

Substance abuse and suicidal behaviour are major challenges to global public health, including the Nordic countries. These phenomena are mainly studied by quantitative designs. This qualitative thesis aims at gaining a deeper understanding of substance abuse and suicidal behaviour, as experienced by young men in different types of treatment. It also focus on the system of services related to the prevention and follow-up of life-threatening overdoses as experienced by individuals and professionals in Oslo.

The main findings in this thesis shows that substance abuse and suicidal behaviour are goal-oriented, communicative and meaning-making activities about the individuals' balance between death as escape and the dream of life. In recovery, enhanced sensitivity to metaphorical expressions about a person's sense of self should be an important part of the suicide risk assessment in the treatment team. Shifting use of metaphors as a marker of change may reflect suicide ideation. To migrating young men substance abuse and suicidal behaviour are explicit expressions of not being well when living in a maze that is perceived as closed. Life-threatening overdoses in Oslo are experienced in a state of existential and material stress, and a wish for follow-up is not always expressed by the young man. Due to structural problems, such as lack of goals and support, professionals do not prevent such events in a planned way, nor do they cooperate between different levels. Several implications for public health work are suggested in order to promote health in young men living with substance abuse and suicidal behaviour.

## Between death as escape and the dream of life

Psychosocial dimensions of health in young men living with substance abuse and suicidal behaviour



Stian Biong

Doctoral thesis at the Nordic School of Public Health  
Göteborg, Sweden  
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Doctoral thesis in public health

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From the bridge in the Vigeland park, Oslo, Norway.  
Gustav Vigeland: Man in a wheel.

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## Between death as escape and the dream of life.

Psychosocial dimensions of health in young men living with substance abuse and suicidal behaviour.

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### ABSTRACT

Substance abuse and suicidal behaviour are major challenges to public health. These phenomena are mainly studied by quantitative designs. This qualitative thesis aims at gaining a deeper understanding of substance abuse and suicidal behaviour, as experienced by young men in different types of treatment. By describing, exploring and interpreting lived experiences, in this thesis I try to give a more nuanced language of both substance abuse and suicidal behaviour, also in young migrating men. I also focus on the system of services related to the prevention and follow-up of life-threatening overdoses by describing and exploring how this phenomenon is experienced by individuals and professionals in Oslo. By researching the lived experiences of substance abuse and suicidal behaviour, combined with researching the phenomenon of life-threatening overdoses, a deeper insight is gained and this can be an important source to both prevention and health promotion for the group in question. The first three papers are based on descriptive, explorative and interpretative studies. How meaning is constructed is the core research question. In the fourth study I describe and explore life-threatening overdoses as a contemporary phenomenon in its context. The research questions are on a descriptive level. In the first three papers, the research object is the personal narratives from in-depth interviews, which are analysed using a phenomenological hermeneutic method. The case study is composed of data collected from different sources, and analysed by triangulation. The main finding in the first paper is that substance abuse and suicidal behaviour can be understood as goal-oriented, communicative and meaning-making activities about the individuals' balance between death as an escape from pain and the hope of a life. In the second study, metaphorical expressions about a shifting sense of self is understood as balancing being an agent or a victim. In migrating young men these phenomena are interpreted as goal-oriented, communicative and meaning-making activities about existing in a maze that is perceived as closed. The findings of the case study show that different forms of life-threatening overdoses in Oslo are experienced in a state of existential and material stress. A wish of follow-up might not be expressed by the individual. Due to structural problems, such as lack of goals, professionals do not prevent such events in a planned way, nor do they cooperate between different levels. Professionals decide what is good quality in prevention and follow-up of life-threatening overdoses.

**Key words:** Public health science, health, substance abuse, suicidal behaviour, men, migration, qualitative methods, phenomenological hermeneutics, case study, health care services.

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## Mellom døden som befrielse og drømmen om liv.

Helsens psykososiale dimensjoner hos yngre menn med rusavhengighet og selvmordsadferd.

Stian Biong.

### SAMMENDRAG

Rusavhengighet og selvmordsadferd representerer store folkehelseproblemer. Disse fenomenene er hovedsakelig studert med kvantitative design. Målet med denne kvalitative avhandlingen er å få dypere kunnskap om rusavhengighet og selvmordsadferd slik fenomenene er opplevd av yngre menn i ulike typer behandling. Gjennom å beskrive, undersøke og tolke levde opplevelser forsøker avhandlingen å få fram en mer nyansert forståelse av, og språk om, både rusavhengighet og selvmordsadferd, også hos yngre menn med migrasjonserfaring. Avhandlingen fokuserer systemnivået gjennom å beskrive og undersøke hvordan livstruende overdoser oppleves og erfares som levde erfaringer og som yrkesutfordring i Oslo. Et omverdensperspektiv, kombinert med en dypere forståelse og et rikere språk kan være viktige bidrag til forebyggende og helsefremmende tiltak. Det første, andre og tredje arbeidet i avhandlingen er beskrivende, undersøkende og tolkende studier som fokuserer yngre menns levde erfaringer med rusavhengighet og selvmordsadferd. Hvordan mening konstrueres er det sentrale forskningsspørsmålet. Det fjerde arbeidet, case studien, undersøker livstruende overdoser i en nå-tidig kontekst, og forskningsspørsmålene er beskrivende. I de første tre arbeidene er forskningsobjektet personlige narrativer samlet gjennom åpne dybdeintervjuer, og som er tolket ved bruk av en fenomenologisk hermeneutisk analyse. I case studien er data fra ulike kilder analysert ved hjelp av triangulering. Hovedfunnet i den første studien er at rusavhengighet og selvmordsadferd kan forstås som måltettede, kommunikative og meningsfulle handlinger om personens balanse mellom døden som befrielse fra smerte og håpet om et bedre liv. I den andre studien kommer metaforiske beskrivelser av en skiftende opplevelse av seg selv i prosessene knyttet til både rusavhengighet og selvmordsadferd tydelig fram. Dette kan forstås som å balansere en selvopplevelse mellom aktør og offer. I den tredje studien kan rusavhengighet og selvmordsadferd hos migrerte menn forstås som målrettede, kommunikative og meningsfulle handlinger om personens opplevelse av å eksistere i en stengt labyrinth. Funnene i case studien tyder på at livstruende overdoser i Oslo erfares i eksistensielt stressfulle omstendigheter. Et personlig ønske om oppfølging gis ikke alltid eksplisitt. Strukturelle problemer medfører at profesjonelle arbeider med livstruende overdoser uten overordnede mål og uten samordnet planlegging. Profesjonelle bestemmer derfor selv hva som er god kvalitet når det gjelder forebygging og oppfølging av livstruende overdoser.

**Nøkkelord:** Folkehelsevitenskap, helse, rusavhengighet, selvmordsadferd, menn, migrasjon, kvalitativ metode, fenomenologisk hermeneutisk analyse, case study, helsetjeneste.

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## LIST OF PAPERS

This thesis is based on the following original papers, which are referred to in the text by their Roman numerals:

- I. Biong, S., & Ravndal, E. (2007). Young men's experiences of living with substance abuse and suicidal behaviour: Between death as an escape from pain and the hope for a life. *International Journal of Qualitative Studies on Health and Well-being*, 2(4), 246-259.
- II. Biong, S., Karlsson, B., & Svensson, T. (2008). Metaphors of a Shifting Sense of Self in Men Recovering from Substance Abuse and Suicidal Behaviour. *Journal of Psychosocial Nursing and Mental Health Services*, 46(4), 35-41.
- III. Biong, S., & Ravndal, E. (2008). Living in a maze: Health, well-being and coping in young non-western men in Scandinavia experiencing substance abuse and suicidal behaviour. *International Journal of Qualitative Studies on Health and Well-being*, 3(4), In press.
- IV. Biong, S., & Svensson, T. (2008). Preventing life-threatening overdoses in young men: the case of Oslo. Submitted.

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# I. AIMS OF THE THESIS

This thesis is based mainly on my own experiences as a professional nurse working with people suffering from long-term substance abuse and mental ill health in different clinical settings in Oslo, Norway, in the period 1991 to 2005. During this period the number of deaths from overdoses in men living with substance abuse increased dramatically. One of my many thoughts at that time was what kind of subjective and tacit knowledge was hiding behind these figures. It became a desire for me to try to describe, explore, and illuminate other dimensions of a possible suicidal process in young men experiencing substance abuse than that of cause, effect and pathology. Understanding the lived experience of substance abuse and suicidal behaviour became my topic.

The World Health Organisation, Europe (WHO, 1998) has established a set of criteria for achieving equal health throughout the population. Target six formulates the need for reducing suicide through improving the (mental) health of disadvantaged groups. As suicidal behaviour may be seen as the result of the complex interaction of genetic, biological, interpersonal and sociological variables (Hawton & van Heeringen, 2000), Scandinavian suicide prevention programmes have stressed the need to complement medical-epidemiological studies of suicide with humanistic perspectives (Sundhedsstyrelsen, 1998). In addition, researchers in the field of suicidology have highlighted the need for developing the language of suicidality, with the task of bringing the work of prevention even further (Qvortrup, 1999; Beskow, 2005).

In this thesis, the concept of *public health science* is understood as the study of the factors in our surroundings that influence the health and welfare of people. Such factors include the environment, social factors, and factors that we can influence through our lifestyle. The organization of health services, and the way these services are provided, can also have an influence on public health (Hummelvoll, 1995). The concept of *public health work* is understood as the practical implementation of the knowledge obtained from public health science.

It has been argued that public health research needs qualitative methods to find meaning behind the numbers (Karlberg, Hallberg & Sarvimäki, 2002). Within a multidisciplinary new public health framework, where different views of reality, knowledge and methods shall complement each other, two different perspectives meet in this thesis. The first perspective is the individual perspective, which in its essence is close to the caring sciences. This perspective emphasizes a deeper understanding of lived experiences (however, the caring

sciences can also be said to be influenced by natural science). The task is to get closer to, and to develop the language of, suicidality and the subjective life-world perspective. The second perspective is a population-based perspective, closer to socio-medical science and its tradition of focusing on risk factors, diagnosis and social conditions of a section of the population. To make lived experiences relevant from a macro-perspective, in this thesis, they are mainly, but not only, contextualized by sociological theories.

In the study of the research literature of suicidology, it is obvious that little attention has been paid to what meaning-making young men with substance abuse actually experience when facing major existential challenges. In order to describe, explore, and understand the meaning-making and contextual dimensions, four studies (Papers I-IV) were planned, each of them representing parts of this thesis.

The aims of the present thesis can be summarised as follows:

1. To contribute to the body of scientific knowledge of suicidal behaviour in young men experiencing psychosocial problems and substance abuse.
2. To generate scientific knowledge to be used in promoting the health of young men with substance abuse and suicidal behaviour.
3. To describe, explore and interpret the multidimensional phenomenon of substance abuse and suicidal behaviour in young men receiving treatment.
4. To describe and explore situational and contextual factors with regard to preventing life-threatening overdoses in Oslo, where most, but not all, of the suicidal behaviour had occurred.

In the general introduction of this thesis a broad theoretical introduction to health, public health and suicidology are outlined. In the following background, leading towards the research questions, relevant concepts and previous research is described. In the methodology part, descriptions of a qualitative approach to knowledge are provided. Methods of data collection and data analysis are presented. The general discussion of the findings are organized in three overriding themes and related to welfare, health and health promotion. Implications for public health work are proposed. This is followed by a methodological discussion, as well as conclusions and implications for further research.

## 2. GENERAL INTRODUCTION

### 2.1. The concept of health

In 1946, the World Health Organisation (WHO) defined health as “*a state of complete physical, mental and social well being and not merely the absence of disease or infirmity*”. This definition, emphasizing an optimistic and holistic view of human beings and health, has been criticized as being unrealistic, but has guided professionals and politicians since it was conceived (Lindström, 1994).

The concept of health may be defined in different ways based on ontological assumptions and views of man, and Tengland (2007) illuminates two other possible perspectives: health as ability and health as balance (Pörn, 1993). Pörn’s perspective on health as balance is based on the idea that a person is healthy if he or she can achieve his or her vital goals through adaptation (action) based on repertoire (the individual) and the environment (context). If there are vital goals that cannot be achieved, then the person by definition experiences ill health, for example if they have problems getting education or work, or receiving social support because of substance abuse. Pörn’s perspective of health emphasizes that the individual interprets his or her contextual situation and himself or herself in relation to this. The interpretation is compared with the (cultural) ideal picture. On this background the individual acts in order to decrease the distance between repertoire and environment, and in order to achieve his or her vital goals over time. If a difficult situation in relation to education, employment or society makes up part of the individual’s environment, and if addiction to drugs is part of the repertoire, it will be difficult to achieve the goal of participating in the labour market. Thus, Pörn’s concept of health seems to be also related to the individual’s perception, that is to make things understandable through interpretation, with emphasis on the cognitive aspect. Whether or not the individual is healthy, will thus depend to a large extent on how the person perceives, understands and deals with his or her situation.

Since substance abuse and suicidal behaviour are complex, multifactorial social phenomena, and are therefore most probably related to both internal and external factors, I have chosen to define health in the present thesis as a balance between the individual’s goals, the individual’s repertoire and the environment in which the individual acts (Pörn, 1993). I then understand health as the process of adaptation by defining and redefining goals, and to achieve them by means of one’s repertoire according to the environment. Thus, as Tengland (2007) points out, a holistic view of health also means

that health can be improved by revising one's goals, increasing one's repertoire (capacity, ability), or influencing the environment in order to make actions easier. The promotion of health then comes into play (see below).

### *Substance abuse and suicidal behaviour experienced as ill health*

Substance abuse and suicidal behaviour might be said to involve a type of double marginalization, in the form of being both individually and socially marginalized, that is to make an individual or a group become less important (Johnsson, 2002). Such a life situation demands more in the form of dealing with continuously recurring problematic situations, and involves a repertoire of reduced control in the form of drug dependence and suicidal ideations, in a context of reduced social support. In a position of experiencing less importance, individually or collectively, achieving vital goals could be hampered, and thus lead to ill health.

Karaksek and Theorell's demand-control model, as presented by Bennett and Murphy (2001), maintains that a situation with high demands and less control involves stress reactions in the body, and has a direct effect through hormonal responses with changes in the central nervous system, the immune system, the endocrine system and the cardio-vascular system. According to Bennett and Murphy (2001), such risk factors for ill health have been shown to be as important as smoking and high blood pressure. The indirect effects of stress on health are related to risk behaviour and possibly reduced compliance (for example in drug-free treatment) in the group that this thesis deals with (Ravndal & Vaglum, 1994).

In between social and psychological dimensions of ill health, Skogman (2006) illuminates the psycho-social perspective, when focusing on the importance of both individual vulnerability and external stressors as risk factors for suicidal behaviour. Examples of external risk factors are living alone, unemployment and having a weak social support network. Negative life events, such as bullying, separation and other loss might count for the individual part (Skogman, 2006).

### *The origin of health*

In his model of "sense of coherence", Antonovsky (1987) explains why some individuals seem to handle stressors in life more successfully than others. He includes three core components in his theory of the origin of health: comprehensibility, manageability and meaningfulness. *Comprehensibility* refers to the extent to which one perceives the stimuli that derive from the internal and/or external environments as

making sense, even if the stimuli may not be desirable. *Manageability* refers to the extent to which one perceives that one has the resources to meet demands. *Meaningfulness* refers to the extent to which life make sense emotionally, and whether life is worth investing energy in and is challenging rather than a burden. Thus, a person with a strong “sense of coherence” is expected to feel that things will work out as well as can reasonably be expected. It can be argued that this is a too “individualistic” view of a personal trait, and not quite in line with Lazarus and Folkman’s perspective on coping (presented later). A precondition for a salutogenic perspective on the origin of health should include a recognition of the importance of social justice and equity in society (WHO, 1986a, 1998). This forms part of what Antonovsky regarded as general resistance to the resources individuals have, or may retrieve, to gain control over their health.

## 2.2. The concept of health promotion and new public health

### *Health promotion*

The Ottawa Charter (WHO, 1986a) followed the Alma Ata Declaration of 1978 (WHO, 1978). Its principles were accessible health care to individuals and families and their full participation in health promotion. Health was adopted as a continuously changing resource for everyday life, a tool for achieving a good and satisfactory life and well-being, not as the objective of living. Additionally, social conditions and the environment were emphasized as determinants of both individual and community health. Health promotion is defined as the process of enabling people to improve and increase control over their health, facilitating the empowerment of individuals and groups, aimed at increasing their ability to alter life conditions (WHO, 1986a). As pointed out by Rappaport (1981), empowerment is both a goal and a strategy for health promotion, and can be adopted both on an individual or a community level. Of special relevance for this thesis is the notion that health is social as much as individual, and that “healthy communities are sustained by people identifying their health agendas as individuals and being sufficiently empowered to develop the necessary social and political skills” (MacDonald, 1997).

### *New public health*

Public health has traditionally aimed at responding to the prevalence of disease in society, to its distribution, and to its consequences for individuals and society. The concept of public health has been defined as “*the science and art of preventing disease, prolonging life and promoting health through organized efforts of society*” (Acheson, 1988). As part of a contextual and dynamic development, views of both health

and public health have changed, going beyond an understanding of the biology of the individual as the main source of health: “The *new* public health constitutes the organized efforts of society to develop healthy public policies, to promote health, to prevent disease, and to foster social equity within a framework of sustainable development” (WHO, 1996). Health problems are then seen as being social rather than individual problems, with concrete issues of local and national public policy underlying them. In the new public health, the environment is social as well as physical. This approach brings together environmental change, enabling people to improve their control over health and personal preventive measures with appropriate interventions. Eklund (1999) points out that the cornerstones of the new public health can be described as: “political and social commitment to health issues, shared responsibility between government and the public, a multidisciplinary mode of working, from top-down approaches towards bottom-up approaches and from a mechanistic viewpoint towards an ecological viewpoint.” Of special relevance for this thesis, the new public health also avoids blaming the victim, and views health as a collective human right rather than the property of individuals (Eklund, 1999).

The phenomena of substance abuse and suicidal behaviour are described as multifaceted and complex problems, and as the outcome of interactions between biomedical, psychosocial and social processes (Wasserman, 2001). Thus, in this thesis the phenomena of substance abuse and suicidal behaviour in young men is defined as a new public health issue and, hence, conceptualized by the complex interplay of individual, cultural and social factors. This should allow us to interpret the phenomena from different angles (Nijhuis & van der Maesen, 1994; Beaglehole & Bonita, 1997). The underlying ontological notion adopted in this thesis is that these phenomena are embedded in the social construct and social matrix experienced by individuals. This calls for a collective understanding of *public*, and for a holistic understanding of *health* (Nijhuis & van der Maesen, 1994) as the collective meaning-making systems are believed to forego individual motives and actions:

- *Public* as the gestalt of the collective (presents the immediate context and community level in which substance abuse and suicidal behaviour are embedded and take place).
- *Public* as the gestalt of the structural (presents the general views and attitudes that permeate the culture at large, but also specifically within the health and social services. It includes laws, social and economic policies, cultural norms, professional cooperation and guidelines).
- *Health* as the balance between vital goals, repertoire and environment.

In 1981, the WHO adopted the strategy “Health for All by the Year 2000”. Equity in health is the underlying ideology of this strategy, forming the background for the adoption of “Health 21” for the European Region of May 1998 (WHO, 1998). More recently, literature on new public health increasingly recognizes that health experiences are shaped by a wide range of social, cultural, economic, political and environmental factors (McQueen & Kickbusch, 2007). These agendas have been developed on the basis of a growing body of evidence, which demonstrates that people who live in disadvantageous social circumstances are more prone to ill health, distress and disability, and die sooner than the more affluent (Black, Townsend & Davidson, 1982). Moreover, evidence from around the world points to an increase in the gaps in health status and health care by socioeconomic status, geographical location, gender, race, ethnicity and age group (WHO, 1996; Zøllner, 2002).

This thesis takes a holistic approach to the human being. Focusing on substance abuse and suicidal behaviour as diseases or health disorders is not sufficient to fully understand the phenomena, and thus for prevention. The social environment with which the individual interacts must also be taken into consideration, as well as recognising that people are active subjects in their own life and health (Eklund, 1999). Another basic assumption for this thesis is that health experiences during childhood and adolescence have long-term implications for individuals, their families and for society as a whole (Borup, 1999). From a new public health perspective, aiming at fostering social equity and the participation for everyone in society, Borup (1999) points out that adolescence is an opportune time to invest in young people and to help them to form a strong foundation for their future health. It is also relevant for this thesis that research has shown that at least six people, that is family and friends, suffer intense grief from every death from suicide (Clark & Goldney, 2000). As the process of adjustment to the loss of a close relation or friend can be several years, the *collective* morbidity from suicide deaths represents considerable public health challenges to health and social services and their practitioners (Talseth, Gilje & Norberg, 2001; Grad, 2005).

Therefore, this thesis is based on the assumption that, as social phenomena, experiencing substance abuse and suicidal behaviour is to be conceptualized mainly as a collective health issue, however it is experienced by the individual. To gain a deeper understanding of the inner perspective of individuals experiencing such serious life events, might prove important when planning health promotion, prevention and better health for the group in question.

### 2.3. Mental health - from an integrated part of humans to a specific entity?

Mental disorders, based on an external description and biomedical perspective, particularly depression and substance abuse, are associated with more than 90 % of all cases of suicide in the USA and Europe (Moscicki, 2001). However, as substance abuse and suicidal behaviour might be related to individual meaning-making and thus the results of many complex socio-cultural factors, the phenomena are likely to occur particularly during periods of socioeconomic, family and individual crisis (WHO, 2007).

Hummelvoll (1995) points out that human beings are complex, and it is therefore necessary to attain a holistic understanding of man. According to Hummelvoll (1995), and of relevance for this thesis, man is seen as a unique being and a complex entity comprising body, soul and spirit in interaction with the environment. Such a philosophic and theoretical view of health could be said to be inspired by the 1946 WHO definition of health as a state of complete physical, mental and social well being. Possibly, as part of a tendency in today's western society of more and more specialization of expertise, more recently the WHO (2005 a, b) defined mental health separately, and as a state of well-being.

