focus. However, as authors, we are nurses and not psychiatrists. This is a limitation in interpreting these texts. We acknowledge that our interpretation is one of many possible.

Thinking theoretically is apparent in new descriptions that were not in the original research. Descriptions emerged through condensation–abstraction and consensual validation between the authors. This study begins to describe responses infrequently verbalized or documented in published literature. As these responses are explicated,

professional issues and theoretical questions emerge that can culminate in further research and affect practice.

The results of this study also facilitate theory development. They describe psychiatrists' responses to patients' suicidal deaths in the light of a model of consolation.[23] The model of consolation[23] illuminates the results of this study from a mediator's viewpoint. The results also describe more in-depth aspects of the model, showing application of the model in practice. They show similarities to nurses' responses to suicidal patients, especially in terms of the self-reflection and self-awareness evoked by the grief of a patient's suicidal death.

The results offer health care professionals a model of self-reflection on a topic seldom addressed in literature. At the interface of philosophy and psychiatry, this study highlights a practical, theoretical and ethical approach to understanding psychiatrists' responses to a patient's suicidal death in the light of a model of consolation. The response of unburdening grief suggests catharsis. Originally proposed by Aristotle and applied to the emotional purgative effect of Greek tragedies,[43] the intent of 'catharsis' was to purge, purify and morally re-educate those who watched the tragedies. Thus, catharsis seems similar to a kind of 'homecoming'; that is, the soul coming home to itself,[21] as addressed in the model of consolation.[21] It is important to conduct further research related to ethical reflectiveness and consolation in professional practice.

Reflections

Embedded in the results of this study is a story about suffering. Suffering is imbued with ethical reflectiveness: looking backward in order to look forward. Ethical reflectiveness is a way of finding self in relation to others. Stories of suffering make an extraordinary ethical demand on us. They lead us to remain in relationship, even past the point of all usefulness.[44]

Grounded in a framework of consolation, this story reveals a possible understanding of past experience that can shift the present to the future; it can illuminate actual experience, yet it can also transform practice from what 'was' to what 'could be'. Passing on lessons learned can help colleagues, health team members and students to experience a situation vicariously. Through becoming engaged with the affective and cognitive aspects of the story, we can actually rehearse how we may handle such a situation in the future.

Telling and re-telling a story of suffering may elicit profound recollections and open up dialogue within and among disciplines. In the midst of dialogue, shared understandings can emerge out of deep ethical reflection. Ethical reflectiveness can help to prepare psychiatrists and other health professionals to respond to those who suffer suicide and suicidal death.

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Anne-Grethe Talseth, Tromsø University College, Tromsø, Norway.
Fredricka Gilje, University of Alaska Anchorage, Anchorage, AK, USA.

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