

Changes in narratives of people with depression that have attempted suicide and a nursing approach

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Abstract

This study was performed to examine changes after talking to alleviate suicidal ideation in people with depression or bipolar disorder that have attempted suicide, and to clarify the role of the researcher in this process. Data were collected through unstructured interviews with participants suffering from depression or bipolar disorder that were hospitalized because of attempted suicide. The interview began when they emerged from the crisis situation, and continued after discharge from hospital. From the contents of the interview, we analyzed the parts where emotions and thoughts before and after suicide were expressed and the remarks of the researcher.

The participants were five women, and the interview number ranged from three to eight times. We extracted six categories based on analysis of participants' narratives. There were four categories regarding strong obsession with death and great anxiety and loneliness: "Obsession with death," "Loneliness the same as before suicide attempt," "Anxiety about an uncertain future," and "Losing self-confidence by confronting reality." In addition, there were two categories regarding alleviation of suicidal ideation and newfound affirmation of life: "Feeling inclined to live" and "Developing motivation for life."

Throughout the interview process, the researcher strove to "wait patiently for participants to express their feelings and thoughts," never hurrying them or interrupting their remarks. In the second half of the interview, to address participants' everyday problems "the researcher's ideas were shared so that participants could change their behavior." When attendees made an effort and experienced behavioral changes, the researcher focused on the positive by "urging participants to be aware that they are changing and to notice what they are doing." The results of this study clearly showed that after a suicide attempt patients with depression were moving forward but still vacillating between life and death. Even those that were hopeless and desperate enough to choose their own death had taken definite steps toward the future. Nurses need to recognize this, come close to their wavering emotions, and provide support to help them think positively and find hope for the long term.

KEY WORDS

attempted suicide, depression, narrative, nursing

Introduction

The number of suicides in Japan was 24,025 in 2015¹⁾. The suicide rate per 100,000 people in Japan is the fourth highest in the world and is considerably higher than that in the developed countries of Europe and the United States²⁾. Today suicide remains a serious public and mental health problem. Suicide involves various factors,

but among them, a past history of attempted suicide and mental disorders such as depression are considered the most important risk factors³⁻⁶⁾.

Few studies have investigated suicide attempts or the actual situation of suicide in Japan and related supportive measures. This might be because of privacy concerns and the tendency in Japan to treat suicide as taboo⁷⁾.

Another factor is the limited time taken to observe patients who have attempted suicide and who are likely to be discharged soon after pharmacotherapy⁸⁾. Although studies on suicide have been conducted in a wide range of fields such as nursing, psychiatry, and social welfare, many are survey studies of the actual condition and age of the suicide attempt patient, means of suicide, background factors, and clinical features⁹⁻¹¹⁾. Few surveys have critically explored individual experiences, and these are limited to randomly selected psychiatric patients and bereaved families^{12,13)}. Even overseas, despite studies showing the process leading to suicide attempts, there is a shortage of articles on the recovery process after attempted suicide¹⁴⁾.

The researchers previously investigated the emotions and conditions before and after suicide attempts in persons with depression by conducting interviews¹⁵⁾. It was found that participants developed an [obsession with death] and [affirmation of suicide] even after attempted suicide, and it became clear that suicidal ideation could easily be increased. Yet, participants who continued with the interviews talked about a [budding desire to live again], suggesting that they were taking the first steps of recovery while wavering between life and death. However, there were problems such as the interview frequency ranging from 1 to 8 times and the lack of similar data from previous studies for comparison. Therefore, based on these results, we decided to conduct interviews in the same way. This study sought to clarify the changes after talking that alleviate suicidal ideation in persons with depression or bipolar disorder who have attempted suicide. We also aimed to clarify the role of nurses in this process. It is hoped that this study will deepen our understanding of suicide and suicide attempts and offer suggestions for effective nursing care to prevent repeated suicide attempts.

Purpose

To clarify changes after talking to alleviate suicidal ideation in persons with depression or bipolar disorder who have attempted suicide. To clarify the role of researchers in this process.

Methods

1. Study design

Qualitative descriptive research.

2. Study participants

We asked the heads of nursing departments at two facilities to identify all persons who attempted suicide and were expected to be hospitalized for depression or bipolar disorder. All study participants satisfied the following conditions:

- 1) Hospitalized due to attempted suicide.
- 2) Diagnosed by a doctor as having depression or bipolar disorder.
- 3) Judged by a doctor to be out of crisis and able to remember their experiences and talk about them.
- 4) Consented to participate in the research.