This *well-being* is based on how individuals can realize their own potential, cope with the normal stressors of life, work productively and fruitfully, and be able to make a contribution to their community. According to the WHO (2005b), public mental health is crucial for achieving such aims. A more philosophical conceptualization of human well-being is presented by Sarvimäki (2006) and this has formed my point of departure when describing alternative ways of well-being in this thesis. Based on Heidegger's ideas of Being, Sarvimäki (2006) points out that well-being could be understood as comprising a sense of familiarity and authenticity in the everyday unfolding of life, as well as orientating towards the future and realizing one's potential. According to Sarvimäki (2006), confronting anxiety and death also forms part of this orientation.

However, on a more practical level, and from a health promotion point of view, policies on labour, urban planning and socioeconomic issues have an important impact on mental health and well-being, and the risk of mental health problems. Hence, a healthy policy requires intersectional linkages and should incorporate multisectoral and multidisciplinary approaches (McQueen & Kickbusch, 2007). The possible positive effect of focusing on mental health and well-being more separately, even though this may conflict with a holistic view of health and man, is that other areas than the health care sector influence

how the mental part of health and well-being is developed and perceived (Bäärnhielm, Ekblad, Ekberg & Ginsburg, 2005).

During the last few years, mental ill health, from a biomedical perspective, and in the forms of depressions, anxiety and alcohol-related problems, has emerged as one of the biggest public health issues in our part of the world. From epidemiological research we know that the prevalence varies in different groups of the population, primarily according to gender, socioeconomic status and ethnicity. On this background, WHO Europe (2005a) established the *Mental Health Declaration* and the subsequent *Mental Health Action Plan for Europe* (WHO, 2005b). In this declaration, the member states address the challenges of promoting mental health and preventing mental ill health, including suicidal behaviour. The term mental ill health should be seen as a broad term for different forms of problems and suffering linked to emotions, relations and thoughts. It includes mental illnesses with serious mental deviation with a clear inception and a distorted view of reality, and classified mental disorders leading to similar functional impairment and suffering. Yet, there has been some controversy in adopting a biomedical paradigm towards experiences of mental ill health, as objective causes of such problems seem difficult to identify (Svensson & Hyltén, 1995). However, in this thesis, the term mental ill health refers to the subjective, experienced and perceived oriented perspective, comprising the individual's self-reported problems with the experience of reduced well-being (Hedelin, 2000).

Since well-being, mental ill health, substance abuse and suicidal behaviour are always experienced and perceived by a person as a social fact, an internal perspective of these phenomena, based on a phenomenological-hermeneutic approach, should avoid explanations and descriptions that are not grounded in direct experience. In a study of the meaning of mental health from the lifeworld perspective of elderly women (Hedelin, 2000), the core constituent of mental health was confirmation. Confirmation perceived of as being noticed, being respected and being regarded as a valuable person was to be realised in the relationship with oneself and with others. It is difficult to say whether this is also valid for young men. External factors, such as unemployment and low income, are believed to be major gendered suicide risk factors for men in a Western society (Qin, Agerbo & Mortensen, 2003). I argue that when men are given the opportunity to speak for themselves, internal and relational factors will probably form highly evident and important parts of individual well-being.

## 2.4. Substance abuse and suicidal behaviour

### *Substance abuse*

The concepts of substance use disorder, substance abuse and drug misuse are, in contrast to drug addiction and drug dependence, not easily defined and the borderline between them is not always distinguishable (Miele, Tilly, First & Frances, 1990). They can cover states from problematic use to established abuse and dependence. Research of suicidal prevention for persons using psychoactive substances may be hampered by the absence of clear definitions (Mino, Bousquet & Broers, 1999). The personal significance of using alcohol and illicit drugs is unique to every person. For that reason, researching the inner perspective, that is the individual's own experience, should use descriptions which are grounded in direct experiences. However, I will use the broader term substance abuse to refer to the wide range of subjective experiences which stem from the intake of alcohol and illicit drugs by the participants.

Substance abuse and male gender are considered to be risk factors for suicide (Suominen, Isometsä, Haukka & Lönnqvist, 2004). In the National Comorbidity Survey from the United States, lifetime prevalence of substance abuse is estimated to be about 5 % for men (Kessler, Borges & Walters, 1999). However, it is difficult to determine the impact substance abuse as a single factor has on suicide in men, as it is comorbid with affective illness (Isometsä, Heikkinen, Marttunen, Heikkinen, Aro, Kuoppasalmi & Lönnqvist, 1995). In men with a major depressive episode, past substance abuse more than tripled the risk of future suicidal acts (Oquendo, Bongiovi-Garcia, Galfalvy, Goldberg, Grunebaum, Burke & Mann, 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 local norms of masculinity, such phenomena could also help explain male vulnerability (Möller-Leimkühler, 2003; Liu & Iwamoto, 2007).

Hawton, Fagg, Platt and Hawkins (1993) found substance abuse to be a key diagnostic predictor of suicide in young people, and Landheim, Bakken and Vaglum (2006a) showed substance abuse with duration of 15 years or more and onset of such abuse before the age of 18 to be independently associated with suicide attempt after controlling for Axis I disorders (that is mood disorders). In another Norwegian study, Rossow and Lauritzen (1999) reported that among 2051 women and men with substance abuse, living in treatment facilities, 45 % of the men had experienced life threatening overdoses, i.e. in need of the intervention of others to survive. Thirty per cent, on one or more

occasions, had 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. Ravndal and Vaglum (1999) also reported a high proportion of suicide attempts (above 30 %) in people with substance abuse receiving treatment for addiction to drugs. In addition, the incidence and prevalence of overdose deaths in Oslo have been among the highest in Europe during the 1990s, especially in males (Reinås, Waal, Buster, Harbo, Noller, Schardt & Müller, 2002). Therefore we need scientific knowledge based on lived experiences to promote health and to design tailor-made local intervention and prevention measures for this group.

### *Suicidal behaviour*

Suicidology is the scientific knowledge of the process of cognitions, emotions, and behaviours that are associated with the full range of the outcome; self-destructive behaviours. Silverman (2006) argues that there is a lack of common nomenclature, operational definitions, common investigative protocols, and a common classification system. Thus, the term suicidal behaviour is not unambiguous, and may cover self-harm (with suicidal intent), suicidal ideation, suicide attempt and suicide. As this thesis is mostly based on empirical self-reports given as personal narrative accounts, the connotation suicidal behaviour is used in a broad manner, and includes every individual experience that the narrator associates with self-harm with suicidal intent, suicidal ideation and motivation, intent, threats or attempts. Assuming that narratives of such cognitions, emotions and behaviours are experienced and expressed through a subject body, and not only about a body, I allow the subject to define when he felt suicidal, regardless of an objectively assessed medical lethality and intention to die.

### *Self-harm*

As self-harm includes a wider spectre of events than suicide, the acts of self-harm are divided into a wide range of activities (Retterstøl, Mehlum & Ekeberg, 2002). In Europe, the term *deliberate self-harm* is widely used to include non-fatal intentional self-poisoning and self-injury, irrespective of motivation. This broader term for self-harming behaviour takes into account the fact that motivation for self-harming behaviour is often complex (Hjelmeland, Knizek & Nordvik, 2002). As the field advances, the scientific language of suicidology needs to reflect accurately the evolving understanding and knowledge base of suicide. In order to improve communication with individuals or groups at risk, or the survivors of the suicide of a loved one, this development should reduce linguistic stigma. As an example, Silverman (2006) refers to the Royal College of Psychiatrists and its response to concerns raised

by users of mental health services in the United Kingdom, adopting the term *self-harm* in preference to deliberate self-harm, as the latter suggest that the preferred outcome of the behaviour was definitely to die, without necessarily knowing the intention of the individual.

### *Suicide attempt*

Attempted suicide has a higher prevalence than suicide in most countries, including the Nordic countries, especially in women. Exact figures are lacking mainly because epidemiological research into attempted suicide, according to Kerkhof (2000), has only recently used standardized definitions and procedures. There are still controversies about a universally accepted nomenclature for suicidology (Gjertsen, 2003; Silverman, 2006). A European multicentre study into attempted suicide showed an 18 % decrease in young males, but the rates for females were still 1.5 times higher than those for men (Bille-Brahe, Andersen, Wasserman, Schmidke, Bjerke, Crepet, De Leo, Haring, Hawton, Kerkhof, Lönnqvist, Michel, Philippe, Querejeta, Salander-Renberg and Temesvary, 1996). Christiansen and Møller (2004) report a three-fold increase in suicide attempts in girls aged 15-19 years of age in Fynen, Denmark, from 1990 to 2001.

Suicide attempts and suicide as communication related to inter-personal events have been highlighted by researchers such as Qvortrup (1999), Lester (2001) and Beskow (2005). Inter-personal phenomena such as separation, divorce, physical abuse and sexual abuse are found to be risk factors for both non-fatal and fatal suicide attempts (Petronis, Samuels, Moscicki & Anthony, 1990; Lamberg, 2000). Grøholt, Ekeberg and Haldorsen (2006) found that having a father who exerted control without affection was a predictor of future suicidal acts in adolescent suicide attempters in Norway. Early research in suicidology has also shown that the vast majority of individuals who experience suicidal ideation communicate their intent to significant others prior to their suicidal actions, either by making direct allusions to suicide and death or by indirect actions, such as cleaning their rooms and giving away their possessions (Robins, Gassner, Kayes, Wilkinson & Murphy, 1959). Furthermore, adults who die by suicide are likely to have been seen by a primary care provider in the year before death (Luoma, Martin & Pearson, 2002). The assessment of suicidal risk, and prevention of suicide attempts, is one of the most difficult and demanding skills that health care practitioners have to acquire (Gilje, Talseth & Norberg, 2005).

In Europe, a definition of *suicide attempt*, by an overdose of heroin or by other means, which fits the suicide attempts experienced by the group in this thesis, is as follows: "An act with non-fatal outcome, in

which an individual deliberately initiates a non-habitual behaviour that, without intervention from others, will cause self-harm, or deliberately ingests a substance in excess of prescribed or generally recognized therapeutic dosage, and which is aimed at realizing changes which the individual desired via the actual or expected physical consequences” (Platt, Bille-Brahe, Kerkhof, Schmidtke, Bjerke, Crepet, De Leo, Haring, Lönnqvist, Michel, Philippe, Pommereau, Querejeta, Salander-Renberg, Temesvary, Wasserman & Sampaio Faria, 1992). However, one might question whether a suicide attempt by an overdose of heroin is in concordance with the notion of “a non-habitual behaviour”, and whether “deliberately” is a fruitful concept with regard to the experiences of severe opiate addiction. Wasserman (2001) has presented a broad model of the development of the suicidal process. Here, the notion of attempted suicide contains events where the risk of death is extremely high (intentionally or lethality) and the probability of rescue or intervention is extremely low. With regard to the often described feeling of ambivalence of living or dying in an individual facing existential pain it is difficult to decide whether an attempted suicide is in fact an attempt or “a failed” suicide. In this thesis the concept attempted suicide is used for both. In conclusion, self-harm and suicide attempt is a complex and multi-factorial phenomena, and no simple understanding or explanations exist.

### *Population-based studies of suicide*

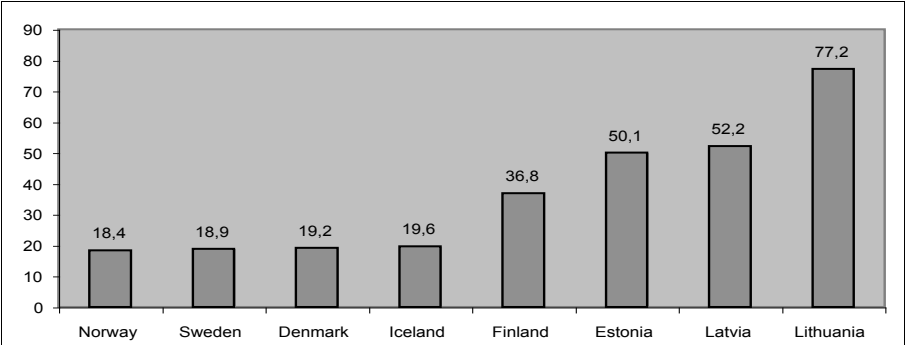
Despite vast research efforts to describe risk factors, develop treatment approaches and implement prevention strategies, suicidal behaviour continues to be a major public health problem (Beskow, Eriksson & Nikku, 1999; Wasserman, 2001). In the last 45 years, suicide rates have increased by 60 % worldwide, and suicide is now among the three leading causes of death among those aged 15-44 years (both sexes). Death from suicide is a predominantly male phenomenon, except for China (Phillips, Li & Zhang, 2002/3). Although traditionally suicide rates have been highest among elderly men, rates among young people have been increasing to such an extent that they are now the group at highest risk in a third of countries worldwide (WHO, 2007). Suicide worldwide is estimated to represent 2.4% of the total global burden of disease in countries with market and former socialist economies in 2020, and the WHO has estimated that the numbers of people worldwide who commit suicide each year will increasing to 1 530 000 by the year 2020 (Wasserman, 2001; WHO, 2007).

National suicide rates differ widely, and local figures may be culturally biased. Because classifying a death as suicide may have negative emotional, religious, legal and financial implications, suicide may be under-reported (Allebeck, Allgulander, Henningsohn & Jacobsson, 1991;

Webster Rudmin, Ferrada-Noli & Skolbekken, 2003). From the African member states, only Egypt and Zimbabwe report statistics on suicide rates to the WHO. Figures tend to be high in industrialized nations, and in Europe the highest suicide rates are found in Russia and the Baltic states. America and Asia generally have lower rates than most of the European countries (WHO, 2007). In 2004, suicide was the eleventh leading cause of death in the USA: 10.9 deaths per 100 000 people. International suicide rates seem to have shown consistent patterns over time, also for European countries (Diekstra 1993; Nordentoft, 1994).

From 1994 to 2004 suicide rates in the Nordic countries decreased. However, the latest figures indicate a shift in this trend among young women in Finland, Norway and Sweden, and elderly women in Denmark (Gjertsen, 2007). Traditionally, the incidence of suicide has increased with age, also in the Nordic countries, and this generally remains the case, especially for men. (Bille-Brahe, 2001; Gjertsen, 2007). Suicide rates for men in the Nordic countries have decreased from the 1980s to the 1990s, and the differences between the countries is less, with the exception of Finland (Gjertsen, 2007; Figure 1). It is unclear if this is due to the government prevention plans in the 1990s. Yet, the most significant trend in Finland has been a high suicide rate in young men, and suicide is still one of the major causes of death for young men in the Nordic countries. In the year 2000, 20 out of 42 suicides among men were committed by men aged 15-29 years in Iceland (Nordic Council of Ministers, 2006; Ólafsdóttir, 2007). This could reflect gender-specific risk factors by pathways either from depression contributing to substance abuse (including alcohol), depression stemming from such abuse (Beskow, 1979; Kolves, Varnik, Tooding & Waserman, 2006), or from socio-cultural conditions (Webster Rudmin et. al., 2003). Qin et al. (2003) report gender-based differences in suicide risk in relation to socioeconomic, demographic, psychiatric, and familial factors in Denmark.

Figur 1. Suicide in the Nordic/Baltic countries. Males. 2001. Per 100 000 mean population (Gjertsen, 2007).



Laur (2005) showed that the number of suicides and the suicide rate for men in Estonia increased dramatically with the political-economic changes towards a market economy that occurred when the Baltic states gained independence from the Soviet Union after the failed coup d'état in Moscow August 1991. The subsequent economic crises, unemployment and privatization, combined with a liberal alcohol policy and less social protection, seemed to strike middle-aged men hard. However, regardless of political system, Nordic and Eastern European countries tend to have somewhat higher suicide rates than southern European countries.

### *Suicide*

The World Health Organisation (1986b) has formulated this definition of suicide: *An act with fatal outcome which the deceased, knowing or expecting a fatal outcome, had initiated and carried out with the purpose of provoking the changes he desired.*

WHO's definition, as many others, emphasizes both the *intentional* aspects and the medical *lethality* of a suicide. According to Silverman (2006), assigning weights to intent and lethality is often a balancing act, as one sometimes has to speculate about this part of the suicidal process, especially in cases where no personal note is left, and when there is no external information from reliable sources. This may explain why few studies of suicide measure either lethality or intent (Moscicki, 2001).

The sociologist Jack Douglas (1967) outlined some fundamental, micro-sociological dimensions of meanings that he believes are required in the formal definition of suicide. He describes these dimensions mainly as the initiation of an act that leads to the death of the initiator, the willing of self-destruction, the motivation to be dead, and finally, the knowledge of the actor that actions he initiates tend to produce the objective state of death.

Both the definitions of WHO (1986b) and Douglas (1967) seem to highlight only the personal perspective. It seems as though the context of the subject is of no importance or interest. More contemporary suicidology emphasizes the dualistic dynamics between subject and context, in which the suicidal process is thought to be embedded. Hammerlin and Enerstvedt (1988) therefore broaden the sociological perspective when suggesting this definition: *Suicide is an activity that involves actions that have the aim and result of causing one's own biological death, based on social and specific historical motives.*

Hammerlin and Enerstvedt's definition is built on a view of humans not only as a product of society creating internal problems, but on the fact that subjects stand in a dialectical relationship with their surroundings in time and space. Thus, this dialectical relationship and the process of suicidal behaviour develop over time, and may contain self-harm, suicide ideation and several suicidal attempts.

Since the young men interviewed for the different papers of this thesis have not actually died from suicide, it is also important to recognize that this thesis in fact focuses on individuals who have attempted self-harm and suicide. A suicide attempt not only refers to an "unsuccessful" suicide, but probably also comprises (self-harm) acts of lower lethality and intention. How people who attempt suicide differ from people who commit suicide is not clear, as they might share many of the characteristics of people who actually die from suicide. Age and gender differ most between the two groups, as suicide attempters are often younger and more often female, whereas persons who commit suicide are older and more often male. However, repeated suicide attempts present one of the most predominant risk factors for completed suicide for both sexes and for all ages, followed by depression (Kerkhof, 2000; Ekeberg, 2006).

### *The societal level and suicidal behaviour*

The roots of a scientific sociological approach extend back to the work of the French sociologist Émile Durkheim (1897/2001). Durkheim argued that people commit suicide because their integration in society is not as it should be, or because society itself is disintegrated. The understanding of suicide is then based on the assumption that rapid social transitions weaken social institutions and that suicide levels will increase due to stressors stemming from either new-found prosperity or poverty. According to Durkheim's theories, based on statistical analysis of data from several European countries in the 19th-century, suicide is the result of how strongly or weakly individuals are integrated in society. He posited four basic types of suicide, each a result of this integration; altruistic (suicide is literally required by society to restore honour), egoistic (the individual's ties to his community are too few or tenuous), anomic (a special kind of loneliness in the individual when the accustomed relationship to his society is disrupted) or fatalistic (deriving from an excessive regulation of the individual). However, also criticized for being social deterministic, Durkheim's theory of integration is still highly regarded as an approach in much sociologically inspired research on suicide (Möller-Leimkühler, 2003). Of importance to this thesis is my understanding of Durkheim, that societal changes may embed anomic suicide, or also egoistic suicide if the individual feels distanced from society.

According to Shneidman (1985), for years after Durkheim sociologists have not made major changes to his theory, until Douglas (1967) pointed out that the meanings of suicide vary greatly, and that the more socially integrated a group is, the more effective it may be in disguising suicide. Further, Douglas (1967) suggested that social reactions to stigmatizing behaviours can themselves become a part of the aetiology of the very actions the group seeks to control. Maris and Lazerwitz (1981) try to combine the perspectives of social integration and the individual, when arguing that a systematic theory of suicide should be composed of at least four broad categories of variables; those concerning the person, the social context, the biological factors and temporality, involving suicidal careers.

Western societies of today might be said to have moved from being collectivistic (modern) to being individualistic (post-modern), and several sociological theorists have presented ideas that are relevant to this thesis on the consequences of this transformation on different levels, that is individual, relational and contextual. Giddens' (1991) position is that post-modern institutions differ from all preceding forms of social order in respect of their dynamism, undercutting traditional habits and customs, which, according to Giddens (1991), may lead to "disembedding" mechanisms. The possibility and the necessity to choose one's own life is therefore a prominent feature for individuals in our part of the world. Bauman (1991), who theorizes about how individuals in contemporary Western societies must live with and handle ambivalence, points out that there are always chances to be taken and decisions to be made in life, without the guidance of stable institutions. In a post-modern context, lacking specific moral guidelines, it is much harder to see what the consequences of one's decisions may be. Bauman (1991) claims this may lead to a sense of mistrust in one's own resources and power, opening up for trusting experts of different kinds.

Choices are linked with risks. One might risk taking a wrong choice. Beck (1992), theorising about the risk society, defines risk as: "probabilities of physical harm due to given technological or other processes." Examples of risk-producing circumstances are unemployment, hazardous working condition and exposure to violence. Given the structure of risk society there are also reasons for increased personal and psychological risk. However, according to Beck (1992), different types of risk are not equally distributed, as: "wealth accumulates at the top, risks at the bottom." In line with this, and of relevance to this thesis, Hardey (1998) shows that male mortality in the UK from the early 1970s to the early 1990s, revealed a relative widening of the gap between social classes with a fourfold difference in suicide between the highest and the lowest social classes in this period.

## *The group level in suicidal behaviour*

Morbidity and mortality from suicide are gender and age biased. The WHO's statistics on suicide show the effect of gender and age (WHO, 2007). The gender effect on mortality seems consistent, even though the reporting countries represent a wide variety of cultures, religions, standards of living, education systems, economies, and other factors that might be presumed to have some effect on reported suicide. The highest incidence of suicide is found in the age groups over 40 years. Figures on *suicide attempts* show another picture. Women in the age group 15-24 have the highest incidence. In their study of culture, age and gender in the epidemiology of suicide, Webster Rudmin and co-workers (2003) examined national figures on *suicide* by Hofstede's theory of cultural variables, that is contextual and local beliefs and meanings of social indifference. Hofstede defines four major dimensions describing and differentiating the cultural values of 39 nations world-wide: 1) Power-Distance, i.e. people's social separation due to differences in status, finances and organizational power, 2) Uncertainty-Avoidance, i.e. people's preferences for stability and predictability, 3) Individualism, i.e. people's self-perception that they are autonomous personalities not defined by, or merged into, collective familial or social groups and 4) Masculinity, i.e. people's differentiation of men and women into distinct roles, with women having lower status.

Strikingly, when taking population-based suicidal figures into account, Webster Rudmin et al. (2003) found that masculinity was not positively correlated with suicide among men, but individualism was. Even though the statistical analysis did not show a positive correlation between suicide and masculinity, one might claim that in daily social life, individualism and masculinity do not have opposing, but complementary effects. According to Webster Rudmin et al. (2003), cultures characterized by self-perception of mainly autonomous personalities, such the USA, Europe and Australia, may in fact facilitate male suicide. This might be said to correspond with Durkheim's topology of an egoistic suicide, supposing that lack of integration of a subject into familial or social groups may function as a stressor by the feeling of marginalization.

One of the key challenges for suicide research is to explain the high and persistent gender difference in attempted suicide and completed suicide. A gender perspective, which has been shown to be a powerful analytic tool in feminist inspired research (Rosaldo & Lamphere, 1974), should be seen as important in relation to men's health. However, this has been investigated less and has been given less focus in suicidology (Scourfield, 2005). Möller-Leimkühler (2003) argues that the gender gap in suicide suggests that important factors may have

changed in different directions for men and women. According to Möller-Leimkühler (2003), social factors, especially linked to gender-roles and changes in gender-roles, are considered to be the most likely explanation. Thus, in explaining male vulnerability, a gender perspective may offer an analytical tool to investigate structural and cultural factors. Relying on empirical data and theoretical explanations, Möller-Leimkühler (2003) proposes a theoretical gender model of male vulnerability to premature death and suicide.

Her point of departure is that the traditional Western construction of masculinity, that is, independency, rationality, competitiveness and striving for control, with its origin in the former agricultural and industrial society, has been shown to be a key risk factor for male maladaptive coping strategies, leading to emotional inexpressiveness, reluctance to seek help and self-destructive behaviour. Möller-Leimkühler (2003) believes that this culturally based male disposition increases both physiological and psychosocial stress-responses in men. Further, the transition of the post-modern society towards a greater extent of social isolation, such as single status, lowered social support, and labour-marked problems, may increase and be in conflict with the aspect of identity and control in men. Thus, because social status via the working role is believed to be essential to Western male identity, by having control over their environment, men seems to be more vulnerable to occupational stressors and feelings of personal failure. The less adaptive responses of men, triggered by cultural norms of traditionally masculinity or personal confusions resulting from gender-role conflicts, may thus be the pathway to risk-taking behaviour such as abuse of alcohol, facilitating a process leading to (masked) depression, and ultimately leading to premature death.

In line with Möller-Leimkühler, Hjortsjö (1983) indicated in his thesis about deaths from suicide in Stockholm that the male:female ratio in suicide might be due to the problems men face when their (perceived) traditional role has been changed, assuming that such changes affect the health of both sexes. For men trying to cope with their inner pressure stemming from external factors, suicide may be considered to be a culturally acceptable way out of the conflicting situation.

However, Möller-Leimkühler's model (2003) gives the impression of being one of cause and effect. Developed into a more system-theoretical figure, it could have emphasized the importance of how men themselves react to the effects of social changes, and how the cultural ideals of masculinity could then have been re-constructed. As masculinity can be seen as something a subject construct within a context, it can be argued that local and traditional values, especially in individualistic oriented societies, need to be changed and lived as other

constructions (Connell, 2005). In negotiating new forms of masculinity, male behaviour might be adjusted more in line with the psychological needs of men experiencing social changes.

### *The individual level in suicidal behaviour*

In contemporary western society, suicide is perceived as a personal tragedy, and lay explanations often focus on the individual aspect of the phenomenon. One might say that suicidology as a science in the 20<sup>th</sup> century was developed within the frames of Durkheim's sociological viewpoint and Freud's theory of the unconscious and his ideas of suicide as a killing of an introjected ambivalently loved object. Theories concerning the individualistic aspect of suicidal behaviour are thus often to be found within psychiatric (Retterstøl et al., 2002) and psychological theoretical systems (Shneidman, 1985). In one way or another these theories highlight the personality, psychopathology or psychological characteristics of individuals who carry out suicidal behaviour. This is not to say that all post-modern psychiatric and psychological perspectives on suicide are of psychodynamics. The psychological approach can be distinguished from the psychodynamic approach in that it does not pose a set of dynamics or a universal unconscious scenario, but emphasizes certain psychological features that seem to be necessary for a lethal suicidal event to occur.

Under the assumption that suicide is a behaviour, and an act of different meanings, and not a disease, which is carried out by a vulnerable subject in time and space, Shneidman (1985, 1993), from a psychological point of view, takes account of the "ten commonalities" of suicide. Based on empirical findings from retrospective psychological autopsies, he presents some common characteristics of suicide, focusing on the individual and interpersonal perspectives of such behaviour. According to Shneidman (1985, 1993), emphasizing emotional needs and psychological pain, these ten commonalities create a special kind of pain, a "psychache", within the subject. The commonalities are ordered in six different domains; situational (stimulus of unendurable psychological pain and frustrated psychological needs), conative (the purpose of seeking a solution and searching for cessation of consciousness), affective (emotions of hopelessness-helplessness and the attitude of ambivalence), cognitive (the state of constriction and dichotomies in thought), relational (the communication of intention and action of egression) and serial (the consistency with life-long coping patterns). Of relevance to this thesis, Shneidman (1985) believes that these commonalities "tell us what suicidal behaviour is like on the inside, and what is sensible about it to the person who does it at the moment of doing."

With this perspective one might argue that Shneidman (1985), maybe from a more paternalistic discourse, observes and describes what retrospective data tells him *about* bodily experiences. Today, describing stories as told *through* the body would require other scientific methods. A post-modern experience of ill health would probably emphasize the view that more are involved in a phenomenon than a professional story can tell (Frank, 1995; Hydén, 1997).

Williams (2001) has presented another version of “the psychache”, formulated in a model of suicidal behaviour as “a cry of pain”. Williams (2001) suggests that we should conceive suicidal behaviour as an attempt to escape from a perceived trap, created from a feeling of being both defeated and closed in. This feeling can stem from external circumstances, or from inner turmoil. Further, the person believes that there is little likelihood that he will be rescued from the trap. Suicidal behaviour may then be thought of by the individual as the only possible activity and solution to get relief from his pain.

Some of the participants in this study told that they were on antidepressant medication. Gibbons, Hur, Bhaumik and Mann (2005) investigated the relationship between antidepressant medication and the rate of suicide in the USA. Selective serotonin reuptake inhibitors (SSRI) and new-generation non-SSRI antidepressants were associated with lower suicide rates both within and between states. This result might also reflect antidepressant efficacy, better compliance, a better quality of mental health care in different counties, and low toxicity in the event of a suicide attempt with prescribed drugs. Bramness, Walby and Tverdal (2007) also reported the fall in suicide rates in Norway to be related to the increase in sales of non-tricyclic antidepressant, even when alcohol and unemployment were controlled for. It is unclear whether the decreasing suicide rates can be attributed to the increasing prescription rates, as randomised controlled trials (RCT), proving a statistically significant treatment effect, are difficult to undertake in this field. Skogman (2006) reports some RCT studies that show that some forms of treatment are associated with lower suicide repetition rates: cognitive-behavioural therapy with elements of problem-solving versus standard aftercare, and psychoanalytically oriented therapy versus standard treatment.

To sum up, the basic assumption guiding this thesis is that suicidal behaviour is a multidimensional process and event, and requires, for its holistic understanding, a multidisciplinary and contextual approach. In narrative terms, no single perspective can tell the whole story. According to Leenaars (2002) and Skogman (2006), the individuals’ view of their suicidal behaviour has been investigated only to a limited extent. This thesis should therefore help to narrow this gap in scientific knowledge.

### 3. BACKGROUND AND RESEARCH QUESTIONS

#### 3.1. The study site

Figures from the National Bureau of Crime Investigation (2008) show that 713 persons are officially registered as having died from overdose in Oslo from 2000-2007. During this period the numbers decreased from 132 to 109. 70-75 % of those who died were men, and the proportion of non-western men has increased (Runa Frydenlund, Oslo municipality, Alcohol and Drug Addiction Service, personal communication). Although it is sometimes difficult to distinguish between accidental intoxication and a lethal and intended overdose, research findings point to a relationship between overdoses and the intention to die (Rossow & Lauritzen, 1999). Hence, the lethal event of life-threatening overdose might indicate suicidal ideation and intention. Suominen et al. (2004) revealed this to be specially relevant for men. However, Bretteville-Jensen (2005) disclosed higher figures for self-reported life-threatening overdoses in young women than in young men.

In Oslo, heroin is mostly administrated by intravenous injection by the dependent person, but there are reports of an increasing prevalence of heroin smoking (Bretteville-Jensen, 2005). Probably for complex reasons, a steep increase in the number of overdose deaths among substance abusers occurred in Oslo during the 1990s, especially among men aged 25-35 years. Therefore, during the period 1992-1997, an out-reach team of social workers and nurses was established to facilitate psychosocial follow-up and clinical cooperation after the initial emergency treatment. Further, an initiative was taken by Oslo in cooperation with Amsterdam, Frankfurt and Copenhagen, to compare drug problems and to investigate factors that influence the rate of overdose.

The multi-centre project also aimed at presenting strategic choices for preventing overdose deaths, with some special recommendations for Oslo (Reinås et al., 2002). The final recommendations focused on four areas: a) structural cooperation between all relevant agencies, b) a joint and simultaneous intervention with police action and adequate availability of treatment and low threshold facilities, including the dispersal of the open drug scene, c) coordination of the policy in Oslo with the policies of the surrounding municipalities, and d) continuous evaluation, improvement and adaptation of the different interventions to changing circumstances.

Up until 2004, Oslo had one political body responsible for the health of people with substance abuse. Due to structural changes in the

Norwegian health care sector in 2004, responsibility was then divided between the state and the municipality. Responsibility for treatment of persons suffering from substance abuse was transferred to the regional health authorities on behalf of the state. The number of persons receiving medication-assisted rehabilitation in Oslo increased from 337 (2000) to 1118 (2007) (Martin Blindheim, Norwegian Directorate of Health, personal communication). The number of seizures of heroin by the police fell by 52 % (National Bureau of Crime Investigation, 2008).

### 3.2. Psychosocial problems

The young men in this study had experienced long-standing psychosocial problems. The concept of such problems is somewhat difficult to define. According to Willumsen (2006), who addressed psychosocial problems in young people living in residential care, some definitions focus on individual factors, while some concentrate on family conditions. Others relate to the interplay between the individual and his/her society. For the purpose of this thesis, psychosocial problems include all kinds of intra- and interpersonal problems, with the exception of genetic make-up. Willumsen (2006) points to the possibility that young people with psychosocial problems, regardless of the reasons, will have problems in functioning adequately in school or (later) at work or in interpersonal relationships. This presents a risk to their development and to society. In such a situation, alcohol and substance abuse may increase the risk of mental ill health, suicidal behaviour and the need for treatment (Grøholt et al., 2006).

Hawton (2005) show that young people who commit self-harm, and as such are at risk for later suicide attempts or suicide, have a mixture of psychosocial problems that interfere with their well-being, associated with major depression, broken homes, lack of social support and knowing someone else who had taken an overdose. On this empirical background, Hawton presents a general explanatory model of attempted suicide in young adults, including the interaction between psychosocial factors such as mental ill health, chronic and acute stress, and the social environment.

Rutter and Smith (1995) believe that cultural change towards post-modern individualism in western society is the main factor contributing to the trends in psychosocial problems and suicide for men, being even more relevant than classical risk factors such as social disadvantage, inequality and unemployment. This hypothesis is not consistent with the findings of Qin et al. (2003), who analyzed gender and suicide risk in relation to socioeconomic, demographic, psychiatric and familial factors in a case-control study of all suicides in Denmark between 1981 and 1997. For men, economic stressors such as unemployment and low

income had the strongest effect, supporting the hypothesis that men respond more to poor economic conditions, possibly reflecting local cultural norms of masculinity. Psychosocial problems such as long-term unemployment, single status and material inequality seem to be especially difficult for western men (Hardey, 1998).

According to Botten, Elvbakken and Kildal (2003), during the 1980s and the 1990s Norwegian society developed into a society with more emphasis on the individual's duty actively to take care of himself. Suffering from substance abuse could make it difficult to live up to such demands. In Sweden, immigrants, single mothers and young adults, were harder hit by the economic crisis in the 1990s (Lundberg & Palme, 2002). Despite an improved employment situation and welfare reforms in Denmark during the 1990s, Kvist (2003) found that people with mental ill health who were homeless and had substance abuse faced social exclusion and marginalization. The societal development in Scandinavia the last two decades might for these reasons be said to add negatively to the abilities to satisfy central needs for young men experiencing substance abuse and suicidal behaviour, and thus their welfare.

### 3.3. Stress and coping

As suicidal behaviour could be viewed as goal-oriented expressions of extreme distress, presented by Mann, Waternaux, Haas and Malone (1999) in a stress-diathesis model, *coping* is important for understanding the lived experiences of the young men under study. A person addicted to drugs, or with suicidal ideations, may in everyday life experience powerlessness and lack of hope for the future, forming psychological stressors. In itself, such a perception of one's existence can be recognised as risk factors that negatively affect the course of life. A basic assumption in this thesis is that emigration (see below) may also form a specifically challenging and stressful process in life, whereby one's earlier coping mechanisms no longer function.

According to Lazarus and Folkman (1984), psychological stress is a relationship between the person and the environment that is appraised by the person as taxing or exceeding his or her resources and endangering his or her well-being. Stress and coping emphasizes a transactional approach between stressful life events and emotional outcomes, and is said to be mediated by two processes: cognitive appraisal and coping. Cognitive appraisal is defined as the two-fold process by which people first evaluate or give meaning to the relevance of the stressful event (harm, threat or challenge) and then assess whether coping options exist for altering the stressor. Coping is defined as a state of *constantly changing* cognitive and behavioural

efforts to manage external and/or internal stressors, and conceptualized as a discrete response to a specific event (i.e. not as a trait, which the sense of coherence could be thought of). The state of response can be differentiated in two main ways; problem-focused coping and emotion-focused coping. Problem-focused coping is goal-directed, as it includes active strategies to solve or manage problems. Emotion-focused coping uses strategies directed at an internal restructuring of emotions associated with specific problems.

Suicide research has shown that stressful life events are associated with suicidal behaviour and the suicidal process (Nordentoft, 2007). In this thesis, based on the idea of health as having balance in daily life between one's vital goals, one's repertoire and environment, despite physical, psychological or social problems, the focus should also be directed towards individuals' repertoire to handle different external and internal stressors. However, coping, both as a part of one's repertoire and as a highly contextual state, could then also include such environmental aspects as equity and equality in health, and thus ethical and human rights dimensions.

Another basic assumption in this thesis is that *emigration* is a stressful process in life. Emigration is the process of leaving one's own country in order to settle permanently in another. Several studies have shown that non-western immigrants experience poorer than average health in Scandinavian countries (Povlsen, 2008). One possible reason for this may be the discrimination experienced by many people with non-western backgrounds in, for example, the labour and the housing markets. The individual lifestyles of immigrants may also play a part (Hogstedt, Lundgren, Moberg, Petterson & Ågren, 2004). Post-traumatic stress disorder has specifically been related to extreme negative life events before, during and after emigration. This condition can impair the social and psychological functioning of the individual (Richman, 1998). Previous research has shown that conditions in the receiving country alter the immigrant's health more than negative life-experiences before emigration (Sundquist, Bayard-Burfield, Johansson & Johansson, 2000).

As I regard substance abuse, suicidal behaviour and emigration as disruptive events in life (Riessman, 1993), I believe that narrative research aids the exploration of the meaning of the lived experiences of such discontinuities. This is especially so in the lives of young male immigrants, who have used illicit drugs and have attempted suicide in their efforts to cope and make sense of disruptive changes. This may also help to reduce stereotypes of "sex", "risk groups" or "immigrants" (Eastmond, 2007).

### 3.4. Pain and hope

Studying the lived experiences of cancer pain and quality of life over a ten years period, Ferrell (1995) describes pain as an experience that overwhelms the individual and consumes every aspect of life, physically, psychologically, socially and spiritually. Pain is described as being closely associated with psychological symptoms, such as anxiety and depression, and resulting in psychological effects such as the sense of loss of control or the feeling of diminished usefulness. Further, poor physical condition has been shown to be linked to suicidal behaviour (Colman, Newman, Schopflocher, Bland & Dyck, 2004).

Shneidman (1993) and Orbach (2003) argue 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. 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 may lead individuals to contemplate alternatives to their current situation, and might be viewed as a global suffering which has 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 the death of their body, soul and spirit, and in which their pain was contained (Eriksson, 1992, 1997; Wiklund, Lindström & Lindholm, 2006). In the present thesis, pain refers to the wide range of physical, psychological, social and existential experiences leading over time to a sense of loss of meaning in life.

Dufault & Martocchio (1985) emphasize that hope, as a multidimensional dynamic life force changing over time, has implications for feelings, thoughts and actions. Hope may therefore be experienced and communicated in a number of different ways, forming turning points. The complexity and magnitude of problems confronting the young men in this thesis from an early age may influence their problem-solving abilities or leave them with hopelessness. Trying to cope with the sense of hopelessness by substance abuse could eventually lead to increased vulnerability and become a part of their later suicidal behaviour (Nielsen, Bille-Brahe, Hjelmeland, Jensen, Ostamo, Salander-Renberg & Wasserman, 1996; Plutchik, 2000). However, as part of one's hope, coping may also involve both substance use as self-medication, body awareness, and actions to maintain culturally accepted everyday activities. When researching narratives of hope in men with spinal cord injury, Smith and Sparkes (2005) found the three kinds of hope used

by the men to be concrete hope, transcendent hope or loss of any kind of hope. In Norway, research is currently being carried out on the dimensions of hope in individuals hospitalized for suicidal behaviour.

Pain and hope, as all human lived experiences, for analytical reasons can be divided into parts or can be studied from different aspects. However, according to Sarvimäki (2006), in order to gain a deeper understanding of lived experiences on an ontological level, one has to transcend the division of, for example, pain and hope as corresponding to empirically based parts, because being, also in this thesis, is more than the sum of body, soul and spirit.

### 3.5. Identities, sense of self and masculinity

The concepts of self and identity can be defined in different ways. From a psychoanalytical perspective, Moore and Fine (1971) define identity as “the experience of the “self” as a unique coherent entity which is continuous and remains the same despite inner psychic and outside environmental changes”. According to Erikson (1977), identity denotes “both a persistent sameness within oneself and a persistent sharing of some kind of essential character with others”. Mahler, Pine and Bergman (1975) correlate “the syndrome of identity diffusion” with psychological characteristics of personality disorders to denote the failure in certain individuals to engage in relationships. Several studies have shown relationship problems in substance abusers due to what is believed to be a personality disorder and a disturbed identity development (Ravndal & Vaglum, 1994).

In this thesis, based on a phenomenological hermeneutic approach (which will be presented later) with the aim of trying to gain a deeper understanding of lived experiences of the social phenomena, the theoretical viewpoint presented above will not fit. Therefore, the sense of self is understood as constructed by social interaction in a certain context (Goffman, 1959). This socially constructed sense of self is also believed to guide moral actions, which thus are contextual and not thought to be pre-determined by a certain trait of “personality” or stages in a specific developmental process. From the perspective of symbolic interactionism, Goffman (1959) writes about the active construction of multiple identities according to the context. Within the field of narrative research on identity, several studies in autobiography, self and culture have been carried out. Bruner (2001) believes that the stories we tell about ourselves and others organize both the construction of self, and of one’s culture. Further, Brockmeier and Carbaugh (2001) present a wide range of anthropological and ethnographic studies of narratives giving voice to social relationships and locally embedded cultural meanings, informing the constructions of identities.

Male sex is a fate, masculinity is not. However, early sociological theory, as outlined by Witz and Marshall (2003), stated that men and women are naturally differentiated. From being preoccupied with the differences between men and woman, contemporary sociology focuses on power relationships and the social-political dimensions of several forms of masculinity (Scourfield, 2005). Of importance to this thesis, Connell (2005) theorizes about how these forms of masculinity are created through relationships. He emphasizes the importance of the relationship between men for how different forms of masculinity are constructed. According to Connell (2005), the reason for this is that the basic relationship both between men, and between women an men, has to do with power, and thus subordination and superiority. He calls this relationship hegemonic masculinity. Hegemonic masculinity is the model of local masculinity that currently has the most respect. Hegemony involves definitional power in relation to other ways of being a man. These other forms, such as gay sexuality, mental ill health or loosing control in intimate relationships, are subordinate to hegemonic masculinity. However, Connell (2005) argues that forms of masculinity change over time, as they are constructed through continuous marginalization processes and resistance to these processes. Young men, like those interviewed for this thesis, are therefore forced to consider several possible masculine identities. But, as Connell (2005) points out, the leading groups of men will still practice hegemonic masculinity, in which other men and women in practice are subordinated through power structures and division of labour. Killing oneself might be culturally viewed as a “masculine” act by male substance abusers in the Western world, as traditional gender roles may still be relevant in daily life (Canetto, 1992-93; Möller-Leimkühler, 2003; Webster Rudmin et. al, 2003).