3. Data collection methods

Data was collected through unstructured interviews with the participants by one of the researchers (K.N.). The researcher informed the participants that she was a nursing college teacher. The researcher told them to interview from the perspective of a nurse. The researcher requested in advance that participants talk freely about their symptoms and daily life and explained that the participants were not required to talk about issues that they did not want to express about. The interviewer made efforts to contact participants during their hospitalization and, whenever possible, after discharge. Interviews were conducted with a participant every 2 or 3 weeks.

The interview was conducted in a private room where privacy within the participating research facilities was maintained. The contents of the interviews were recorded on an IC recorder with the consent of the participants.

In accordance with the principles of the narrative approach, the interview was conducted as follows:

- 1) The researcher positioned participants as "experts in their lives" and listened to their stories with an "attitude of ignorance"¹⁶⁾.
- 2) The researcher paid attention to encourage participants to talk freely about their thoughts.
- 3) The researcher helped participants develop their thoughts while they talked by asking, "What did you think at that time?" "Please tell me a bit more about that."
- 4) The researcher utilized repetition techniques (e.g., speech promotion) to help participants analyze themselves objectively and guide them toward life-affirming thought patterns. In addition, the researcher strove to draw out even more detailed thoughts after any events that triggered recovery or after positive remarks about themselves and others.

4. Data analysis

We made a verbatim transcript of all contents of the interview data and repeatedly perused the contents. Regarding the participants' stories, we extracted parts related to emotions and thoughts after the suicide attempt and then coded them as chunks such that the meaning of the context was maintained. We categorized the coded chunks in terms of their similarity and dissimilarity. Furthermore, we showed the entire picture of the change in stories during this process of alleviating participants' suicide ideation. In this process, the researchers extracted, coded, and categorized parts indicating changes in the participant and parts that the researchers intentionally told the participants.

To ensure the validity of our results, we received advice from psychiatric nursing experts during the analysis process.

5. Ethical considerations

Much effort and attention was given to the ethical considerations in this study, which dealt with patients with depression or bipolar disorder who had attempted suicide. This study was approved by the Medical Ethics

Committee of Kanazawa University (Approval No. 453) . Prior to the study, patients were informed that study participation would be voluntary and that refusal to participate or withdrawal from study would not disadvantage them in any way. Before signing the consent form, patients also received an explanation orally and in writing that data would be stored in a secure place, individual patients would not be identified, data would be used in only the present study, data would be destroyed as soon as the study was over, and the results would be published while maintaining their anonymity.

During the interview, we paid attention to changes in the participants, such as any reduction in suicidal ideation and signs of deterioration. We collaborated with medical staff and exchanged information when necessary regarding the presence or absence of any changes in the participants' condition.

Results

1. Characteristics of research participants

Table 1 shows the characteristics of the five participants (A to E) .

Table 1. Patient Characteristics

ID	Age	Sex	Diagnosis	Number of interviews	Means of suicide
A	Early 40s	Female	Bipolar disorder	8	Drug overdose
B	Late 50's	Female	Bipolar disorder	5	Drug overdose + Cuts in both forearms and neck
C	Early 70s	Female	Major depressive disorder	3	Drug overdose
D	Late 40's	Female	Major depressive disorder	4	Drug overdose
E	Late 60's	Female	Bipolar disorder	6	Wrist cuts