### 3.6. Protecting factors

According to Wasserman (2001), what make the difference between life and death is not only the presence of risk factors, but also the presence of protective factors to build sufficiently strong defences against suicidal impulses. A social and cultural context, with the experience of meaning for the individual's and the family's life, seems to be part of such protective factors. Hawton (2005) identified preventive factors that may inhibit translation of suicidal thoughts into self-harm, i.e. suicidal attempts of mixed motivation with the intention of death among youths, to include social support and personal beliefs against self-harm and suicide. Cullberg (1991) has highlighted the importance of protective factors such as social network, employment and experiencing meaning as more general means to promote mental health. Skogman (2006) found factors which might prevent suicide attempts, in the view of the individuals who recently had attempted

suicide, to include improvements in the professional help offered, and improvements in one's own capabilities to deal with problems and to seek help. In order to understand and help individuals who attempt suicide in the best possible way, Skogman (2006) argues that it is important for clinicians to consider different perspectives of suicidality, especially the perspective of the suicidal individual herself or himself.

The Swedish Minister of Public Health publicly announced in June 2007 a "zero-vision" on suicide, indicating the direction of future actions led by the national preventive programme in Sweden. The statement is understood by actors in the field of research and prevention of suicide as a very important message about the direction for future work, not as a goal in itself (Riksförbundet för SuicidPrevention och Efterlevandes Stöd, 2007). However, it could probably also function as a foundation for research on protective and salutogenic factors. From a macro-level perspective, a "null-vision" on suicide may reinforce social integration by alleviating socio-economic inequalities in suicide (education level, income, marital status). Lorant, Kunst, Huisman, Bopp and Mackenbach (2005) point to the necessity of improving support from the family, fostering community mental care and providing after-care support when people are discharged from psychiatric wards to groups with low socio-economic status. Interestingly, from a Durkheimian view, this European comparative study did not show that countries with more comprehensive welfare policies had a lower buffering effect of being married. Marriage was a protective factor, especially for individuals with lower socio-economic status, and especially in Norway. In this thesis, individual or societal protective factors are labelled turning points.

### 3.7. The inner perspective - the need for an idiographic approach

In the last few decades, researching the inner perspective and meaning of a wide variety of phenomena has gained importance (Williams, 1984; Ferrell, Grant, Padilla, Vermuri & Rhiner, 1991; Kitzinger, 1995; Honkasalo, 1998; Smith, 1998; Råheim & Håland, 2006). Within suicidology there has been a commitment to understanding suicide behaviour both in general (nomothetic) and in particular (idiographic), and it has been recognised that both the general and the unique are critical to the development of any science. However, to my knowledge it was not until 2002 that the scientific journal *Archives of Suicide Research* explicitly called for more qualitative research in this field (Leenaars, 2002). Yet the study of suicide notes and psychological autopsies has had a place in suicide research from before that time (Shneidman, 1985). To a large extent suicide research has been carried out according to medical research traditions and according to a positivistic paradigm. Focusing on the distribution of independent variables, means, statistical significance and generalizations, Leenaars

(2002) rhetorically asks whether such generalizations help clinicians to come closer to preventing individual suicidal behaviour, or whether generalizations are relevant for people receiving treatment.

Although there has been a vast amount of research about suicide, few studies focus on the inner world of the suicidal individual, or those who are left behind (Talseth et al., 2001; Leenaars, 2002; Skogman, 2006). Yet, in recent years, interest in suicidal behaviour as experienced by the individual has been given more attention. For example, Shneidman (1998) focuses on the importance of studying the phenomenology of suicide as “the drama in the life of the mind”, and Beskow (2005) presents a model labelled “the language of suicidality” in which he attempts to view suicidal behaviour from an inside perspective. Hammerlin (2005) calls for a more holistic understanding of the phenomenon, by means of research based on subject-in-context and interpretation of the inner-perspective of the people in question. To come closer to an understanding of and the language of such a subject-in-context drama, addressing *metaphors* seem to be helpful (Rhodes, 1984; McMullen, 1989; Levitt, Korman & Angus, 2000; Kirmayer, 2004).

Much has been written about the function and meaning of metaphors (Steger, 2007). Here, the term metaphor will be used in a wide sense, expressing one aspect of experience in terms of another and also suggesting that metaphors provide the possibility to interpret human understanding of reality on an ontological level. Talking about pain and hope, identities and self, may be difficult for various reasons, as substance abuse and suicidal behaviour are not usually part of everyday life. Therefore, metaphors are particularly likely to be used in situations in which ordinary language seems inadequate. According to Kirmayer (2004), metaphors can also be used to explore the cultural diversity and micro-dynamics of pain, suffering and recovery. Kirmayer’s point of departure is the ability of metaphors to link sensory, affective and conceptual aspects of experience to explain how symbolic processes influence bodily experiences of pain and the emotionally charged meanings of suffering. In cases where trauma has occurred, talking directly about it could also create much anxiety. Such experiences and their meaning can then be mediated by metaphors.

Lakoff and Johnson’s (2003) cognitive-semantic theory of the metaphorical concept, claims, in line with Ricoeur (2003), that metaphors are not linguistic ornamental style, but that they potentially affect and change our conception of reality. According to Lakoff and Johnson (2003), this conception then guides our cognition and actions, and they introduce a typology of metaphors, divided into four types: structural, orienting, ontological and new metaphors, contributing in

different ways to explain and give meaning to all aspects of individual and cultural processes.

Lakoff and Johnson's point of departure is that structural metaphors are categorized by the fact that there is no particular difference between the literal and intended meaning of the utterance. In other words, such metaphors are less dependent on context, i.e. less interpretive. Orienting metaphors relate to the notion that human perception is a bodily process from experience within a cultural context. We both have, and are, our body, making us embodied socially (in place) and historically (in time). In contrast to structural metaphors, orienting metaphors then become more open to interpretation. As orienting metaphors are rooted in bodily and cultural experiences, they often organize whole systems of interlocking meanings. Ontological metaphors assist individuals to handle their life experiences by quantifying, identifying or explicitly motivating actions. New metaphors are generally structural, but add a dimension of coloured experience to the meaning. The function of colouring is to emphasize, tone down or hide different aspects.

By drawing one's attention to, identifying and analyzing the interviewee's use of metaphors, it is possible for me to arrive at a deeper understanding of the phenomena under study on the micro-, meso- and macro levels, as language is held to reflect socio-cultural realities (see chapter 4). This can be important when public health researchers try to understand and communicate relevant individual experiences and knowledge related to political, historical and cultural contexts (Riessman, 1993).

To sum up, the task seems to be how to develop a fruitful cooperation between quantitative and qualitative research in public health and suicidology. Idiographic studies, for example from a clinical context, can provide a source of hypotheses about the complex aetiology of suicide, and inspire other clinicians with similar cases, or initiate quantitative research testing the actual hypothesis. On the other hand, nomothetic studies can be applied in the discussion of the findings of qualitative studies, indicating the effectiveness of different theories in a differentiated understanding of suicidal behaviour (Lester, 2002). In the end, it is the research question that determines the choice of research method and the method of data analysis.

On this background, the aims of the thesis were to be achieved by addressing the following research questions:

1. How do young men with substance abuse construct meaning when narrating their experiences of suicidal behaviour? (Paper I)
2. How was meaning and sense of self constructed by the use of metaphors? (Paper II)
3. How can knowledge about client's sense of self be identified and used in recovery? (Paper II)
4. How do young men with emigration, substance abuse and suicidal behaviour construct meaning when narrating their experiences? What impact do these experiences have on health, well-being and coping? (Paper III)
5. How are life-threatening overdoses experienced by male drug users and by health and social professionals after Oslo adopted several strategic choices in 2002? (Paper IV)
6. How do health and social professionals perceive the support they are provided with to prevent life-threatening overdoses in the context of recent changes in the Norwegian health care system? (Paper IV)

## 4. METHODS AND METHODOLOGICAL CONSIDERATIONS

### 4.1. A qualitative approach to scientific knowledge

The fact that more than one million people in the world commit suicide each year (WHO, 2007) means that no single research method or combination of several methods can capture the whole and complex reality of the phenomenon. Over the last few centuries, a transition has been observed of the public health challenges of the Western world, from infectious and life-style diseases to relational ill health. This may be one of the reasons for the need for qualitative studies of health, ill health and quality of life (Hjort, 1993). Relational ill health, then, requires an understanding of variations, structures and processes in life-world phenomena that are not fully understood or described.

From a social constructivist perspective, Burr (2003) points out that individuals have a relationship to their surroundings. This makes our perception of ourselves, and our relationship to others, relative, dependent on time and place, and on our social, historical and cultural context. As a reaction to the notion that *one* reality exists, to a reductionistic view of the human being, and especially to the idea

that scientific knowledge can only be acquired by direct observation, social constructivism, developed as a critical perspective within the humanities and social sciences, claims an idealistic ontology and the possibility to gain such knowledge by interpretation (Berger & Luckmann, 1967; Wenneberg, 2000). As I understand the broad concept of social constructivism, the question is whether or not social reality exists outside our human perception. An idealistic ontology claims that it does not.

On the epistemological level, I understand social constructivism to emphasize the possibility of a multiple construction of scientific knowledge. Hence, social constructivism does not seem to be a specific theory, but more a relative attitude to the world and how scientific knowledge is gained. It is further characterized by a critical attitude to “taken-for-granted” knowledge about the world and ourselves. A basic view is that scientific knowledge is constructed in social processes of interpretation. Language therefore constitutes a decisive element, because, among other things, language does not exist in a vacuum, but has reference to the world that we are part of. Further, it is assumed that scientific knowledge influences social action, and that these are therefore related. From such a perspective, scientific knowledge is to be constructed through social interaction, and hence will be expressed by language (Gergen, 1985). Language, through written narratives, can therefore be studied to construct scientific knowledge. Within the frame of social constructivism, researching social phenomena, this thesis claims for a plurality in social realities and an epistemological possibility, by interpretation, to generate scientific knowledge by improving and deepen our understanding of the constructed meaning of substance abuse and suicidal behaviour. Based on these presumptions, I argue that the research methods chosen for this thesis are credible.

Research methods are not neutral or free of value (Denzin & Lincoln, 1994). Qualitative studies are carried out under specific basic assumptions of reality, the human being, knowledge, scientific research and methodology (Barbosa da Silva & Wahlberg, 1994). The underlying assumption of my work is that there is neither a single absolute truth in social reality nor one correct interpretation or understanding of human experiences and existence. Social reality is assumed to be multiple and constructed, and our perceptions of it are mediated through a series of distorting lenses (Sandelowski, 1993; Rolfe, 2006). Claiming for such an ontological idealism advocates pluralism, relativism and subjectivity. In this thesis I present some of many possibilities of experiencing substance abuse and suicidal behaviour. The inside perspective emerging from the participants’ lived experiences has been the point of departure. Researching such ontologically subjective

phenomenon, Barbosa da Silva and Wahlberg (1994) argue that qualitative methods can be epistemologically objective when subjective experiences through robust scientific methods can be intersubjectively communicated and tested. I am therefore responsible for providing a systematic and coherent rationale for my choice of method and a clear exposition of the selected processes that have produced the findings, interpretation and conclusions of this thesis. Hence, the use of qualitative research interviews invites participants to speak about the perceived world in their own words, and qualitative analysis of perceptions are believed to provide scientific knowledge about lived experiences in a broader historical, social, and cultural context (McQueen & Henwood, 2002). Thus, scientific knowledge, understood as constructed by intersubjective communication, may also be viewed as plural and uncertain (Foss & Ellefsen, 2002).

The qualitative methods I have used in my work provide the opportunity to capture different kinds of knowledge of substance abuse and suicidal behaviour: ideographic knowledge about the individual participants' subjective meaning and the interaction between the participants and society, and scientific knowledge from the evaluation of the community of researchers (Barbosa da Silva & Wahlberg, 1994). In order to gain a deeper understanding of the meaning of substance abuse and suicidal behaviour, a narrative method based on a phenomenological hermeneutic philosophy was conducted in Papers I, II and III. Paper IV, a case study, was intended to provide a holistic description and context-specific exploration of how life-threatening overdoses are experienced and prevented. The aim of the methods used has been to derive data collection techniques and analysis from the research question, rather than vice versa.

Table 1. Overview of aim, method and participants included in the thesis.

Paper	Aim	Method for data collection and analysis	Participants
I	To illuminate and interpret the lived experiences of suicidal behaviour in young men suffering from long-term substance abuse	In-depth interviews and phenomenological hermeneutic analysis	4 (aged 32-40)
II	To investigate and interpret the lived experiences of the sense of self in young men recovering from substance abuse and suicidal behaviour	Same as Paper I, followed by an anthropological analysis of metaphors	Same as Paper I
III	To illuminate and interpret the lived experiences of emigration, substance abuse and suicidal behaviour in non-western men in Scandinavia	In-depth interviews and phenomenological hermeneutic analysis	4 (aged 30-40)
IV	To describe the lived experience and professional challenge of preventing life-threatening overdoses in male substance abusers in Oslo	In-depth interviews and narrative analysis  Written accounts and narrative analysis  Focusgroup discussions and content analysis  Non-participant observations and anthropological analysis	Same as Paper I  4 (aged 23-55)  3+6  8

## 4.2. Papers I, II and III - researching lived experiences

Three of the four studies were carried out under the ideas of phenomenological hermeneutic philosophy. A brief description of the ideas of this philosophy is therefore given. Hermeneutic, originating from the tradition of interpreting religious and juridical texts, has been developed during the last 200 years or so from what was called a methodological hermeneutic, represented by Schleiermacher, to a more philosophical hermeneutic, inspired by Heidegger, Gadamer, Merleau-Ponty and Ricoeur (Allwood & Erikson, 1999). The latter is oriented towards understanding and the interpretation of texts.

Ricoeur's phenomenological hermeneutic philosophy seeks to integrate Heidegger's view on human existence as "being-in-the-world", that is subjects being related to an exterior and inner world at the same time, with the ideas of hermeneutic (Ricoeur 1976; 1984; Hallberg, 1999). One of Ricoeur's major ideas is that meaning, understanding and knowledge are primarily based on a hierarchical process of interpretation by telling, listening to and reading a text. Furthermore, he adds an ethical dimension, arguing that we do not understand anything new until our pre-understanding (horizon), and thereby our appropriation and actions, are changed.

Ricoeur's theory of interpretation (1976) gives the researcher the means to deal with the meaning of a text, in a way that makes new understandings possible. His point of departure is how the hermeneutic circle is entered. The hermeneutic circle is a metaphor for the process between a text and a reader, forming a set of hierarchical relationships between the different parts of the text and the text as a whole. Interpreting a text is not, according to Ricoeur, to realise or understand the intention of the narrator, but to understand the meaning of the text itself. It is conceived of as the directions of the thoughts that are opened up by the text's referential function. What is opened up, is the disclosure of new possible ways of being in the world. To understand the text is to follow its movement from what is said, the manifest description, to what it talks about, i.e. human conditions. By this, Ricoeur (1976) tries to bridge the gap between explanation and understanding, as both the semantic and the discursive dimensions of the text are examined.

The hermeneutic circle is, according to Ricoeur (1976), to be entered by making a first attempt to grasp an intuitive understanding of the text. To search for the meaning is to facilitate a phenomenological attitude to the text, refraining from making judgements about the facts and to be open to what the text tells about being-in-the-world. This first naive interpretation is the first comprehension of the relationship between the

whole and the parts of the text, and the researcher must reflect upon whether the naive interpretation is credible or whether the result of the interpretation are pre-understandings.

Then, to explain the parts of the text, the process of distanciation is a way of dealing with the reader's/researcher's pre-understandings, trying to put the context aside and deal with the text as text. Explanation thus becomes the dialectic counterpart to understanding in the interpretation process, and explanations are means to deepen and expand understanding. Explaining the text is a way to validate the naive interpretation, and is done by means of (different) structural analyses. By explaining the structure of the text, it is possible to comprehend the meaning of the text.

The last step in the hermeneutic process is to merge the suggestions for interpretation, trying to grasp the inherent meaning and thereby opening up a new perspective. By re-contextualizing the findings and confronting different interpretations, a new, deeper understanding can arise. It is not so much a question of making a decision between plausible interpretations, but of actually confronting different interpretations, and searching for new ways of understanding the text. According to Ricoeur (1976), by having an open attitude to the text, and by listening to what the text wants to present, the author and the reader will have a changed understanding of the text and of himself/herself, opening up new possibilities in life. Thus, understanding may guide possible references of being-in-the-world, reconfigured as a new pre-understanding and appropriation in the reader.

One has to keep in mind that Ricoeur's interpretation theory presents *ideas* concerning interpretation of texts and the nature of understanding of human phenomena, rather than an empirical method describing how to interpret a narrative in order to arrive at a more comprehensive understanding. To analyse stories transcribed into written text, inspired by Ricoeur's philosophy, I turned to already developed empirical methods (Lindseth, Marhaug, Norberg & Udén, 1994; Lindseth & Norberg, 2004), as outlined below.

### *Narrative methodology*

According to narrative methodology, to narrate is a prerequisite for human existence and necessary for exploring, organizing and expressing our lived experiences, memories and self (Polkinghorne, 1988, 1991). By remembering the remembered, a story constitutes a dialectic between the past, the present and the future (Gergen, 1994). The temporal dynamics between lived experiences (there-and-then) and context (here-and now) have the function both of meaning-making

and identity by interpreting subjective experiences (Gibson, Acquah & Robinson, 2004). The most basic way to gain understanding and meaning out of our own experiences is to narrate them and to listen to others' narratives (Polkinghorne, 1988). Narrativity represents the ability to narrate, whereas narration represents the narrating process, and narratives are the result of this process. Types of narratives are the myth, the legend, the fable, the short story, the novel, the tragedy, the comedy, the film, the cartoon, artwork, the life story and human discourse or dialogue (Ricoeur, 1984).

Narratives describe the experiences of a person, experienced in a life situation, but they are not held to be identical with the situation, as they are constructed after the event. Narrativity, narration and narratives can be said to represent a consciousness raising, a verbalization and an interpretation of an actual experience. The lived experience becomes the object of reflection in order to make it possible for the person to create meaning and coherence and thus be able to anchor their existence temporally.

Narrative research is, under certain basic assumptions as presented earlier, believed to be an appropriate method for constructing scientific knowledge out of lived experiences (Mishler, 1986). Social constructivism designates the understanding that human beings are born into a social world and from their earliest moments live their lives inextricably bound to the social matrix, particularly by language, which serves as an a priori interpretative framework for experience (Wenneberg, 2000; Burr, 2003). Thus, social life has a determinant role in establishing not only what experiences an individual will have, but how these experiences will be interpreted and understood. Biographical narrative accounts are then a form through which this interpretation is mediated.

Narratives can be described as a number of coherent events with a beginning, a middle and an end, including the temporal aspect (Labov, 1982; Polkinghorne, 1988; Riessman, 1993). Bruner (2001) states that a narrative account must have at least two characteristics. It should centre on people and their intentional states, and it should focus on how these intentional states lead to certain kinds of activities. Yet, several elements regarding the form or the content of narratives might be required to build a narrative that is conducive to analysis (Labov, 1982; Kleinman, 1988; Frank, 1995; Charmaz, 1997; Hydén, 1997; Liebllich, Tuval-Mashiach & Zilber, 1998). In this thesis, narratives of experiencing substance abuse and suicidal behaviour are understood as entities that are distinguishable from the surrounding discourse (Labov, 1982). As a beginner in doing narrative research, it felt somewhat more methodologically secure to use such a strict structural approach,

but also because Labov's definition of a personal narrative focuses on individual meaning in the evaluation part of the narrative account (presented on page 44). This could facilitate the process of explanation.

Narratives are highly context sensitive and determined by situational factors (Hydén, 1997). A narrative form of interviewing, i.e. the way the interview is prepared and conducted, is carried out under the notion that both the narrator and the listener are active participants in the creation of the understanding of the lived experience (Mattingly, 1998). Relevant to this thesis, the idea is that open-ended unstructured narrative interviewing provides possibilities for the speaker to make choices about what to narrate, to interpret his earlier experiences, and to obtain meaning and identities. The possibilities for this are greater with unstructured narrative interviewing than with structured questions on different themes (Ricoeur, 1976; Polkinghorne, 1988; Stern, 1989; Riessman, 1993). The epistemological challenge is to construct scientific knowledge out of the theoretical analysis of the narratives by intersubjective communication and testing (Barbosa da Silva & Wahlberg, 1994).

Wiklund, Lindholm and Lindström (2002) argue that to be able to narrate, one must be capable of comprehending and interpreting the world of human activities as a story, with content, involving different actors, and be able to grasp the events in terms of culturally recognisable and acceptable patterns. However, if this capability of different reasons is affected, this insufficiency of articulating events and experiences might *generate* experiences of ill health and bodily suffering (Hydén, 1997). In this thesis, one might suspect that long-term substance abuse, several life-threatening overdoses and other types of trauma experienced by the narrators could have affected this ability. Yet, being in residential care, or receiving out-patient services, influences both the participants' narrativity, narration and narratives in different ways. However, in this thesis, and in the papers, even if it is based on personal narratives of substance abuse and suicidal behaviour, in the end it is my voice you hear, except in the quotations. My considerations, issues and interpretations are presented in the final text.

From a philosophical point of view, it can be argued that there is an antagonism between the ideas of social constructivism and phenomenological hermeneutics. The reason is that social constructivism may claim that reality is interpretation, while a phenomenological hermeneutic notion is that there are realities to be interpreted. However, on an epistemological level, social constructivism applied to social realities, a phenomenological hermeneutic philosophy and narrative methodology could be argued to be related to each other by

assuming that understanding, meaning and scientific knowledge are developed through language, relation and context.

### *Participants*

The issue of the choice of participants, or selection, is related to credibility, because for the data to be credible the individuals in the different samples must be able to talk about the chosen themes out of their own experiences. The samples were purposeful, as the purpose of the studies was not to generalize the findings to a larger population, or to explain relationships between cause and effect, but to describe, explore and interpret to obtain a deeper understanding of the phenomena of substance abuse, suicidal behaviour and emigration.

I wished to contact special individuals, who, through their personal experiences with substance abuse and suicidal behaviour, could talk in depth about the subject. Because of the skewed gender and age distribution in relation to premature death and overdoses, I chose men over 25 years of age with a career of dependence on opiates and other drugs in Papers I, II and III. I chose participants from treatment institutions where I had no responsibility at that time, so that they would not feel any pressure to participate or have any kind of dependent relationship to me. The participants had more than five years' experience of the drug scene, in order to discuss the characteristics of the culture and drug dependence in depth. I chose participants who were not under the influence of illicit drugs, so that they could reflect and express themselves verbally about the subject. However, some were on medication-assisted rehabilitation, but not in the initial phase. It was also important that the participants were in a supportive environment, so that adequate information could be given before the interview, and follow-up could be provided if required afterwards (since the theme was so personal and sensitive). The participants were therefore chosen among men who had a full-time place at an institution, or who had contact with an institution or medical expertise. Eight men were interviewed for these studies. One participant in Paper III was recruited by word of mouth.

I was given help by the owners and management of different treatment institutions to contact individuals who could consider participating. In order to ensure confidentiality with a small number of participants, I do not disclose the participants' country of origin, but all the four participants in Paper III had spent their childhood in a country outside Scandinavia. Most of the eight participants had one or both parents still alive. One had a partner at the time of the interview and three had children who they had regular contact with. Several had work or were participating in work training within or outside the institution. They

had all been at the institution, or on medication-assisted rehabilitation, from between a few months to several years. One participant in Paper III received treatment for addiction while he was in prison and for that reason he was interviewed in the prison. For six of the eight participants in these studies their suicidal behaviour had taken place more than one year before the interview, one had attempted suicide within the last year, and one about four weeks before the interview. The interview was therefore delayed in order to have more time between the interview and the crisis.

### *Data collection*

For Paper I, II and III, I wrote to the owners and management of the institutions to obtain permission to carry out the studies and to obtain help to choose the participants. After permission had been given, I visited the institutions and met the potential participants so that I could introduce myself and tell about the studies. They could then assess whether they wanted to participate. After the presentation, those who wanted to participate contacted me, and arrangements were made for the interviews. The participants chose the place for the interviews, in order to create an interview situation that was as comfortable as possible. For practical reasons, one interview was done in the participant's country of origin. As a symbol that I valued the time they gave, the participants were given NOK 200 for the interview, handed over after the interview session. This was also stated in the information letter. In order to create a calm and relaxed atmosphere at the interview, the participants and I first had a cup of coffee and an informal chat. One of the participants had prepared dinner for us, and another had arranged a day-trip in the area where he lived.

I wanted to create a climate between the participants and myself that was as safe as possible and that inspired trust. Therefore, before the interview started, I asked the participants whether there was something they wondered about, or whether there was anything that needed to be clarified. I also told them a bit about how the interview would be carried out, repeated the purpose of the actual study, and explained about the sound recording equipment. The first interview was a pilot interview, to gain experience about the process and the content. One lesson I learned from this pilot interview was that I needed to be more silent in the interviews, to facilitate the telling of the narratives. The interviews were unstructured, with one opening question, which the participants could then associate freely around. The opening question in Paper I was: *“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 intention was that the participants should be able to tell what they wanted to tell

about their experiences related to suicidal behaviour. I asked probing and follow-up questions as required, and the interviews mainly had the character of a conversation, in line with the perspectives of Denzin & Lincoln (1994). Paper II was a secondary analysis of the data collected for Paper I.

For Paper III, the ethical committee had opinions about how the opening question should be formulated, with regard to cultural and social factors related to suicidal behaviour in African and Asian countries. Thus the question was formulated: "*Can you please tell me the story of how you came to Scandinavia, what it was like to arrive, and, if possible, also tell me how you became addicted to drugs?*" In all the interviews I tried to be conscious about the fact that these research interviews should not be a therapeutic interview, while at the same time I gave support to statements the participants made and the feelings that they showed. The interviews lasted between one and a half to two hours, and were ended by asking if there was something more they would like to add. After the tape recorder had been switched off, we sat and talked a little about how it had been to participate, and how the participant felt at that moment. I asked the participant if he felt that he needed some kind of follow-up. I made an agreement with all of them that I would contact them again in a short while to hear how they were. I carried out one interview at a time, because I wanted to be as observant as possible. I recorded the interviews on tape and transcribed them during the following one or two days. In connection with the interview session, I wrote down my own associations and experience of the dialogue, and the non-verbal communication as soon as possible, in order to supplement the account and the interpretation of the interview, in addition to what was on the tape.

I chose to interview the participants just once, even though in other narrative studies several interviews have been carried out with the same person (Trulsson, 1999). This was because of the sensitive theme for the interviews, and because I did not want to expose the participants to more stress than was necessary. To my knowledge, several of the participants received closer follow-up from staff after the interview due to the reactions they experienced. However, the participants shared their experiences willingly, and several of them said that no-one had talked to them *in this way* about their experiences and thoughts about what had happened. All said that they had been motivated to participate because "hopefully this can help others".

### *Data analysis*

In the Nordic countries, an empirical method for entering the hermeneutic circle inspired by Ricoeur's philosophy (1976) has

been developed and applied by nurse researchers and philosophers (Lindseth et al., 1994). Lindseth and Norberg (2004) emphasize the dialectic movement between understanding and explanation, and between the text as a whole and its parts, in order to get at the constructed 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, aiming to obtain a *first understanding* of the whole material. Lindseth and Norberg (2004) emphasize that it guides and provides the direction of the following structural analysis (step 2). In the naïve reading, each transcribed interview is repeatedly read by the researcher 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. In this thesis 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 there are several kinds of structural analyses that can be used to *explain* the text by identifying meaning-units and condensing them by formulating sub-themes and themes. In Papers I, II and III, Labov's definition (Labov, 1982) was used to identify meaning units in forms of personal narratives of substance abuse and suicidal behaviour. Labov argues that a personal narrative has two functions; first, to re-tell an experience, and then to evaluate the meaning of the experience from the perspective of the narrator. Labov claims that a fully-developed personal narrative has formal properties and 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, the personal meaning), 5) Resolution (what impact did it have), and finally 6) Coda (bringing the story back to the here-and-now).

In Paper II, metaphors from the meaning units in Paper I was extracted for further analysis (Steger, 2007). Inspired by Steger's anthropological method for analyzing metaphors, the analysis was carried out by first rereading all the text, and the process then proceeded with a search for metaphorical expressions in the personal narratives. Assisted by the co-authors, metaphors specifically representing the sense of self were then identified and selected.

The meaning units in forms of personal narratives (Paper I and III) and metaphorical expressions (Paper II) were then condensed. Condensation is to express the meaning of each meaning units in everyday words as concisely as possible. All condensed meaning units

where then analyzed for their similarities, differences and temporality. This process of analyst-constructed content of meaning formed themes (see Table 1, Paper III for an example). Finally, with the research questions and the naïve reading in mind, we again returned to the original text to interpret the personal narratives and metaphors in a broader context in step 3.

*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 clearly distinguish between the findings and the discussion, in Paper I we chose not to include illuminating literature as part of this step. Becoming more experienced with the research method, this was done in Paper II. The main theme of the studies was constructed by reflecting on the naïve reading and the structural analysis in relation to the actual research questions and the authors' pre-understanding. This represented a *comprehensive understanding*, or the main interpretation, of the meaning of the studied phenomenon.

#### 4.3. Paper IV- researching a contemporary phenomenon in its context

Case study design is recommended by Yin (2003) to obtain knowledge of a complex contemporary social phenomenon and to enable a broad analysis. The importance of *triangulation* is underlined, which means that the case study builds on information collected by using different methods and sources. Furthermore, continuously comparing different findings with findings from other sources contributes to a broader and deeper description and understanding of the case.

The sources of data in this study were fourfold. First, lived experiences from individuals who had actually been rescued from life-threatening overdoses were obtained. Second, focus group discussions were arranged with health and social professionals who have prevention of overdoses as one of their tasks. Third, non-participant observation was carried out to investigate how the initial care of persons who experienced a life-threatening overdose was handled. Fourth, relevant official documents, such as laws, regulations, reports from supervision, political documents and newspaper articles, were retrieved.

Public health science has been described as a multidisciplinary field involving the natural, social and human sciences. This means each discipline studies the health of human beings on its own terms and with its own methods (Hedelin, 2000). In a complex post-modern Western world, different types of triangulation can be used in public health research in order to provide a holistic view of the actual phenomenon. Denzin and Lincoln (1994) define triangulation as the combination of two or more data sources, investigators, methodological

approaches, theoretical perspectives, or analytical methods in the study of a phenomenon. These combinations result in four types of triangulation: 1) data triangulation, 2) investigator triangulation, 3) methodological triangulation, and 4) theoretical triangulation. Theoretical triangulation (Papers I, II and III), investigator triangulation (Paper II) and data triangulation (Paper IV) have been used in this thesis to increase the validity and interpretative potential of the data, and to provide multiple perspectives.

### *Participants*

In order to examine men's experiences of life-threatening overdoses and their personally assessed needs related to prevention of such events, biographical accounts from men who had experienced life-threatening overdoses in Oslo were collected. Staff from some local relevant in-patient and out-patient services were asked to assist in collecting the accounts, and they were provided with written and verbal information. At one in-patient service, I also gave verbal information to potential participants. In the end, we analysed biographical accounts from eight men of different ages, all representing men with a long history of substance abuse and life-threatening overdoses. As I do not know how many young men were asked to participate, I cannot assess what information they could have provided.

In order to investigate professionals' perceptions, attitudes and behaviour with regard to the prevention of such events, two focus group discussions were carried out, inspired by Kitziinger (1995). Participants for these groups were also purposefully selected, representing a variety of positions within the health and social services. All had several years of experience from the field. Further, the prevention of life-threatening overdoses was one of their explicit or implicit professional tasks. A total of nine health and social workers were recruited with the assistance of the Alcohol and Drug Addiction Service in Oslo and the state-run Emergency Service Headquarters.

During a period of six weeks in the spring of 2007 and the winter of 2008, I carried out 40 hours of non-participant observation in specific areas in the centre of Oslo. The aim was to investigate the phenomenon of life-threatening overdoses more authentically, that is, without the effect of the researcher. When such an event was identified, I got as close as possible, and if possible, for ethical reasons, acted the role of an ordinary member of the public. Eight events were identified and observed, all involving men. Field notes describing the events were made directly. Efforts were made to be as descriptive as possible. After the event, the field notes were organized and systematized chronologically and thematically. When analyzing the field notes in this

way, the empirical material was organized into qualitative data.

### *Data collection*

Data on men's lived experiences of life-threatening overdoses were collected in cooperation with different types of out-patient services for persons with substance abuse. For various reasons these accounts had been written down by staff. They were then sent anonymously to me, in line with the instructions given from the Regional Committee for Medical Research Ethics. In addition, lived experiences of being rescued from life-threatening overdoses were collected from the transcribed text in Paper I (Lieblich et al., 1998).

The idea of the two focus groups was that the group interaction and group processes could get professionals to produce data by exploring and clarifying their practice and views on the topic, in a way that would be less easily accessible in a one to one interview (Kitzinger, 1995). For practical reasons, the paramedics had their own focus group, so that this group was more homogenous than the other group. The sessions were held in a way that was practical, and thus not in a neutral place, and lasted for one and a half to two hours. The discussions were open-ended and unstructured on the basis of two guiding questions: 1) Who is involved in situations of life-threatening overdoses?, and 2) What is being done to prevent further life-threatening overdoses? The discussions were tape-recorded and transcribed verbatim.

The aim of non-participant observations was to investigate the phenomenon of life-threatening overdose more authentically, that is without the effect of the researcher (Hellevik, 1991). For this reason, I carried out about forty hours of non-participant observation in specific areas in the centre of Oslo. When a life-threatening overdose was identified, I got as close as possible, and if possible, for ethical reasons, acted the role of an ordinary member of the public.

Information from political-administrative sources was obtained by retrieving several relevant documents (Merriam, 1994). These documents were related to health and social services for persons with substance abuse, strategic choices to reduce life-threatening overdose in Oslo, or structural changes to the system. Data were collected electronically from different sources of the political-administrative and professional care systems.

### *Data analysis*

Lived experiences of life-threatening overdoses were analysed using a narrative approach aimed at identifying variations in how such an event

had been experienced over time, and then grouped into four parts: 1) What was before, is now a story of, 2) Experiencing life-threatening overdoses has been a story of, 3) What is now, is a story of, and 4) What will happen, is a story of (Sagvaag, 2007).

The professionals' perceptions, attitudes and behaviour with regard to the prevention of life-threatening overdoses and the support they are provided with to prevent such events in the context of recent changes in the Norwegian health care system, were transcribed into texts and analysed by manifest content analysis, inspired by Graneheim and Lundman (2004). The texts were read carefully several times to obtain an overall impression, followed by identification of words and sentences expressing a central meaning (meaning unit). Then the data were condensed without changing the original meaning (codes) and finally grouped into five categories by labelling the meaning. Efforts were made to create codes and categories with internal homogeneity and external heterogeneity. The five categories were: understanding one's task, structural issues, the preventive content of one's position, the autonomy of the client, and cooperation between services.

Non-participant observations were analysed in an anthropological fashion (Hammersley & Atkinson, 1987). Field notes describing the events were made. Efforts were made to be as descriptive as possible. After the event, the field notes were ordered and systematized chronologically. When analyzing the field notes, the empirical material was organized into descriptive qualitative data according to the categories: the scene, the actors, the activities, the objects in use, and the time spent.

The political-administrative sources were analysed with the research questions in mind. They were carefully read, reread, reflected on and analysed using a broad discursive approach aimed at identifying content, patterns and context, in order to grasp the social praxis (Merriam, 1994). In line with the principles of data triangulation, the different findings were also illuminated with information from the other sources, so that, for example, findings from the micro level could be assessed with findings from the macro level, and vice versa.

#### 4.4. The researcher's pre-understanding and positioning myself

My professional background is nursing. My view of humanity is based on the understanding within this profession of the human being as a comprehensive whole, comprised of physical, mental, social and spiritual dimensions (Karoliussen & Smebye, 1981). I therefore endeavoured as much as possible to have an egalitarian "I-you" relationship with the participants, to be open to the other's uniqueness

and not to be driven by prejudices. Apart from seeing human beings as a whole and unique, another perspective, among others, of my profession is to improve the health status of fellow human beings in need, and to raise their perceived control over their lives (Wallerstein, 2002). Identification of the person's resources is therefore a central part of the dialogue and alliance.

I am a man, a son, a partner and a father, of about the same age as the participants, with fifteen years of professional work experience of acute care, treatment and care of people with alcohol and drug problems. I have grown up under the same historical conditions as the participants in Papers I, II and IV. I do not know whether we have the same social class background. The differences between me and the participants in Paper III are greater, as they grew up in other parts of the world. This has influenced the contextual relationship between us, and also the data collection and interpretation. I do not believe that I have assumed the role of an expert. Thus, the participants may have dared to open up in a more personal way, and not felt any pressure to perform more than they actually did. Because I have long experience, the participants may have felt that they did not need to explain everything. My feedback to what they told me may have been regarded and experienced as adequate and relevant. As men, they may have felt in competition with me. On the other hand, this may have created a fruitful situation for dialogue, since I was prepared to talk to *them*, and to value their stories, without placing them in a sick versus health or cause versus effect dimension. In Paper IV, my personal and professional experience may have created a trustful relationship in the focus group discussions.

In the interpretation and analysis phases, an increasing theoretical sensibility gradually developed, so that after a while I was able to see different perspectives in the data. For example, my original theoretical point of departure in Paper I was a salutary perspective (Antonovsky, 1987). But the content of the data changed this to a communication theoretical perspective (Qvortrup, 1999; Beskow, 2005). When I was analysing Papers III and IV my father died. This could have influenced my interpretations. Personally, my work with this thesis has led to reflection over the following issue: Do we as human beings have the right, or the obligation, to exist, regardless of what we perceive as negative life situations? The theme of the right human beings may have to decide about their own death has been introduced at a societal level in our part of the world through discussions about euthanasia during the last few years. In summary, my practical and personal background, and my developing theoretical understanding and reflexivity, should have given me the possibility to arrive at a credible and reasonable interpretation of the data.

To keep the focus on the subjective perspective, the often tacit knowledge, as the point of departure for the scientific knowledge generated by this thesis, the notion of ill health and experiences of bodily suffering is replacing illness, as I find the concept of illness to still have some biomedical connotation. For analytical reasons I also describe the different interviewees as belonging to one group: young men living with substance abuse and suicidal behaviour, even though individually they are very heterogeneous.

#### 4.5. Ethical considerations

The principle of respect for persons incorporates two fundamental ethical principles; respect for autonomy and protection of vulnerable persons. When carrying out research on moral themes such as substance abuse and suicidal behaviour, ethical concepts must be taken into consideration and incorporated (World Medical Association, 2004). In the research, the risks of the research had to be considered in relation to the potential benefits. The risks of studying the life-world perspectives of substance abuse and suicidal behaviour in persons undergoing treatment are possibly large, as the intervention could have caused unpredictable and unforeseen harm. The risks of not interacting with individuals experiencing such phenomena and not gaining knowledge are also large.

With the help of either the management of the treatment centres or health and social services, potential participants received an introductory letter describing the project and emphasizing autonomy and confidentiality. In addition, they were provided with verbal information of the project and follow-up activities before deciding whether to participate (Papers I, II and III). If they agreed to participate, the time and place for the interview were arranged. A declaration of consent was signed by all participants in Paper I, II and III. Professionals in Paper IV gave verbal consent.

Participants may become distressed by recalling painful, frightening or life-threatening events, or by an insensitive interviewer. Therefore, practical follow-up activities after the interview session were planned in advance and every possible precaution was taken to minimize harm.

The studies in this thesis that involved individual interviews were approved by the Norwegian Regional Committee for Medical Research Ethics before they were carried out (Papers I and II, Dnr: 03143, Paper III, Dnr: 05023). One interview was reported, planned and carried out in accordance with the current regulations for research ethics in the relevant Scandinavian country (e-mail, November 25<sup>th</sup> 2005). Paper IV was carried out in line with the principles of the National Committee

for Research Ethics in the Social Sciences and the Humanities (2006). The part of the case study that included lived experiences in the form of written accounts was submitted to the Regional Committee for Medical Research Ethics, but the study design was not assessed by the committee. As long as this part of the case study was carried out anonymously, the committee had no objections (e-mail, April 7<sup>th</sup> 2006).

## 5. OVERVIEW OF THE FINDINGS

### **5.1. Paper I 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**

This study focused on the lived experiences and meaning of substance abuse and suicidal behaviour in some Norwegian young men who had attempted suicide. The aim of the study was to describe, explore and interpret these lived experiences.

The findings showed that in young men, escalating substance abuse and life-threatening suicidal behaviour are goal-oriented phenomena, embedded within a situation of poor family communication, problem-solving and loss of different kinds. This was initially experienced in the relationship between the participants and their fathers, and hence related to the constructions of forms of masculinity. These gender-specific problems existed before the start of their substance abuse. As a result of their unsolved relational problems, and increasing addiction, life came to be perceived as unbearable. The escalation of pain led the young men to contemplate alternatives to their current situation. 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.

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 the consequences of deteriorating substance abuse, pain affected the participants' thoughts and decision-making processes. When pain got the upper hand, leaving the person unable to perceive any future relief or help, escaping from pain was acted out and expressed through excessive substance abuse, and impulsive or planned suicide attempts.

To be rescued from dying could sometimes be experienced as a turning point in one way or another, and could be 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 also experienced as an important turning point of hope. Another resource that the participants drew on was to follow daily routines, such as school, sports and being with peers, which at times of trouble created a safe space and a feeling of belonging. When experiencing relationships as adults, nature, faith in God or their relationships with their own children, seemed to have had a protective effect in their difficult everyday life by providing a feeling of closeness. Belonging and closeness filled a sense of emptiness and created a more hopeful position in life.

Hope was experienced as different types of turning points, and in this state of mind participants felt more invigorated and optimistic. All participants experienced how decision-making and actions regarding life or death could fluctuate and turn. Being met in a subject-subject relationship, for example by health care professionals, was experienced as a protective factor. Access to psychosocial care when needed could also signalize that a better life might be possible. Attitudes, courtesy and the practical approach of health personnel were experienced as a life-saving turning point of reduced pain and creation of hope. Some participants told that they had found God. Then they experienced a turning point in which hope got the upper hand through providing a feeling that they were not completely on their own. This experience of having a nurturing relationship could function as a new platform from which they could see their complicated relationship (with their father) in a new way. Their relationship to nature could also bring about an external focus, which expanded their vision of life in times of distress.

The meanings assigned to the six identified sub-themes were constructed into three themes; the meaning of relating, the meaning of reflecting, and the meaning of acting. These were interpretive filters through which subjective experience was conveyed. The three themes described the lived experiences of pain and hope, and could be understood as living in a movement between different positions of whether to continue to exist or whether to end their life. Which of these positions they currently highlighted depended on their perception of being seen and confirmed in social relationships, their possibilities for verbal communication of existential thoughts, and their assessment of possible actions. The comprehensive understanding of the findings was formulated as *between death as an escape from pain and the hope of a life*.

The conclusion was that, as substance abuse and suicidal behaviour in this study seemed to be receptive, reducing pain and creating hope by

being seen and confirmed in social relationships, and being helped to verbalize existential thoughts and openly discuss possible solutions, are of importance. 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.

## **5.2. Paper II Metaphors of a shifting sense of self in men recovering from substance abuse and suicidal behaviour**

By attending to the symbolic language of metaphors in the personal narratives in Paper I, the purpose of this study was to describe, explore and interpret the individual experiences of meaning and shifting sense of self inherent in the process of these phenomena over time.

Substance abuse and its consequences caused the participants' consciousness to be directed towards their physical and social body, leading to a notion of having a body more than being a body. Having an (addicted) body means that one must take action to control one's body by external means (drugs). The loss of autonomy this process led to put the sense of self at stake, because the sense of loss was ultimately destroying the participants' dignity and self-worth when they could no longer act in accordance with cultural values. When internal locus of control forms the foundation of the contemporary conception of local masculinity, their perceived loss of control to substance abuse might have undermined their sense of self as men. This loss of control was constructed by an identity as a victim, being isolated and close to the point of no return, whereby the risk of suicide attempts increased.