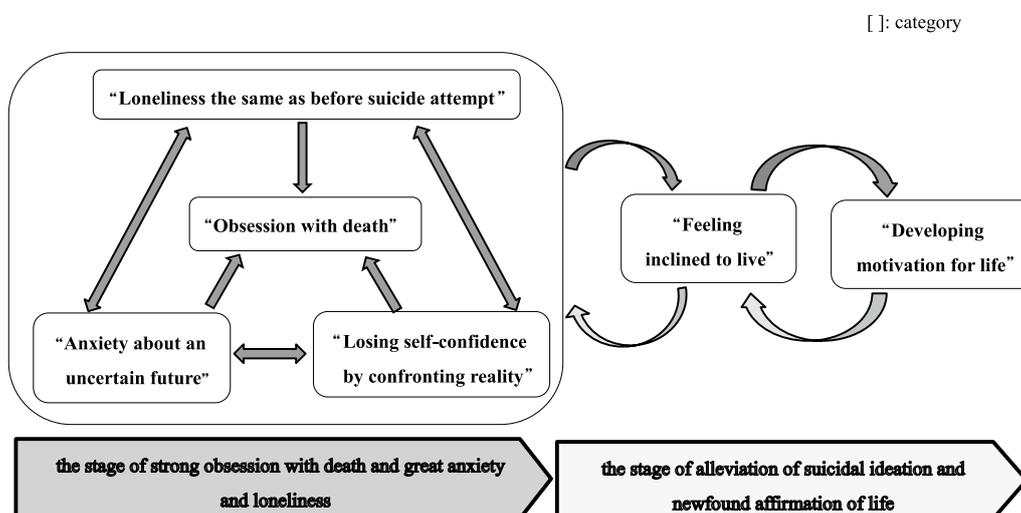


Figure1 Changes in participants' narratives

Table 2. Category list of changes in participants' narratives

“category”	<subcategory>	{code example}
“Obsession with death”	<I would be better off not being saved>	{I thought that it would have been better not to have been helped} {It might be considered cowardly, but I want to die and be free from it all}
	<I did not regret attempting suicide>	{I would like to say that I had my own idea to attempted suicide.}
“Loneliness the same as before the suicide attempt”	<Unsympathetic family reactions to the attempted suicide>	{They did not think about the cause of my suicide attempts} {Only my action (attempted suicide) was to blame}
	<Even after my suicide attempt, they do not understand my feelings>	{I wonder why (my husband) did not accept my feelings} {In order to avoid the same situation (before hospitalization), I often thought that I needed to convince him to understand}
	<Feeling that I do not belong>	{I want to be here but I think that there was no place for me} {I am sad that my whereabouts are gone}
“Anxiety about an uncertain future”	<Not confident that I will not commit suicide again>	{I feel like I am getting weak and wanting to escape from painful things} {I would hate it if the future was going to be the same as before. I think that I don't matter at all}
	<No hope for life in the future>	{I wonder what I was born for} {My life is going to get worse}
“Losing self-confidence by confronting reality”	<Having an inferiority complex because reality is far from ideal>	{I am lonely and envy other people, so it is difficult to attend gatherings with friends.} {It is most miserable that money does not become free}
	<My body and mind are unsatisfactory>	{Returning home from the hospital was harder than I had thought} {I thought I could do it a bit more, but I felt sick}
“Feeling inclined to live”	<A sense that my condition has improved a little>	{I did not feel insecure} {I can talk with a laugh now}
	<Talking makes me feel better>	{I feel better after I talk to you} {I feel better if I think someone understood me}
	<Feeling that I should try somehow>	{I hope I can do something because I was helped} {I'm not confident, but I believe I will not try (to attempt suicide again)}
	<Dealing with not making the situation worse>	{I can't change even if I try to change my son, so I am careful not to collide} {In order not to remind as much as possible, when I go to bed I close my eyes to not think about anything.}
“Developing motivation for life”	<Trying to have fun>	{Even if there are problems in the future, I'll try hard and overcome} {I would like to do a few favorite things such as traveling}
	<Composure after getting rid of feelings of being stuck>	{I thought that my husband was bad, but I also did wrong} {I thought that is silly to think too much at the negative side by myself}
	<Feeling I can change my ways of thinking and behavior>	{Even if it does not work, I think I can make a way out} {Regardless of how much I believe it will not end unless I change my way of thinking}

2. Changes in participants' narratives

We extracted six categories based on the analysis of narratives of depression or bipolar disorder that led to suicide attempts. From the contents of these categories, we identified two stages in the narrative process: (1) the stage of strong obsession with death and great anxiety and loneliness; and (2) the stage of alleviation of suicidal ideation and newfound affirmation of life (Fig.1) . In the interview, the participants provided information about the emotions and circumstances of at the time of the interview, which was expressed as a change in the narrative of the participants during the interview period.

Table 2 shows categories, subcategories, and code examples.

Below, categories are shown in “”, subcategories in < >, codes in {}, and raw data of the participants' thinking in “ ”. We also described the six categories. Supplemental information is contained in parentheses to provide additional clarification. Categories were named based on the data obtained in this study with reference to previous research.