However, when communicating their grief and anger by actions such as substance abuse and suicidal behaviour, the participants seemed to ground their preferred construction as an active self, taking moral responsibility for their lives. This type of communicative activity happened to be life-threatening. At some point the participants' active life-threatening behaviour facilitated one or several turning points. Such turning points emphasized subjectivity, and gave possibilities for the participants to reduce communicating distress through suicidal behaviour. In this position of still being on the edge with an unpredictable end of the story, professionals are provided with possibilities for validating the self and supporting alternative ways of acting. The structural analysis of the metaphors suggested that the participants constructed meaning and a shifting sense of self, labelled in three themes; being isolated, being close to the point of no return, and still being on the edge. As a whole, the different types of metaphors described a circular existence from life before the first suicide attempt, to the narrowed situation just prior to suicide attempts and then back to life as experienced after, and between, suicide attempts. Ultimately one,

or several turning points seemed to have changed the course of their lives to the better.

The comprehensive understanding of the findings was formulated as *balancing being a victim or an agent*. By using different types of metaphors and constructions of self in their narrative accounts, the participants recalled the struggle for keeping life-saving individual control of the balance between their own situation, abilities and knowledge, and social and cultural demands. Keeping, or loosing, this balance, embedded within both an intra-subjective and contextual framework, seemed to influence suicidal behaviour.

The conclusion was that metaphors impart subjective knowledge about individual existence. From a clinical point of view, to recognise this knowledge, and to facilitate its expression, could be of utmost importance in health and social care. Shifts in the sense of self, communicated by the use of metaphors, possibly reflecting shifts in a gradual suicidal ideation, could form an important part of the clinical evaluation of suicide risk by the treatment team. To engage in a mutual exploration of different possible interpretations of the participants' symbolic language might also lead to a change in the way the person perceives himself and his existence. Through narrating and metaphors, individual perspectives on pain, self, change, hope and recovery could be released, and form a resource in the professional-individual relationship. A holistic and phenomenological attitude towards the individual's lived experiences is then necessary.

### **5.3. Paper III Living in a maze: Health, well-being and coping in young non-western men in Scandinavia experiencing substance abuse and suicidal behaviour**

This study focused on the lived experiences of emigration, substance abuse and suicidal behaviour in some young non-western men in Scandinavia. The aim of the study was to describe, explore and interpret these experiences, and to investigate the impact they had on health, well-being and coping.

The participants' perceived insecurity in life was embedded within a pre-migrating situation of feeling different from others, mostly because they were the only or oldest son with special expectations put on them, but also due to war, civil war or conflicts with authorities. This was also experienced in the relationship between the participants and their fathers, and hence related to the local constructions of forms of masculinity. Such external or gender-specific problems preceded the start of their substance abuse. Emigration then functioned as a coping strategy aimed at increasing their possibilities to reach vital goals in life.

The process of immigration imposed an increasingly perceived insecurity on the participants in the new environment, and earlier coping strategies failed. They felt that they did not belong, and they were unsure about their identity and ended up in new conflicts. Lack of belonging was perceived as a feeling of being distanced from others. In this position substances were used to cope with distress. Drugs initially functioned as a doorway to relaxation and as an escape from pressure and insecurity. However, recreational use of drugs led to dependency.

As a result of the insecurity and the substance abuse getting out of control, life became perceived as unbearable. Living up to two sets of cultural demands was perceived as falling between two stools. The escalation of distress led the young men to contemplate alternatives to their current situation. Suicidal ideation, but also 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. The social death they experienced was transformed into thoughts of the possibilities of seeking a physical death. Suicidal behaviour was described as one step further on the path of dehumanization that they were already on. Killing themselves was experienced as a window they could approach, open and jump out of. The window functioned as a border, from where they could escape.

To be rescued from dying could sometimes be experienced as a turning point in one way or another, and could be followed by a reduction in substance abuse or by active seeking for help. Help and treatment were described as being initiated by being seen as a subject, and then getting the addiction under control, and finally as a positive reorientation in the relationship between themselves and their family.

The meanings assigned to the 14 identified sub-themes were constructed into three themes: the meaning of getting in a tight spot, the meaning of being in a fog, and the meaning of the burning bed, and thus became interpretive filters through which subjective experience was conveyed. The comprehensive understanding of the findings was metaphorically formulated as *living in a maze*. Entering the maze had started before emigrating, and the way out of it had not yet been found.

The conclusion was that ill health involved impaired possibilities to define and redefine goals by having a sense of liminality in an unknown environment. Substance abuse and suicidal behaviour were explicit expressions of not being well when living in a maze that was perceived as closed. Different coping responses were used in different situations to enhance health and well-being.

#### **5.4. Paper IV Preventing life-threatening overdoses in young men: the case of Oslo.**

The aim of the case study was to describe and explore how life-threatening overdoses in Oslo are prevented and perceived, in a situation where the city still has one of the highest incidences of deaths from overdose for men in Europe. By addressing contextual and structural issues, as well as lived experiences, triangulation of data was intended to arrive at a more holistic description and understanding of a contemporary phenomenon within its real context.

713 persons are officially registered as having died from overdoses in Oslo in the period 2000-2007, showing a decrease in prevalence from 132 (2000) to 109 (2007). On average 70-75 % were men, with an increasing proportion of non-western men. After 2004, no data on age, gender or ethnicity are available for Oslo.

The lived experience of substance abuse leading to an overdose is one of existential and stressful events. Being homeless created a sense of vulnerability, inflicting a wish for help. Internal factors, such as deteriorating ill health or ambivalence about the future, were described as leading to life-threatening overdoses from self-medication or to existential conflicts. Then the wish for follow-up was more explicit, but not necessarily expressed by the individual. Yet all except one reported that at some time they had been advised or helped by the paramedics to get some form of psychosocial follow-up after the acute phase, and they reported that they were satisfied with the help they had received. External factors, such as who they bought the drugs from, the purity and price of the heroin, and whether they injected alone or with friends who could manage life-saving tasks, also seemed to be vital factors for how life-threatening overdoses were embedded and experienced. Three of the eight persons in the sample had been taken to the emergency unit or to a detoxification unit. One reported that his mental health status had been assessed at the time of overdosing.

The focus group discussions gave the impression that the physical condition of substance abusers has improved, especially for those living in sheltered homes, and more recently, as a result of mental health nurses and the injecting room. It was reported that over the last few years, the number of substance abusers who were born in other countries (or who had parents who were born in other countries) had increased, so they also face a higher risk of overdose-related deaths. It seemed a challenging task for professionals to implement preventive measures and to communicate about drug problems with this group of the population. Professionals understood their tasks very differently. The paramedics highlighted the importance of maintaining

vital functions, whereas the social workers emphasized the process of change.

Both groups addressed the lack of goals, guidelines and routines, and verified that follow-up and prevention of further events is not carried out in a planned or coordinated way. Structural problems created discrepancy between potential access to health and social services and real access for people in a vulnerable group who are in need of public health services that are in concordance with their needs in order to survive. People with intoxication from heroin who are in need of a hospital check-up for mental health problems or suicidal behaviour, but who do not want to be taken by the ambulance to the hospital, seemed to be a specific problem. On the other hand, the paramedics also reported problems in mobilizing the street-based social service when they were needed for following up and preventing further life-threatening overdoses.

The non-participant observations of life-threatening overdoses on the street identified three types of intervention. In one type the ordinary public intervened and assisted in getting the person on his feet. In another type, the paramedics had to intervene medically and the person was left, or left the scene, after some minutes. One of the eight persons who was observed was taken away by ambulance. The last type involved both the ambulance, other out-reach services and/or the police. On this occasion, people from the out-reach services stayed with the person for a while. All the people who were observed receiving help from the paramedics for intoxication were men with white skin. The age of the men was not possible to determine, but some of them had some grey hair. At the time of the observations, four of the intoxicated people were alone, and the other four were with peers. All were in a public place with ordinary people watching at least some part of the event.

Analysis of documents revealed that in Oslo there are no explicit political or professional targeted goals or guidelines to prevent such events, including when the person has suicidal intentions. Since the municipality of Oslo is a goal-oriented organization, one might speculate whether the lack of epidemiological and gender-based goals and professional guidelines to support staff, has negative effects on processes and cooperation at lower levels. As part of a nationwide supervision, the Norwegian Board of Health Supervision examined the chain of events from when an emergency service is informed that an unconscious person has been observed until the pre-hospital service has completed dealing with the event. The findings showed that the emergency service, including Oslo, did not always follow the Index (the professional protocol). For several emergency events, the

emergency service did not collect adequate information about the patient's vital functions, nor did they follow up what happened to the person if referred to another service.

The documents analyzed in this study, and especially the reports from the Norwegian Board of Health Supervision, stressed the importance of better coordination and cooperation in the services for substance abusers. The official reports of countrywide supervisions of emergency and social services for substance abusers, including some services in Oslo, also revealed problems with provision of services that fulfil the requirements laid down in the legislation.

To summarize, life-threatening overdoses can be viewed as a communicative activity and a process of coping in a vulnerable and stressful situation, often in the context of long-term life problems on different levels. Subjects do not necessarily express a wish or need for medical or psychosocial follow-up, so health and social professionals must adopt a sensitive approach in every encounter. Professionals do not seem to cooperate in cases of life-threatening overdose, nor do they seem to coordinate their preventive services. This can create a discrepancy between potential access to health and social services and real access for people in a vulnerable group who are in need of public health services in order to survive. The municipality of Oslo is responsible for the prevention of such events, and are in need of explicit political and professional goals and written guidelines to support professionals in a divided system.

## 6. DISCUSSION

### 6.1. Psychosocial dimensions of health related to substance abuse and suicidal behaviour

The aim of this thesis was to describe, explore and interpret the constructed meaning of suicidal behaviour in some young men receiving treatment for substance abuse. The aim was also to describe and explore how life-threatening overdoses in Oslo are prevented and perceived by individuals living with substance abuse, and by professionals.

In this thesis the problems of substance abuse and suicidal behaviour in young men is defined as a new public health issue. According to the underlying ontological assumptions, these phenomena are embedded in the social construct and social matrix experienced by the individuals. This calls for a collective understanding of *public*, and a holistic understanding of *health* (Nijhuis & van der Maesen, 1994). Collective meaning-making systems are believed to forego individual motives and

actions concerning life and death, freedom and responsibility, closeness and isolation, trust and mistrust. They then become important factors to focus on in public health research.

The young men in my studies reported that existential life experience affected their health and well-being from early childhood or adolescence, and that their experiences developed over time and at different stages of life. Most probably their experiences will affect their future health in one way or another. Substance abuse and suicidal behaviour caused ill health and serious bodily suffering, not only for the participants, but also for their families or significant others, and therefore created a need for a wide range of health and social services over a long time. Economic factors then come into play.

The findings in the studies have been discussed in each paper. In this general discussion I will elaborate on some of the main results and their public health implications. Inspired by Allardt's (1978) model of Nordic welfare (the material and impersonal vs the non-material and social), the discussion of the psychosocial dimensions of health related to substance abuse and suicidal behaviour is organized in three overriding themes. Allardt defines welfare as a state where people are able to satisfy their central needs, thus possibly related to both health (Pörn, 1993) and health promotion (MacDonald, 1997):

1. Having health is expanding one's territory
2. Doing health is doing gender
3. Being healthy is being enable to verbalize.

6.1.1. Having health is expanding one's territory

#### *Substance abuse*

Acting out substance abuse seriously reduced the participants' life space and level of living over time. My findings show that a major element in the young men's experiences of substance abuse is the perception of having a painful life (Papers I and IV), with an increasing sense of being a victim of external forces (Paper II), ultimately closed in without seeing any way ahead in life (Paper III). One of several outcomes was the perception of having lost everything in life (Papers I, II, III and IV). The origin of these experiences was to be found in the social matrix of early life, such as a family breakdown or emigration. An overlapping issue seems to be that such early life experiences, and subsequent life situation, narrowed their territory by social marginalization. Means to create welfare and spaces in life, such as education and employment, problem solving, decision-making and social interaction, may become more difficult when one is marginalized and addicted to drugs (Johnsson, 2002).

The use of drugs was initially introduced to ease a wide range of pain in the participants (Papers I, III and IV). However, after a positive effect, using drugs brought about stigmatization and ambiguity of one's sense of self as both subject and object. Symptoms of withdrawal led to a painful objectification of the body in the participants, exemplified by Vidar, telling that in the end it was drugs that got him on his feet on a daily basis (Paper I). Honkasalo (1998), in a phenomenologically inspired ethnographic study of chronic pain in Finland, found long-lasting pain to be an experience of alienation and of feeling homeless in one's body. If the body becomes an alien urging for repeated intake of drugs on a daily basis, one's life space may shrink towards (only) satisfying physical bodily demands here and now and one may become less capable of fulfilling one's different needs and wants (Paper IV).

Safety in treatment was a prime concern for all the participants, and formed an important foundation for having health as expanding one's territory. One participant expressed this in the following way: *"I never felt secure, as the most important part of my problem was missing. I could not handle the force of the drugs."* When he was given treatment for both substance abuse and psychosocial problems, he felt safer and found it possible to plan to extend his territory (Paper III). As opiates are harder drugs than most other substances, both in intensity of effect and frequency of injection, greater dependency on them may have a negative influence on the changes needed for completing treatment and recovery (Papers I and III). In a follow-up study from Sweden, Ågren, Anderzon, Berglund and Dundar (1993) report that people abusing opiates had a significantly worse outcome one year after completion of treatment than those abusing amphetamine. The two groups did not differ in any specific way. In a recent cohort study of Norwegians with substance abuse, Ødegård, Amundsen and Kielland (2007) found duration of abuse to be a risk factor for premature death from a fatal overdose. In individuals with a long duration of substance abuse, my findings highlight the importance of controlling substance abuse at the same time as treating mental ill health and also dealing with psychosocial problems related to unemployment, education and housing (Papers I, III and IV).

However, at the time of interviewing, all the participants in Papers I and III had managed to co-operate with the health and social system to be referred, and to continue, with treatment, indicating hope for the future and transformation of demanding experiences into personal growth as part of their repertoire. Some of the participants in Paper IV were more ambivalent about the future. All participants, except two, who were being followed up as outpatients, were on social welfare, indicating the stabilizing and positive effect of having at least some control of their income as a necessity for continuing treatment.

Contradictory to the participants who grew up in a non-western country, the Scandinavian participants used alcohol at a very early stage as a means of alleviating pain, coping with identity problems and creating good feelings. However, this caused more suffering in the long run (Beskow, 1979) (Paper I and II). The alcohol (ab)use started with peers and in sports, indicating possible specific meaning-making rituals in men, which are discussed below. The alcohol (ab)use rapidly developed into psychological dependency, and was followed by abuse of cannabis and other hard drugs, including injected heroin.

At the time of narrating, all the young men in Papers I and IV had experienced serious polydrug abuse, narrowing their territory towards ending at rock bottom where the perceived level of living and quality of life was like zero. In a Norwegian prospective follow-up study on the impact of comorbid psychiatric disorders on the outcome of substance abuse, Landheim, Bakken and Vaglum (2006b) found that 11 % of the original sample had died, of whom 18 % were men with alcohol abuse compared with 6 % of men with polydrug abuse. Only one person was registered as having died from suicide (however, in seven cases information on cause of death was lacking). This indicates the importance of not neglecting the high mortality from alcohol abuse also in young men suffering from addiction to illicit drugs. The question of attitudes towards, and availability of, alcohol then also comes into play from a health promotion perspective.

### *Poverty*

The findings from these studies support the Danish finding of a positive effect of easy access to low-threshold psychosocial care and treatment for individuals at risk of suicide (Nordentoft, Branner, Drejer, Mejsholm, Hansen & Petersson, 2005) (Papers I, IV). This seems especially important for people who are homeless, for example people living in a shelter, in the street or staying with friends (Papers I, III and IV). These are situations in which one's environment and level of living become both insecure and risky. The participants perceived such a situation as a highly painful experience that gave them a sense that everything in life was lost. In a Swedish study, individuals' own experiences and views on suicidality and its origins, and what might prevent suicide attempts were investigated (Skogman, Ågren Bolmsjø & Öjehagen, 2006). These researchers showed that it is important to meet basic physical needs such as regular eating and sleeping as a means of preventing vulnerable people entering an acute suicidal state of mind. This was also heavily emphasized by participants in my studies (Papers I, III and IV). Receiving non-judgmental help, when feeling left behind with few resources turned suicidal ideation and plans in a safer direction. This finding supports the results of Cutcliffe, Joyce and Cummins' findings

(2004), that if we view a person's suicide as the endpoint of a complex process of external and internal factors, then there are likely to be several occasions when health and social professionals can intervene with a wide range of actions to prevent a person committing suicide. Recognising individuals in need of material and psychosocial assistance, instead of generalizing about "drug abusers" or "males", seems to be necessary in order to make encounter turning-points for revising vital goals. Then, paying attention to the individual language of suicidality becomes an important task also from an environmental point of view (Papers I, II, III and IV).

The recent national strategy to reduce social inequalities in health in Norway aims at implementing special measures to help individuals with the most problems (The Ministry of Health and Care Services, 2006-2007). The government acknowledge that, in a tradition of general welfare schemes, Norway is a stratified society, where the most privileged ones (in economic terms) have the best health. The inequalities in health are assumed socially determined, unfair and modifiable.

In my studies, environment in the form of lack of material resources added to the participants' sense of entrapment, and thus gives empirical support to the model of suicidal behaviour as a cry of pain (Williams, 2001). An existence on the margin was perceived of as a repertoire of loss, for example in terms of dignity, identity and basic material goods. A sense of being defeated and left with a feeling of social isolation and with few positive visions of one's future arose (Papers I, II, III and IV). When in this state, a sort of tunnel-vision without seeing any way out, pushing for the ultimate action, could be experienced. Seeking help was then perceived as problematic, and professionals must be very sensitive and patient in such encounters (Paper II and IV).

From a psychological perspective, Pollock and Williams (1998) point to a probable trait of less effective problem-solving in individuals experiencing suicidal behaviour due to an over-generalized autobiographical recall as part of their vulnerability to feeling entrapped. However, my findings do not support the view of a tunnel-vision based on an over-generalized autobiographical recall, as all participants could both recall and describe very specific memories of negative life-events, sometimes down to year, day and place, tone of voice and words. Yet, in a state of despair and stress and with few material resources, intentions to die could be strong and focused, regardless of other people trying to intervene (Papers I and III).

### *Spaces for legitimate actions and participation*

An important finding when reading the narratives horizontally, is that the participants did not say that they had been part of an informal or formal group that could have expanded their repertoire and environment by providing social support, acting on their behalf, or giving them encouragement (Papers I, III and IV). An important part of their treatment and recovery may have been to engage in education, cultural or political activities. From a health promotion perspective, having health can be said to be linked to the processes of enabling young men experiencing substance abuse and suicidal behaviour to expand their territory in order to increase “flexibility, reflexivity and reinvention of an active self in a modern society” (McQueen & Kickbusch, 2007). By this they mean that by making personal health into a political issue, risk, ambivalence and choice in everyday life could be put on the political agenda and put into action, focusing on structural problems and setting new themes. The other side of the coin is that such activities could change a sense of victimization in vulnerable persons to a sense of being a social actor focusing on issues outside oneself and with a repertoire of feeling less ashamed (Smith, 1998) (Papers I, II and III).

With regard to health as expanding one’s territory, some spaces for legitimate actions and participation for substance abusers have been established in Scandinavia. However, they differ in structure, aims and focus. Yet, stigmatization and marginalization are among the key issues addressed by these organizations. Within the field of mental health and suicidal behaviour, the basis of the mental health programme 1998-2008 launched by the Norwegian Government, is the emphasis on the users’ views and perspectives. The programme states that the experience and knowledge possessed by users and their relatives is unique and necessary in improving and optimizing services and treatment. This is in sharp contrast to the experience of different organizations for persons with current or former substance abuse in Norway, who report that they feel that they have not been taken seriously and have acted as a sort of alibi in official structures (Willersrud & Olsen, 2006).

In Oslo, a plan of action from 2002 aimed at discouraging substance abusers from congregating in the city centre by offering alternative sites. No representatives for the group were consulted during the plan’s preparation, and none of them were invited to sit in the steering committee. However, from 2004, Oslo has consulted with users to find out what they thought of the situation in the centre of Oslo. Since none of the participants in my studies told about being involved in such activities, one can speculate about the organization’s credibility. Yet, due to the possible positive effects of forming collective identities and

fighting oppression for individuals to expand their territory, health and social professionals ought to encourage such participation. This also seems to be important from a new public health perspective, aiming at foster an environment of shared responsibilities, a bottom-up approach and increased control for individuals and communities in a demanding situation (Rappaport, 1981; Eklund, 1999; Williams, 1999; Malterud & Solvang, 2005).

### *Implications for public health work*

The young men in the present studies had all tried to take their own lives. Therefore they constitute a high-risk group for future fatal outcome. Fatal or non-fatal suicide attempts can be considered as severe and preventable complications of a wide range of situations in which material, social and individual aspects play an important role. For this reason, elements from disease prevention might be compiled in an overriding health promotion approach (Prilleltensky, 2005; Nordentoft, 2007). Based on my findings in Paper I-IV, having health as expanding one's territory should include the following integrated promotive and preventive measures:

- Level of living. Increased material and social support and close monitoring of the individual's sense of pain and self, specifically aimed at avoiding relapse to substance abuse, or preventing further harm while using drugs. Restrictions on access to alcohol, and a restrictive attitude to alcohol are important. In the case of relapse, it is important to use out-reach or follow-up programmes. Case-management in the form of individual plans or open referral to health and social services in times of crises are also important preventive measures to secure the level of living.
- Expanding one's social power. Help to education and employment, and to engage in political, social or cultural actions could help the development of a sense of citizenship, control and mastering.
- Exercising one's voice and choice. Being invited to be part of an activist group, or (being helped) to express one's views in treatment or within core group meetings should be regarded as vital health promotion activities. For this to be effective, moral and ideological judgements should be challenged by recognising subjectivity and a change in perceptions of people who have problems with drugs.
- Language and stigma. Introducing and developing a more differentiated language of substance abuse and suicidal behaviour could bring about a change in social meaning and hence a positive change in the perceptions of people who have tried to take their own life or who are using drugs.

## 6.1.2. Doing health is doing gender

### *Confusion in expectations between generations*

A puzzling similarity between the young men interviewed, is that seven of eight of them were the oldest sibling in the family, or the only son (Papers I and III). The psychosocial problems of the young men who were born and raised in Scandinavia (Papers I, II and IV) started during their childhood. Vidar exemplified this when narrating about how from the age of 7 he was forced into an adult role, in order to protect his mother and his siblings from a violent and drunk father (Paper I). Having to take on this role altered his sense of self and relationship to others, and especially to his father. The isolation he felt was described as having painful and negative consequences for realizing his potential and thus for his sense of self by having caused confusion related to expectations of responsibilities within the family and his everyday unfolding of life (Sarvimäki, 2006) (Paper II). This perceived confusion added to later external demands that became greater than he could manage, and created a repertoire whereby he seriously reflected about how he could act to be freed from life, as he was heading towards the point of no return (Paper II). His vital goal of getting away did not necessarily mean reflections about actively seeking death, though death, also in his *thoughts* could seem like a hopeful release in the long run (Papers I and III). One way to survive with his confusion in daily life was to reject and abandon his father, both psychologically and socially. Vidar described this as a well-functioning problem strategy and emotional strategy for him to cope (Paper I). However, this may also have made it impossible for his father to give Vidar support, adding to Vidar's increasing sense of having a devastating void in life. The study of Grøholt et al. (2006) indicates that generational problems in the father-child relationship are of importance when weighing up the consequences of continuing to live or to die for this group (Papers I and III).

As the field of suicide research is dominated by quantitative methodology, and although research has given attention to the gendered character of suicidal behaviour, studies tend to compare “men” as a group with “women” as a group. Environment in forms of power relationships and social-political dimensions between men when constructing forms of masculinity, seem under-researched (Scourfield, 2005). In a forthcoming paper, I will illuminate some fathers' lived experiences of their relationships to their sons with substance abuse and suicidal behaviour. From two of the interviews that have been carried out so far, confusion in the construction of fatherhood and family relationships are described, illustrated by one participant as “*What is the role of a father, actually? You don't learn the role of a*

*father, you experience it. You cannot read in a book how to be a father, you have to do it*". In the other interview, fighting between father and mother was an issue: *"They have also seen us fighting. If there is something I blame myself for, it is that I didn't manage to avoid fighting in those kinds of situations. My oldest son also doesn't manage to avoid fighting"*. Conflicting or confusing ideals of both fatherhood, family practice and constructions of forms of masculinity may indicate that some fathers have difficulties in succeeding in the father-son relationship (Papers I and III).

### *Risk-taking and masculinity*

Substance abuse and suicidal behaviour in native Scandinavian men involved risky activities in which they demonstrated fearlessness (Paper I and II). Such activities could be viewed as readily accessible means of enacting masculinity, and a more frequent construction at hand when other ideals became unavailable due to the participants' life-experiences. As this thesis is based on the assumption that individual behaviour is embedded in the social construct and social matrix that precedes one's perceptions and actions, Courtenay's relational theory (2000) of gender and men's health forms the point of departure reflecting on "doing health is doing gender". Partly drawing on the ideas of hegemonic forms of masculinity (Connell, 2005), this theory suggests that health-related beliefs and behaviours are means of demonstrating masculinity in everyday life. Further, the theory proposes that health-related beliefs and behaviours are used in interactions in the social structuring of gender and power. However, according to Courtenay (2000), such practices might at the same time both function as signifiers of forms of masculinity and instruments that men use in the negotiation of social power and status, and undermine men's health. Further, he assumes that other social constructs, such as class, ethnicity and sexuality, influence which beliefs and behaviour are used to demonstrate forms of masculinity. In negotiating this different landscape of gender, the body is often used as a vehicle (Bordo, 1993; Courtenay, 2000).

Compensating for a perceived subordinated status, a repertoire of alternative forms of masculinity, inheriting different forms of risk, were constructed by the participants (Connell, 2005). In Paper I, Per and Knut told about engaging in crime, while Ola rejected asking for help, and Vidar took up the fight and protested against his father's domination. For the participants in Paper III, other notions and constructions of masculinity than those of a western society might have influenced risk taking and masculinity. Mohammad told about how he protested against his father's expectations, and this was the reason why he emigrated. At the age of 40, twenty-five years after he

left, in the research interview he could reflect on his father's attitude, and construct a self that had come to terms with his father's viewpoint *"I now see the point. I see it differently than before. As the oldest son, I know I have responsibilities for my younger brothers and my sister"* (Paper III). Pax opposed his father's authority after emigrating to Scandinavia, when he understood that by law parents were not allowed to hit their children *"I raided cars and I intoxicated my self. I argued back (with his father), and threatened him. He did not know what to do. It is inconceivable for a son to do that"*. However, Pax also constructed a kind of forgiveness and understanding when reflecting on his experience *"My father turned prematurely grey because of me. That is something I regret"* (Paper III).

While men's greater use of substances is well known as a risk factor for suicide (Suominen et al., 2004), the reasons why western men are more likely to use substances are poorly understood and rarely addressed (Courtenay, 2000). To my knowledge, few public health scientists have attempted to identify what it is about men that leads them to have health beliefs and engage in health behaviours that seriously threaten their health. Instead, men's risk taking may be taken for granted. My empirical findings lend support to the notion that cultural myths of masculinity may predict what is acceptable behaviour (Canetto, 1992-93), or may prevent males from admitting difficulties or seeking help from health services. This has also been illustrated by Cutcliffe et al. (2004). The local man-of-steel myth may lead to risk taking in the form of suicidal behaviour in some Canadian men. In a state of pain and despair, being close to the point of no return or in a maze that is perceived as closed, one might speculate if controlling death could function as a foundation for the participants' sense of self as men (Paper I, II and III).

The Norwegian anthropologist Fredrik Barth was inspired by Goffman's perspectives of the presentation of self in everyday life (Goffman, 1959). In his fieldwork from Middle Eastern countries, he described patterns of father-son relationships. Three of the participants in this thesis were from this area (Paper III). Barth's study (1994) shows how insight into local rules and ideology, and in the formal distribution of power, is not sufficient for understanding the emergent phenomenon, i.e. the ways fathers and sons really behave. Barth's work describes how fathers and sons interact within the context of their own homes. As a consequence, he manages to describe how contextual factors influence the ways fathers and sons interact when picking up their different roles. For the construction of forms of masculinity, depending on the father-son relationship in the specific region, the attributes are about continuity, inclusivity, authority and asexuality. Related to the often risky consequences of emigration, Mohammad broke

loose from continuity, Pax challenged the notion of all-inclusivity and respect between next of kin, and Fahrads and Mahmoods had sexual relationships with Scandinavian women without their fathers' explicit approval (Paper III). This type of risk taking could have increased the participants' insecurity in life, as opposing their fathers' authority led to less social support and increased conflicts. On the other hand, these activities also seemed to work in the opposite direction, towards a life more in line with their own needs and wants, revised goals and hopes for the future (Paper III).

As an immigrant, not accepting the authority of men outside their family, for example Scandinavian men, may have reinforced social isolation and narrowing of the maze (Paper III). Then, struggling with two sets of cultural notions on constructing forms of masculinity, substance abuse and suicidal behaviour could be seen as part of situational meaning-making and coping mechanisms. The participants' challenge was to compose their construction of forms of masculinity so that the behaviour did not conflict with either notions in the country of origin, or in the host country, that is, in such a manner that it is both adjusted to the concrete new environment, without breaking the attributes of the original father-son relationship. They seemed to fail in this task, and individual risk taking, such as substance abuse and suicidal behaviour, became part of their repertoire to cope with stress, or that could have been picked up to prove to others that they were "men" (Paper III). With Möller-Leimkühler's model in mind (2003), one could say that vital goals made up by cultural ideals, a repertoire of psychological needs and the environment of social realities came into play and made up the origins, maintenance and process of their increased substance abuse and suicidal behaviour.

### *Sensitivity in services*

Regardless of country of origin, all participants who were interviewed disclosed that they had been helped to develop a longer-lasting abstinence than before as part of their recovery process (De Leon, 1996; Topor, Borg, Mezzina, Sells, Marin & Davidson, 2006). This is not quite in line with another study in this field. In a Norwegian study, Berg (2004) focused on the meaning of gender and illuminated the interaction between professionals and non-western male clients in the context of drug treatment. She points to the problems of delivering health and social services that are sensitive to subjectivity and that take individual meaning-making into account. Another factor was talking intimately to female clinicians about personal problems when having grown up in a society with strong segregation between the sexes. As a result, the men in Berg's study (2004) refused to engage in the clinicians' "talking cure", and dropped out of treatment, increasing

the risk for overdoses with a possible fatal outcome. For a number of reasons, it may be difficult to ask men experiencing substance abuse about aspects of suicidal behaviour. Both on an individual and professional level, it may be difficult to differentiate between self-harm, accidental overdoses, intended suicide attempts and suicide (Miller, 2006) (Papers I, III and IV). It is also difficult to determine the impact substance abuse as a single factor has on suicide in men, as it is shown to be comorbid with affective illness and long-lasting psychosocial problems. However, according to Wiklund et al. (2006), the caring relationship between one who suffers from addiction and the care-giver is important for how “the drama of suffering will be performed”.

An environment of sensitive services, recognising the actions performed by the individual as part of an adequate repertoire in relation to his perception of life, will probably count for preserving the individual's sense of dignity. From this mutual understanding, Wiklund et al. (2006) argue that for this group it is possible to find new ways not only to deal with suffering, but also to reconcile. This seemed to be neither an important part of today's prevention of life-threatening overdoses in Oslo, nor of the relevant policy documents (Paper IV).

My results support the characteristics of substance abuse associated with suicide risk in men, such as heavy abuse (Papers I, III and IV), increased severity of (polydrug) abuse (Paper I, III, IV), and aggressive behaviour, mostly directed at themselves (Paper II). Encounters may then also induce stress in the professionals (Pallikkathayil & Morgan, 1988). From Paper IV it cannot be verified that professionals in Oslo are supported structurally or individually to tackle such stress in order to provide services in a sensitive way. Nor can it be verified that new public health principles, such as a multidisciplinary mode of working between different levels, are planned (Eklund, 1999). More positively, the findings of Paper IV indicate that individuals at risk are satisfied with the service they have received from the health and social professionals. My findings complement previous findings of a positive effect of psychosocial treatment and problem solving on relapse, hopefulness and reduced substance abuse among people attempting suicide (Nordentoft & Sogaard, 2005) (Papers I and III). However, recovering from substance abuse and suicidal behaviour is a long-standing process with uncertain outcome when still being on the edge or getting back into a tight spot for different reasons. In every encounter, working on the different dimensions of hope will be of importance for long-time survival (Papers I, II and III).

### *Implications for public health work*

Young men struggling with uncontrolled substance abuse, suicidal ideation and plans may hide behind a silent mask (Papers I, II, III and IV). Individuals at risk do not necessarily express a wish or need for medical or psychosocial follow-up. Thus, a sensitive approach must be adopted in every encounter (Paper IV). This silent mask may be interpreted wrongly by health and social professionals due to cultural bias, as men may be reluctant to ask for or to receive help (Charmaz, 1997; Möller-Leihmkühler, 2003). Based on my findings, “doing health is doing gender” should therefore include the following integrated promotive and preventive measures:

- A sensitive individual approach. This should be an aim in every encounter and in treatment for this group. Subjective and experience-based knowledge should also guide the language and understanding of the situation within the treatment team. Health and social services and treatment facilities should not regard all men as being alike. Professionals must receive structural support and supervision to facilitate a sensitive individual approach.
- Supporting social networks and families. Continuous societal efforts to facilitate meaningful activities seem important. Men experiencing suffering and loss from the breakdown of daily life or family are in need of stabilizing their position in the chaotic situation. Other people may need to step in to create a sense of security. Information about the situation and talking about possible outcomes in a way that is comprehended by the young person play a major role. A further promotion of attachment and caring between father and child adopted by structural means in the Nordic countries should continue and be developed, however in a culture-sensitive manner.

#### 6.1.3. Being healthy is being able to verbalize

##### *Developmental aspects*

Mostly embedded in environmental problems related to the social relationship domain, the young men in my studies narrated about gradually being confronted with social isolation, lack of belonging and an absence of faith in themselves (Papers I, II and III). Erikson (1977) has been criticized for being too preoccupied with certain definite stages of development in human life. His theories concerning human development suggest that individuals who are hindered in developing the capacity for trust during their formative years, for example due to marginalization (Papers I and IV) or immigration (Paper III), will

have difficulty trusting themselves and others later in life. My findings confirm that existential problems may stem from early problematic developmental processes, and that such problems created a wide range of pain in the young men (Papers I, II, III and IV). One sort of pain was described as not being able to verbalize their problems, or not being invited to engage in a two-way communication of their inner reflections about negative life-experiences. One might also speculate that heavy use of drugs over time to ease pain could have impaired their repertoire, perception and ability to focus and formulate thoughts and feelings. However, from a phenomenological-hermeneutic perspective of individuals experiencing substance abuse, being a “drug addict” or a “criminal” probably hinders their interaction with others, because the general public is too preoccupied with cultural stereotypes. Such stereotypes are that these people have a lack of impulse control and moral, and low tolerance for frustration or risk-taking. These stereotypes do not allow for identifying and recognizing the individual.

A critical difference between the young men originating from outside Scandinavia and the participants born here, was that the problematic developmental process emerged somewhat later in life (from the ages of 15-17), even though the immigration problems were often embedded in a repertoire of insecurity, unclear identity and an environment of conflicts with authorities (Paper III). The encounter with the host society impaired their possibilities for communicating, for example not knowing the structure of health and social services, or not speaking a Scandinavian language at that time.

For these reasons, the participants' ability to verbalize may have been hampered (Papers I and IV). One possible way to enhance verbalizing and personal development, and thus to aid problem-solving in persons at risk of suicidal behaviour, could be to participate in Dialectical Behaviour Therapy (DBT). This treatment combines strategies from behavioural, cognitive and supportive psychotherapies. Linehan, Armstrong, Suarez, Allmond and Heard (1991) have shown that it can reduce the frequency of suicidal behaviour and keep participants in treatment. However, Linehan et al. (1991) disclose that even the intervention showed a clear treatment effect, it is unclear which aspect of treatment this can be attributed to.

From my findings, another strategy, that of a repertoire of holding on to a conversational domain, in a subject-to-subject relationship, was experienced as hope, and counted for turning points and development (Papers I, III and IV). Further, attitudes, courtesy and the practical approach of health care professionals and others were experienced as a life-saving environment of some turning points, reducing pain and creating hope. For example, this influenced Vidar's and Mahmood's

motivation and later decision-making and actions towards engaging in treatment (Papers I and III). Such an encounter could thus have functioned as an increase in their sense of comprehensibility, manageability and meaningfulness in life (Antonovsky, 1987).

### *Structures and attitudes*

My results highlight the consequences of environmental deficiencies in formulating political goals, and thus for the coordination and delivery of services at different levels for preventing life-threatening overdoses in Oslo (Paper IV). Some of the frontline health and social staff burned for this issue, as observed in the non-participant observations and the focus group discussions. However, the youngest participant (23 years old) and the oldest participant (56 years old) addressed needs for follow-up that for different reasons were not understood or met by the paramedics. The main shortcoming seems to be structural: the lack of political and professional goals, lack of agreement about the tasks of different services, and lack of a monitoring system at different levels. Because there are no guidelines or procedures for preventing life-threatening overdoses, health and social professionals have to decide what to do, and communication is less structured. Dealing with people with complex psychosocial problems, structural problems could leave vulnerable people without adequate help (Willumsen, 2006).

For this group, my results indicate that being healthy is a repertoire of being able to communicate with health and social professional and vice versa. This was not always easy, for example, because there were too many actors on the scene (Paper IV). However, frontline personnel have a special professional and ethical responsibility to ensure that communication is two-way. On an individual level, Wiklund et. al (2006) conclude that suffering must be expressed before it can be alleviated, and thus health and social professionals must understand that suffering can be expressed and handled in different ways, also in ways that professionals may deem as morally difficult. This could further challenge professionals' attitudes and actions. My results support those of Berg (2004), that the frontline health professionals did not seem to fully engage with the participants as individuals in an insecure and vulnerable state, but as "drug addicts" (Paper IV) or "immigrants" (Paper III). Therefore this part of the service could fail to meet their subjective needs, and real access to health services was hampered. Communicating with individuals at risk about suicidal ideations and plans is essential from a preventive perspective, because previous suicide attempt is a risk factor for fatal outcome, and because the language of suicidality may not be part of everyday life (Beskow, 2005) (Paper II). The problems for health professionals to communicate directly about sensitive social phenomena (Paper IV) were recently

presented in Häggblom's thesis (2008) on intimate partner violence in Åland. Häggblom's research disclosed that battered women expect nurses to take the initiative and ask, and thus meet the often non-verbalized need of the woman to break the silence and suggest solutions when they attend health service. One participant in my study formulated this as *"I wanted the paramedics to take me to a place, but they were in such a hurry that I didn't manage to ask them for more help."* On the other hand, the paramedics understood their tasks as follows: *"The main thing we focus on is to ensure that the patient is breathing."* This conflicting finding identifies the need for more serious efforts to be taken by politicians and professional leaders, not only in formulating goals and guidelines and facilitating communication, but also providing training and continuous support and supervision to develop the skills and attitudes of frontline staff who experience difficult ethical dilemmas (Paper IV).

### *Communicating by suicidal behaviour*

My findings show that it is possible to argue that suicidal behaviour in men with substance abuse is a dialectical and communicative activity about the individual's lived experience of pain and hope (Paper D), their shifting sense of self (Paper II), perceived insecurity (Paper III) and ambivalence about their future (Paper IV). However, as pointed to by Hammerlin and Enerstvedt (1988), communicating specific motives by intentional aspects and lethality is not always understood by society. According to the Danish sociologist Qvortrup (1999) there is a dual relationship between society and individuals, whereby human actions have potential to inform and change both individuals and society at large (and vice versa) and thus can be regarded as a communicative phenomenon. Qvortrup's theory of suicidal behaviour as communication claims that suicidal behaviour is the outcome of a complex process, by which the "self" ultimately seeks to communicate either a desire to destroy itself or to terminate its relationship to its surroundings. Qvortrup categorizes suicidal behaviour according to its communicative function. These are "Emotional in regard to self" (whereby the behaviour communicates the individual's emotional relationship to himself or herself), "Emotional in regard to others" (whereby the behaviour reflects the emotional relationship between the individual and those to whom the behaviour is meant to communicate something), "Regulatory in regard to self" (whereby the behaviour implies an objectification of the self), and finally, "Regulatory in regard to others" (whereby the behaviour is meant to influence a power dynamic between the individual and others). Adapting Durkheim's typology of suicide to Qvortrup's model, it can be argued that egoistic and anomic suicide belong to the emotional domain, while altruistic and fatalistic suicide belong to the regulatory domain.

Several of the personal narratives in Papers I and III dealt with substance abuse and suicidal behaviour in the context of “Emotional in relation to oneself” (Qvortrup, 1999), and had the “self” as their main object. The relationship to “self” in the young men was embedded in a painful repertoire of a sense of lack of belonging and unclear identity, or in an environment with loss of family support, lending support to Morano, Cisler and Lemerond’s previous findings (1993) that perception of loss and low family support are strong predictors of suicide attempts in adolescents. The complexity and magnitude of the problems confronting the participants, coupled with confusion between the generations and in expectations between father and son, seem to have negatively influenced participants’ repertoire such as problem solving abilities, as they became preoccupied with the internal consequences (Paper I). When coping by using morally condemned substance abuse, relational and social problems added negatively to their sense of self, and hindered the socialization process of the participants. The participants experienced intense and negative feelings, and to a large extent, were unable to communicate this pain verbally (Papers I, II, III and IV).

The coping which participants used to deal with pain from social isolation in the closed maze, and to create a more active sense of self, also involved a repertoire of maintaining normal, everyday activities, relationships with friends, nature and God (Papers I and III). Further, they strived to create and stay within a conversational domain, sometimes only as a life-saving inner monologue with themselves, or a dialogue with God (Papers I and III). The meaning-making function of comradeship, nature and God was the creation and the importance of a safe space in life, from where hope for a way out of the maze, and not (only) being a victim of uncontrollable forces, could be nurtured (Johansson, DeMarinis, Sundquist & Bergman, 1997) (Papers I, II and III).

The description of God differed from communicating and feeling the presence of a higher supreme being (Paper I) or to life itself with all its good and bad things (Paper III). The effects of comradeship, nature and God, thus meant a sense of security and belonging, and the possibility of focusing on something outside themselves. 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 himself in a new way. This change of perspective allowed him to communicate forgiveness towards 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 in control, hopeful and constructive towards his future (Papers I and II).

Narration on “Emotional in regard to others” (Qvortrup, 1999) dealt mostly with the feeling of not being seen, valued, and loved by the father figure. This lack of attention seemed to be experienced as especially traumatic, and had serious consequences in the participants’ life (Grøholt et al., 2006) (Papers I, II and III). However, the literature is not clear about how western hegemonic masculinity, i.e. striving for power and dominance, independency and autonomy, as part of the environment corresponds with suicidal behaviour (Webster-Rudmin et al., 2003).