1) The stage of strong obsession with death and great anxiety and loneliness

“Obsession with death”

This category consists of two subcategories: <They would be better off not being saved> and <They did not regret attempting suicide>. Although a non-fatal suicide attempt meant their life lives were saved, they wondered whether that was a good thing or not, feeling that they would be better off if they had not been saved. After all, they still faced the same painful situation that was present before the suicide attempt and they had a strong desire to die.

Participant A continued to have trouble with her family after discharge. She said {I thought that it would have been better not to have been helped}; {If I had known I'd end up in this situation, it'd be better if they hadn't helped me}.

“Just like before, my son suddenly came in and beat me up. I wish I hadn't been saved because this is what ends up happening. I always felt this way, but my husband... although he was on my side, he did not stop it.”

Participant C said {even now I wish I had died at that time} and {it might be considered cowardly, but I want to die and be free from it all}.

“I think that I did not really need to be helped. Even

now... (omitted) ...I was told that I should go to hell if I did such a thing, but I thought that it was hell when I was living.”

“Loneliness the same as before the suicide attempt”

This category consists of three subcategories: <Unsympathetic family reactions to the attempted suicide>, <Even after my suicide attempt, they do not understand my feelings>, and <Feeling that I do not belong>. After discharge, the unsympathetic attitude of participants' family made them feel lonely. Despite their suicide attempt, they felt they were not understood by their families.

Participant A said that there was no place for her to relax at home, and because she survived, she felt that she would always be indebted to her family for the rest of her life. She was in a difficult situation because {they did not think about the cause of my suicide attempts} and {only my action (attempted suicide) was to blame}.

“Three people (except me) are good family members. How can I fit in with them? I was worried or irritated for a long time, and then when tough words directed at me, I would feel downhearted and rejected because I have to live with these negative feelings about my life and what I did...”

Participant B said {I wonder why (my husband) did not accept my feelings}. {In order to avoid the same situation (before hospitalization) , I often thought that I needed to convince him to understand}. However, she could not obtain his understanding and cooperation. She said {I could not communicate with my husband about my daily life or my body}.

“My husband says that what I did, I did on my own. That is right, but he can't understand that he had driven me to it.”

Participant E said that she was not allowed to be discharged by her family because she had attempted suicide, and that {I was not trusted by my family because I had attempted suicide}.

“My brothers are very smart, but I'm not. Besides, I attempted suicide. That is why I'm not trusted.”

“Anxiety about an uncertain future”

This category consisted of two subcategories: <Not confident that I will not commit suicide again> and <No hope for life in the future>. Participants were anxious as to whether they would want to commit suicide about something in the future even though they had

relinquished their “obsession with death”. Furthermore, they put themselves into the same environment as before the suicide attempt and had no hope for the future.

Participant C calmly looked back on her suicide attempts. However, she said {I have a feeling that I will not try (to attempt suicide) again, but I'm not confident that I won't do it} and {I feel like I am getting weak and wanting to escape from painful things}. She also told the researcher that {I would hate it if the future was going to be the same as before. I think that I don't matter at all}.

“My son and my daughter blamed me for what I did, and as the days went by, I also began to believe that what I did (attempted suicide) was wrong. I began to think that it had caused trouble. But if anything happens again, I'm not confident that I won't ever do it. Because I feel like I want to be at ease.”

Participant D was in a situation where she had no joy or hope after discharge, and said {my life is going to get worse}.

“It's almost as if my life has already ended; I've lived more than half my life already. I really think that I will not have much fun in the future.”

“Losing self-confidence by confronting reality”

This category consists of two subcategories: <Having an inferiority complex because reality is far from ideal> and <My body and mind are unsatisfactory>. Participants were discharged with expectations for their life. This category expresses the frustration that they cannot do what they had hoped to do and the misery that comes from feeling that their life is far from ideal.

Participant B was not able to rest due to concern for her husband despite her poor physical condition after discharge. She said that {returning home from the hospital was harder than I had thought} and {I thought I could do it a bit more, but I felt sick}.

“I understand that I can't go on as I had expected. I was discharged from the hospital more than three weeks ago, so I thought I could do more, but I was feeling sick and it was not easy to walk...”

Participant C compared herself with other people of the same age. She said {I am lonely and envy other people, so it is difficult to attend gatherings with friends}.

“When I see that people appear to be happy with their families, I feel jealous. Honestly, I don't have a good relationship with my family, which makes me feel lonely and miserable.”

2) The stage of alleviation of suicidal ideation and newfound affirmation of life

“Feeling inclined to live”

This category consists of four subcategories: <A sense that my condition has improved a little>, <Talking makes me feel better>, <Feeling that I should try somehow>, and <Dealing with not making the situation worse>. After the second interview, participants noticed mental and physical changes with an objective view of themselves. Despite having thoughts that still fluctuated between life and death, they were trying to move away from suicidal thoughts.

At the third interview, Participant C told the researcher {I feel better after I talk to you}, {I hope I can do something because I was helped}, and {I'm not confident, but I believe I will not try (to attempt suicide again) }. She also talked about changes in her own feelings.

“When I come here and talk, I feel better. When I come here, I come without really seeing anything, but after the interview, I can return home and enjoy the scenery... (omitted) ...After all, I guess I want someone to tell me that I am not wrong...”

“I'm not confident, but I'm thinking about trying not to do that kind of thing (attempting suicide) . I am not 100% confident. But I am trying not to think about doing that kind of thing.”

Participant D looked back to when she stayed overnight during her hospitalization and said {I was looking ahead} and {I did not feel insecure}.

“There is nothing to think about so much at night. Well ... (omitted) ...I think I am not as anxious.”

“Developing motivation for life”

This category consists of three subcategories: <Trying to have fun>, <Composure after getting rid of feelings of being stuck>, and <Feeling I can change their ways of thinking and behavior>. This represents the state of participants who are clearly motivated to live rather than just “Feeling inclined to live”.

Participant B acknowledged that, up to that point, she had obsessed over her home and husband, and she talked about a change in her feelings. {I thought that my husband was bad, but I also did wrong}. {I thought that is silly to think too much at the negative side by myself} and {I no longer wanted to die}.

“Before, I couldn't think about it (having another choice) . I thought he didn't listen to me at all. So, I

thought that there was only one choice and I was obsessed with only that. I thought that he didn't understand me so I wanted to die. Thinking now, although I had another choice, I didn't do anything. I came to think so. I think it's because I had enough rest."

Participant C reconsidered her relationship with her son, saying {regardless of how much I believe it will not end unless I change my way of thinking}, {I would like to do a few favorite things such as traveling}. Now she could turn her attention to her life.

"No matter how much I say, it will not end, unless I change my mind. Uhhh, but I can't change my mind. After all, it is very difficult. I do not have deep discussions with my son. It was ordinary words, not kind words, from my son, but I was happy with that."

Participant E had repeated manic and depressive states for many years. She talked about her motivation for treatment.

"Would I get better if I went to the other hospital? I would like to get over it. I will go anywhere to get better."

3. Involvement of the researcher

We extracted nine categories based on an analysis of the researchers' involvement in the interview process. Throughout the interview process, the researcher strove to "wait patiently for participants to express their feelings and thoughts", never hurrying them or interrupting their remarks. Instead, the researcher advanced the interview according to the pace of the participant. During the first interview, which was the first meeting, the researcher sought to establish a relationship so that they could talk with confidence. The researcher also strove to "listen carefully to details in order to understand the participants' past progress and current feelings". Furthermore, the researcher showed interest in their experiences, made encouraging remarks, and asked questions to clarify any ambiguities. Given that the participants had all experienced various hardships related to their suicide attempt, the researcher actively listened to their stories to "show sympathy for their long-term hardship and effort". After the second and third interviews, although showing understanding, the researcher also tried to "express participants' feelings and their family's position" to provide a multifaceted viewpoint. "The researcher's ideas conveyed a different, objective perspective". On the other hand, after "the researcher's experiences and troubles were shared", participants were told that everyone suffers in some way.

In the second half of the interview, to address participants' everyday problems "the researcher's ideas were shared so that participants could change their behavior". When attendees made an effort and experienced behavioral changes, the researcher focused on the positive by "urging participants to be aware that they are changing and to notice what they are doing". The researcher also thanked them for the encounter and interaction using words tailored to the tone and expression of each participant. Finally, the researcher endeavored to create a cheerful atmosphere by "having fun talking, with smiles and light laughs" to facilitate meaningful interactions.

Discussion

1. Characteristics of changes in the narratives of a person with depression who attempted suicide

Although participants' lives were saved after the suicide attempt, they felt <I would be better off not being saved> and <I did not regret attempting suicide>. That is, they could not relinquish their "obsession with death". They felt even lonelier than they did before their suicide attempt due to their family's unsympathetic attitude and inadequate understanding. Although hospitalization shielded them from reality, after discharge they had to face a harsh reality and were struck by helplessness. That led to "anxiety about an uncertain future" and eventually feelings that they should have died at that time. But as time passed and after repeated interviews, we observed a change in their narratives. They began to notice that they were gradually getting better, and they felt comfortable talking at the interviews. Although their situations remained painful, they realized that they still had to live somehow, so they thought about how to deal with it and not make it worse. They sometimes expressed positive feelings, such as wanting to deal with problems likely to occur in the future and changing their way of thinking and behavior instead of blaming others. However, participants' narratives fluctuated between embracing life and obsession with death, rather than in one direction only. Despite individual differences in how to proceed, based on narratives about wanting to escape from a painful reality (they wanted to die) or anxiety over reattempting suicide unless a spouse was understanding, the possibility exists that the participants in this study might eventually die by suicide. These findings have strengthened the results of the researchers' previous research¹⁵⁾. In the

overall image gleaned from the previous study¹⁵⁾, the change in ideation was in one direction, but this time it was bidirectional showing that the ideation was returning. Also, the category names were revised slightly, though it was still reconfirmed that “obsession with death” is central, while factors such as loneliness, anxiety, and loss of confidence are contributory. Furthermore, it was clear that if the participants got out of the vicious circle it will lead to “feeling inclined to live” and will lead to “developing motivation for life”. Furthermore, even those who were desperate and compelled not to think about options other than death had slight hope and an ability to recover after their lives were saved.

Takahashi¹⁷⁾ argued that no one has “100%,” whole-hearted suicidal desire; instead they shift between the painful cry of wanting to die and the desperate wish of wanting to live. Even in interviews with patients after a suicide attempt, Vatne¹⁸⁾ found that they wanted “success” (suicide) on the one hand and failure on the other. When they were feeling alive, they wanted to rise up again. We observed the same thing. Participants felt that it would have been better not to be saved, but somehow they still tried to seek enjoyment in their own lives. This indicates the possibility of recovery from a suicide attempt as well as the importance of support on the path to recovery.

2. The researchers’ involvement

The researchers conducted full interviews in accordance with the principles of the narrative approach. Considering the very delicate and personal nature of suicide and depression, each narrative was heard with an “attitude of ignorance”¹⁶⁾ and the interviewer strove to be unthreatening. By waiting patiently to give participants space to easily express their feelings and thoughts, showing acceptance, and making encouraging remarks, we found that participants articulated various feelings never before shared, showing that < talking makes me feel better >.

From the second to third interview, the researcher attempted to “express the participants’ feelings and their family’s position” and share “the researcher’s ideas to convey a different, objective perspective”. It has been pointed out that depressed patients have markedly decreased cognitive function¹⁹⁾, which affects negative automatic thinking²⁰⁾. Thus, distorted cognition increases the risk of suicidal thoughts and behavior²¹⁾. Participants in this study had various problems, and we can infer that

they had depressed mood for a long time. After attempted suicide, if family problems exist, distortion of cognition can be heard in remarks such as “I wish I had never been saved” or “I have no choice but to die if he does not understand.” Chikada²²⁾ stated that in the process of depression recovery, an objective perspective of the self is indispensable. As for participants in this study who looked back at the self in accordance with the recovery phase, those who realized that “there are various ways of thinking” and “I have options” seemed to be able to find a renewed sense of the value of life. While accepting participants’ stories, the researcher extended their range of thought by conveying to them what their families might be feeling.

3. Suggestions to nurses

The results of this study clearly show that after a suicide attempt patients with depression were moving forward yet still vacillating between life and death. Even those who were hopeless and desperate enough to choose their own death had taken definite steps toward the future. Therefore, nurses need to recognize this and “get close” to the wavering emotions of the person with depression who has just attempted suicide and provide support to help them think positively and find hope for the long term. In this study, as a nurse, the researchers examined the role of nursing in support of persons with depression or bipolar disorder who have attempted suicide. However, we believe that, in addition to nurses, other medical professionals, such as doctors and counselors, can play a similar supportive role.

Fukuda et al.²³⁾ reported that over 50% of nurses felt conflicted about life-saving efforts for those who wished to die. In addition, there is a report that most nurses working at emergency medical centers form ambivalent attitudes toward suicide attempts²⁴⁾. These facts suggest that patients who have attempted suicide also experience a sense of alienation because they are not well understood by medical staff. Although patients with depression who have attempted suicide maintain connections with their family, friends, and community, reports indicate that they do not have anyone with whom to talk openly and, as a result, they feel a sense of alienation and deep loneliness¹⁵⁾. Cho⁷⁾ argued that a society that can talk about wanting to die, that can accept it, and can deal with it would be the foundation for reducing suicide. Medical personnel need to deepen their understanding of suicide

and attempted suicide, and adopt an enlightened stance so that society as a whole can deal with the issue. With the rising level of nursing education, there is a report that nurses' attitudes towards suicide attempts have become more positive²⁵⁾. In addition, reports indicate that nurses with psychiatric nursing experience have a more positive attitude toward patients with suicidal ideation than nurses without psychiatric experience and they are proud to have the appropriate skills for these patients²⁶⁾. Chi¹⁴⁾ also found that it is important for nurses to be involved in the treatment of suicide attempts and for them to use sophisticated communication techniques. We believe that it is crucial for nurses to raise their knowledge of suicide and suicide attempts, such as background factors leading to suicide and the psychology of those who attempt suicide, and they should acquire sophisticated communication skills. Therefore, it is necessary to provide opportunities for nurses to attain the appropriate knowledge and skills.

Limitations and challenges for the future

This study has limitations. First, the number of participants in this study was small and the number of interviews per participant ranged between three and eight. Second, various factors such as the passage of time, changes in post-discharge environment, and pharmacotherapy might have influenced the participants' recovery process. Therefore, we cannot report that changes were associated with the interview process alone. The position of the interviewer was not that of a medical person in charge of the participants. Therefore, the participants' perspective may have been influenced by the existence of supporters other than the medical person in charge. Future research is needed to increase the number of participants who continue the interview process and to

establish a nursing care system that will facilitate suicide prevention by further investigation related to [developing motivation for life] after a suicide attempt.

Conclusion

1. The following six categories were extracted as a result of analyzing the narratives of depressed individuals who attempted suicide: "Obsession with death", "Loneliness the same as before the suicide attempt", "Anxiety about an uncertain future", "Losing self-confidence by confronting reality", "Feeling inclined to live", and "Developing motivation for life".

2. The following nine categories were extracted as a result of analyzing the researcher's involvement in the interview process: "Wait patiently for participants to express their feelings and thoughts", "Listen carefully to details in order to understand participants' past progress and current feelings", "Show sympathy for their long-term hardship and effort", "Express participants' feelings and their family's position", "The researcher's ideas conveyed a different, objective perspective", "The researcher's experiences and troubles were shared", "The researcher's ideas were shared so that participants could change their behavior", "Urging participants to be aware that they are changing and to notice what they are doing", and "Having fun talking, with smiles and light laughs".

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自殺企図後のうつ病者の語りの変化と看護アプローチ

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要 旨

本研究は、自殺企図を行ったうつ病あるいは双極性障害をもつ者の希死念慮を緩和していく過程における語りの変化と研究者の関わりを明らかにすることを目的とした。自殺未遂が原因で入院となったうつ病あるいは双極性障害をもつ者を対象に、ナラティブ・アプローチの原則に基づいた非構造化面接を行った。面接内容より、自殺に至るまでや自殺企図後の感情や思考が表現されている部分とその前後の研究者の発言を分析対象とした。

参加者は女性5名、面接回数は3～8回であった。参加者の語りを分析した結果、1) 死への執着があり不安や孤独感が強い時期には【死への執着】【自殺前と変わらない孤独感】【先がみえない不安】【現実に直面することによる自信喪失】の4つのカテゴリー、2) 自殺念慮が緩和し生きることを肯定し始めた時期には【生きることに気持ちが向く】【生への意欲の芽生え】の2つのカテゴリーが抽出された。研究者は、参加者が考えや気持ちを表現できるようにゆっくり待つ姿勢を示した。面接の2回目以降は、参加者が多面的な見方ができるよう、また変化を自覚できるよう問いかけた。参加者は生と死の間を揺れ動きながらも前に進んでいること、一度は自ら死を選ぶほどの絶望の淵に立たされた人であっても、わずかながらの希望をもち将来に向かって歩き始めていることが明らかになった。看護師は、自殺企図に至ったうつ病者の揺れ動く気持ちに寄り添い、肯定的に思考を変化させて希望を見出せるよう長期的にサポートしていくことが重要だと考えられる。