Patterns of relationship to the “self” in childhood, adolescence and adulthood reveal a similarity in the young men’s experience of their fathers. The central similarity is one of painful loss, as shown by Johansson et al. (1997), who studied suicidal behaviour in native and immigrant women in Sweden. Two central patterns of loss, such as described by Johansson et. al (1997) between mother and daughter, are reported in this thesis between father and son, leading to pain and a sense of being a victim in a closed maze (Papers II and III). The first pattern reflects a loss of the father-son relationship and communication due to the absence of the father through death, divorce or emigration. The second pattern reflects a loss of the relationship and impaired communication through an increasing sense of insecurity towards the father because of his behaviour, mainly his demanding expectations of his son, physical violence/abuse or alcohol abuse and rage. Both patterns challenged the father-son relationship in a profound way and led to both increasing (Paper I) and decreasing (Paper III) substance abuse and suicidal behaviour over time. Communication with the mother figure was absent in the narratives constructed in Paper I, but highly significant in Paper III. This may indicate major differences in family structures and relationships in extended families from north-Africa, the Middle-East or south Asia. This was described by one participant as “*My family and I are glued together*” (Paper III).

Only a few of the narratives from the stories of the native Scandinavian participants fit into the category “Regulatory in regard to oneself” (Qvortrup, 1999) (Paper I). This may signify that these participants’ vital goal seems to be less concerned with self-destruction and more preoccupied with breaking free from the environment, as an inner repertoire of punishment was not highly evident in the narratives. This is in line with the findings of Skogman (2006), that punishing or manipulating motives are seldom reported by individuals who attempt suicide. Further, Retterstøl et al. (2000) argues that those who have a sense of loss are nevertheless hopeful that solutions can be found. In my studies, the type of protest happened to be life-threatening (Paper I).

However, this picture was not so clear in the narratives presented by the young immigrants, as two of them disclosed suicidal behaviour aimed at self-destruction: *“I have become useless. I hate myself so much. I could do my family a favour by getting rid of myself”* and *“You are not part of reality any more, you are an observer. Then the wish to die developed”*. When the pain from being in the fog in an insecure and unknown environment became too hard, the repertoire of further substance (ab)use and suicidal behaviour formed a space for a possible internal regulation of emotions and communication of pain (Lazarus, 1993; Orbach, 2003).

Finally, narration on “Regulatory in regard to others” (Qvortrup, 1999) contained stories dealing with power, where the behaviour could be seen as a means to redistribute power within the context of an interpersonal relationship, for example leaving others with long-term feelings of remorse. The participants of Papers I and III expressed a perceived need to end their lives in order to make significant others suffer *less*. Despite their difficult life experiences, the participants seemed to hold on to a repertoire of a conversational domain, i.e. the inner monologue, or a dialogue with others, nature or God, which moderated the need for suicidal behaviour as a means of securing “the last word.” (Qvortrup, 1999) (Papers I and III).

### *Implications for public health work*

My findings are mainly constructed from retrospective narrative events. From the position of being in treatment, or having undergone treatment for substance abuse and suicidal behaviour, the participants gained hope for the future and feelings of belonging and self-worth. Focusing on life-threatening overdoses in their contemporary context revealed a strong need to look for the communicative aspect of the event, and to secure adequate help. Based on these findings, being healthy is being able to verbalize, and should therefore include the following integrated promotive and preventive measures:

- Recognise subjectivity. The process of recovery and treatment may be slow and difficult, and subjects do not always express a wish for treatment or follow-up in times of distress. Thus, engaging in communication in the context of a subject to subject relationship with others is of utmost importance for survival, as the basis for a more agentic identity and hope. As substance abuse and suicidal behaviour have complex causality, society should uphold a broad variety of treatment facilities, and professionals not act as experts in defining what treatment or help is best.

- Create an interactive context. Suicidal behaviour in my studies seems to be receptive. Thus, reducing pain and creating hope by being seen and confirmed in social relationships, and being helped to verbalize existential thoughts and openly discuss needs, wants and possible solutions, are of importance. The same counts for easy access to psychosocial care when in need. An open attitude to the individuals' use of metaphorical language is of importance, as this provides important, often tacit, information about suicidal ideation.
- Create meaning. At the time of narrating their stories, the participants were still facing an insecure and uncertain future. It was uncertain whether new incidents of substance abuse or suicidal behaviour would occur. However, at the time of telling, the personal development they had achieved from care and treatment had at least given them the courage to communicate a hope for a better future. To a large extent, this was due to the fact that turning points had been facilitated through sensitive and active listening by health and social professionals, possibly bridging the perceived disruption between ideal and reality and thus creating meaning.

## 6.2. Methodological considerations

An overall aim of research is to produce knowledge that can be shared, and that to some extent is relevant outside the actual study situation (Malterud, 2001). When considering methodology and assessing the quality of qualitative studies with a naturalistic design, Barbosa da Silva (2002) mean that one has to consider the purpose of the inquiry and its philosophical and theoretical orientation, and the credibility of the findings. As outlined in the introduction, the aim of this thesis was to describe, explore and interpret the meaning of substance abuse and suicidal behaviour in some young men. Another aim was to describe and explore the phenomenon of life-threatening overdoses in a broader context. The applied philosophical and theoretical framework was mainly social constructivism and interpretativism. Hence, the credibility of the findings is dependent on the information the researcher presents about the overall research process, the role of the researcher and his pre-understanding (I as the researching subject), and an ongoing criticism and openness to competing interpretations (Kvale, 1989; Malterud, 2001). Trustworthiness, referred to by Sandelowski (1993) as a matter of persuasion whereby the scientist is viewed as having made her/his practices visible and therefore auditable, forms an alternative to adopting the concepts and terminology of positivist research into qualitative studies. According to Sandelowski (1993), a study is considered trustworthy if the reader of the research report, or thesis in this case, judges it to be so. This notion stems from her observation that judgments are never directly about the research study itself, but only

of the study as it is represented in the report. This thesis then becomes what Sandelowski and Barroso (2002) names a dynamic vehicle that mediates between researcher/writer and reviewer/reader, rather than a factual account of events after the fact. The scientific appraisal of the study is then concerned with the exercise of wise judgment and keen insight in recognizing the nature and merits of a work. Appraisal of research is therefore, in Sandelowski and Barroso's words (2002), subject to individual judgment based on insight and experience rather than explicit predetermined criteria.

The story about life is created through the choices we make when narrating, and how we position ourselves in relation to other characters in the story, and to the listener. What happens when we interpret our experiences, render them significance, emphasize some and diminish others, is that we tie stories together to larger wholes, and present them as a life story. Life, identities and stories melt together in a dialectical process. Thus, with special relevance to narrative research, Lieblich et al. (1998) has developed four criteria for the evaluation of narrative studies: *width* (the comprehensiveness of evidence), *coherence* (the way different parts of the interpretation create a complete and meaningful picture), *insightfulness* (the sense of innovation or originality in the presentation of the story and its analysis) and *parsimony* (the ability to provide an analysis based on a small number, and elegance or aesthetic appeal). These criteria consist of judgments to be carried out in a process of consensual validation between the researcher and the community of researchers and interested, informed individuals. However, since this is a thesis in public health science, it could be argued that being inspired by a broader and more general approach to appraisal and evaluation is more sound. This is the main reason for adopting Lincoln and Guba's (1985) operationalization of trustworthiness in qualitative inquiries as the point of departure in this thesis.

Lincoln and Guba (1985) have operationalized the term trustworthiness into credibility, transferability, dependability and confirmability. They have further developed techniques for each criterion. How these techniques have been applied in this thesis is outlined below, and the effect of the researcher is reflected on. According to Malterud (2001), reflexivity is defined as an attitude of attending systematically to the context of knowledge construction, especially to the effect of the researcher, at every step of the research process. Malterud (2001) points out that subjectivity arises when the effect of the researcher is ignored, and thus forms a threat to scientific principles of knowledge production.

### 6.2.1. Credibility

Credibility roughly corresponds with the concept of internal validity. It is about whether it is possible to study what one has decided to study with the method one has chosen. According to Lincoln and Guba (1985), it also means that the researcher is able to demonstrate how she/he became familiar with the context, minimized distortions and built trust.

In order to avoid a conflict of interests between the participants and myself, I recruited participants from treatment facilities where I had no current position. In this thesis, *prolonged engagement*, as a criteria of credibility, refers mainly to my fifteen years of professional experience in caring for and treating persons suffering from substance abuse, psychosocial problems and existential crises. This allowed me to be familiar with certain important features of the participants' culture, both inside and outside the treatment setting (Papers I, III and IV). I was familiar with salient factors such as the multifactorial background for substance abuse, and its manifold consequences, and the legal and formal structures for applying for treatment (Paper IV). My professional experience has shown me how challenging it can be to hold on to one's fluctuating motivation in the waiting period prior to intake, how difficult it can be to hold on to an intention of abstinence, and some of the problems of individualizing treatment and follow-up. Persistent observation, as indicated by Lincoln and Guba (1985) as part of prolonged engagement was especially done in Paper IV when I carried out non-participant observation in central Oslo for a period of forty hours spread over some months in 2007 and 2008.

*Building trust* to me as a researcher was emphasized by providing both the institutions and the potential participants with written, and sometimes oral, information before they decided to participate (Papers I, III and IV). Having long and broad professional experience from the field of treatment of substance abuse, I could easily respond to the potential participants' comments and reflections in these meetings. At three institutions I attended meetings with staff to present information about the project (Papers I, III and IV).

For several years, the young men participating in Papers I, II, III and IV had all been part of the culture I wished to collect information about. They had all had serious thoughts about committing suicide, and had attempted suicide. Many of these thoughts and some attempts had occurred close to the time of the interview, so they were still fresh in their memory. Other attempts were recalled when narrating. All of the participants in Papers I, II and III were positive to participating in the study, and an important motivating factor seemed to be that the study

could be helpful for others in the same situation. It is not easy to assess whether the payment the participants received influenced them to take part, or to answer in a way they thought I wished them to answer (Papers I, II and III).

For several years, the participants in the focus groups had been working with persons with substance abuse who had experienced accidental overdoses and suicidal behaviour (Paper IV), so they could reflect in depth on the two guiding questions. At the time of the focus group discussions, I had no professional engagement with the participants, although I knew some of them from my earlier work. I sometimes acted as a group member in the sessions and not as a moderator.

According to Lincoln and Guba (1985), *premature closure* is reaching a conclusion too soon. This was worked on mainly by in-depth reflections with my supervisors (from the fields of sociology and psychology) as I was writing the papers. They have monitored my research project during its various phases, and questioned decisions, stimulated and challenged other possible perspectives on the data than mine, and thus ensured reflexivity and quality. Also peer debriefing, by which one can “explore aspects of the inquiry that might otherwise remain only implicit within the inquirer’s mind” (Lincoln & Guba, 1985), has been used for Papers I, III and IV by presenting them to peers on different occasions. Important contributions to the research have been made through doctoral seminars, research workshops, poster presentation and abstract presentations at national and international conferences, and the peer review process with Papers I, II, III and IV and the thesis.

*Triangulation*, in the forms of data triangulation, investigator triangulation and theory triangulation (Denzin & Lincoln, 1994) has been adopted in this thesis as part of the credibility criterion. For example, a variety of data sources were used to provide confirmatory and complementary findings for Paper IV. An additional investigator was engaged in Paper II to assess the findings and make sound and relevant proposals for clinical implications. Different theoretical perspectives on the findings have been discussed in each paper and in the thesis. Triangulation is no guarantee of correctness or truth, but the findings are grounded on a firmer base. However, specially in Paper IV, one of the disadvantages of using several data sources and data analysis methods may be that the researcher lacks expertise or knowledge about some of the methods (Häggbom, 2008).

Kvale (1997) refers to three classical criteria of truth: correspondence, coherence and pragmatic benefit. The criterion of coherence will

probably make up the central part of the assessment of the truth of my findings. This is due to the basic assumption about human existence as a comprehensive whole, because the study has an idealistic ontological and interpretative epistemological point of departure. The criterion of coherence relates to the internal logic of the study, while the pragmatic criterion relates to the pragmatic consequences of the knowledge. This thesis is an example of what Kvale (1997) describes as establishing truth through well-founded theorizing and interpretation of data, and through discussion of the interpretations.

*Negative case analysis* requires searching for and discussing elements in the data that seem contradictory to the emerging interpretation (Lincoln & Guba, 1985). A possible limitation of the main method used in this thesis is that the construction of the whole, the comprehensive understanding, should cover the naive reading and all the parts of the structural analysis. This could lead the researcher to overlook and not present contradictory findings in order to follow the method in a rigorous way. As relatively new in qualitative research methods, I could have been imperfect in this. However, in all the studies, different theoretical perspectives have been discussed to count for an openness to different interpretations. Another limitation is the sample. Although purposeful, the sampling of participants was coloured by the fact that the institutions did the first selection by deciding who to ask. Yet, they were guided by the inclusion criteria (men, aged 20-40, self-reported previous suicidal behaviour, and using illicit drugs for more than five years. For Paper III an experience of emigration was added). There is little variation in age and gender, due to the epidemiological knowledge of premature death from suicidal behaviour. Yet, characteristics of psychosocial problems, residential institutions, kind of treatment and place of birth and upbringing provided a variety of data thus leading to a more nuanced picture of substance abuse and suicidal behaviour. The way the interviews were carried out should facilitate for a broad variety in the later text. No relevant information was left out due to lack of sub-themes or themes.

There seems to be little agreement about the number of participants necessary in qualitative research. Thus, the total number of young men interviewed for Papers I, II and III (n=8) may be regarded as a limitation by some. More information could probably have been gained by increasing the numbers of participants, or doing more than one interview with each. However, it can be argued that the aim of these three studies was to describe, explore and interpret the meaning-making of social facts in depth. Validity and quality seems then more important than numbers per se. Wengraf (2001), in his guide to biographical narrative interpretation method, remarks on the number of interviews used in completed and approved PhD theses with such a

task. They range mostly from between 3 and 7, clustering around the 4 mark. To deepen our understanding of social facts requires in-depth study of contextualized thick descriptions, and analytic capabilities in the researcher, more than a broad variety in the sample (Patton, 2002). Assessing the question of the number of participants in retrospect, I claim that the number of persons interviewed, and the number of interviews, provided very rich and varied information, and that the analysis produced insights and knowledge that is very relevant to the purpose of this thesis.

*The member-check* includes comparison of the researcher's interpreted constructs with those of the participants, in order to establish the level of correspondence between the two sets (Lincoln & Guba, 1985). There also seems to be disagreement among qualitative researchers of the necessity of member-check. In my studies, the participants were given the opportunity to act as a co-researcher in the interview session, as I tried to keep my own interpretations within the subjects' context of understanding. At the end of the sessions, the participants were asked to reflect on their narration. From this point onwards, I see myself as responsible for the interpretation and analysis of the transcribed life as text, and the following writing up was therefore not tested with the participants. Such a procedure could be argued as assuming that there is an external world that is open to more or less objective scrutiny by the researcher and co-researcher. However, there are of course ethical research and methodological principles to be followed, so that over-interpretation should be avoided, and interpretation close to the data enhanced. One should also keep in mind that life as told, or life as text, are not held to be life as experienced within narrative methodology.

### 6.2.2. Transferability

The criterion of transferability deals with the question of how my findings are relevant to other settings, such as whether or not they apply in similar contexts (Lincoln & Guba, 1985). As the sampling has been purposeful, not all aspects of the phenomenon under study are accounted for. Yet, if transferability is considered as an empirical question, provision of thick descriptions and detailed information in the Papers (I, III and IV) and in the thesis is emphasized in order to allow the reader to judge the degree of transferability of the findings to other settings. Further, the theoretical contextualization may count for an analytical generalization, allowing clinicians to reflect on the findings and possibly refine their practice towards young men with substance abuse and suicidal behaviour (Paper II).

In my studies, the participants' wide range of psychosocial problems embedded their substance abuse, suicidal behaviour and later help-

seeking. Therefore, it can be assumed that the findings then apply to other young men in the Nordic countries who inject heroin. However, there are differences in national patterns of such abuse. In Denmark, heroin is reported to be the primary drug for about 60 per cent of those who seek treatment, and heroin has been injected for several decades. In Norway, drug users who seek in-patient treatment are primarily intravenous heroin users. In Sweden, and to some extent in Finland, there is a tradition of intravenous amphetamine use, though the number of those who use heroin is increasing (Anker, Asmussen, Kouvonen & Tops, 2006). To my knowledge, Iceland does not report to the European Monitoring Centre for Drugs and Drug Addiction, probably because alcohol-related harm is most common (Ólafsdóttir, 2007).

As the socioeconomic environment in Scandinavia is quite similar, and as these countries are all welfare states, the findings related to psychosocial problems could be assumed to be transferable to other Nordic countries (Qin et al., 2003). However, as my studies focused on the contextual and the particular, it may be more difficult, if not impossible, to transfer the findings to young men injecting heroin in other countries with different social, economic, or cultural conditions. Nevertheless, my results demonstrate the wide range of societal and individual factors that may be assessed and targeted in Nordic suicide prevention programmes to a certain group of the population. Therefore, it is reasonable to take gender, age, class, ethnicity, and individual meaning-making into consideration in all settings where health promotion and prevention of substance abuse and suicidal behaviour are at stake.

### 6.2.3. Dependability

Lincoln and Guba (1985) claim that it is sufficient to demonstrate credibility in order to establish dependability, as dependability focuses both on the process of the inquiry and the inquirer's responsibility for ensuring the whole research process to be logical, traceable and documented. The presentation of how decisions in the research process have been handled, resistance to early closure, and the willingness to criticize one's work are central issues in dependability. In this thesis the research process has been documented and presented in as transparent a manner as possible. According to Willumsen (2006), this should facilitate the inter-subjective negotiation of the overall study design, to trace various steps, phases and decisions made during the work of the thesis and for the assessment of the reasonableness of the conclusions. The supervisors' continual feedback provided stability over time and under different conditions and thus acted as an audit of dependability of the process.

The participants decided themselves where the interview should take place, and to my knowledge, the atmosphere during the interviews quickly became relaxed and direct. It is difficult to say what possible effect the fee of NOK 200 may have had on their participation, or on how they narrated. However, as the participants already had some form of income, my impression is that this small fee did not effect the relationship between us or the narration in a negative way. The narratives were given with reflection and consideration. Experiences, descriptions, thoughts and feelings about the theme were revealed. In situations that I perceived as strongly emotional, I did not press the participants in order to gain more data, because I knew that I would be leaving them soon. Also, it was up to the participants to decide what they would tell me and what they would not tell me. This may have weakened the dependability of the study, but was ethically necessary. A criticism of qualitative research is whether the statements made by the persons who are interviewed are trustworthy. Life as text, that is the researcher's interpretation and presentation of the personal narratives, does not represent life as lived or experienced. Hence, our interpretation is not established truth, but verisimilitude.

With regard to this thesis, it is relevant to point out that the trustworthiness of self-reported data from people with drug problems has previous been shown to be high when compared with official records (Ravndal, Hammer & Vaglum, 1984; Gossop, Marsden, Stewart, Edwards, Lehmann, Wilson & Segar, 1997; Johnsson & Fridell, 1997). In the interview situation I experienced that the participants were open and honest. Several of the men had emotional reactions during and after the interview (Papers I and III). I interpret this as a sign that they told about what they really had experienced. However, some of the participants may have presented a too positive or negative picture, and recall bias may have had an impact (one can discuss how fruitful the notion of recall bias is within narrative research).

The fact that I have the same age and gender as the participants may have helped us to be regarded as equals, despite the uneven power relationship of the interview situation. As I became more secure in the interview situation, I became quieter, and managed to use probing and silence actively during the narratives. This approach seemed to help the participants to narrate, and the narratives became richer. I believe that the men felt free to tell about their experiences with drugs and suicidal behaviour, since I was an outsider. To my knowledge, not all Scandinavian treatment institutions place so much emphasis on telling about one's past history, and when someone listens to these narratives it may be experienced as a form of release. As a nurse with long experience of working with people with drug and existential problems, it seemed to me that the participants really wanted to tell me about the

relationship between previous and recent life situations, intoxication and suicidal behaviour.

#### 6.2.4. Confirmability

Lincoln and Guba (1985) link confirmability in qualitative research to the researcher's ability to form interpretations grounded in events rather than from the inquirer's personal constructs. In phenomenological hermeneutic versions of qualitative research, the researcher's different pre-understanding forms an important and vital factor in the hermeneutic circle, and is thus not seen as a bias. However, as pointed out by Malterud (2001), pre-understanding must be addressed openly to avoid hidden skewness. Dahlgren, Emmelin and Winkvist (2004) claim that confirmability refers more to the neutrality of the data than the neutrality of the researcher in qualitative studies. This is that the various sub-themes, themes and main theme identified by the analysis are developed from the data and not from theories or preconceptions. For example, in Paper I, the initial theoretical perspective was changed due to the content of the data (see page 49). Further, the use of quotations in the different Papers (I, II, III and IV) should help the reader to decide whether neutrality of the data has been successful.

My private and professional background may have created problems in fully understanding the narratives from the participants' perspective. But at the same time, I have training in an empathic approach to other people and their life situation. In the analysis phase of the first interviews, particularly in the phase of naive reading, it was a challenge to remain in the phenomenological domain. By training this became easier in the last interviews and writing (Paper III), and this developed my ability to stay closer to the language used and thus to an inductive approach.

#### 6.2.5. General limitations

The fact that the different treatment institutions selected the participants, although according to some inclusion criteria, could mean that there has been some selection bias. It is not possible to assess the impact of potential "missing data". Including other and more participants would have constructed other narratives with another content. However, when doing in-depth interviews, it is also a question of keeping the amount of data manageable. In Paper IV, valuable documents could have been missed, depending on the researcher's ability to retrieve all relevant documents. The same applies to the non-participant observation, as there are indications that most life-threatening overdoses in Oslo happen in private homes, and not in public places.

The research process and findings are also coloured by the researcher. Other researchers, belonging to other professional or research traditions would have emphasized other aspects. A pitfall may be that the use of one opening question in Papers I, II and III, and not using an interview guide, may have counted for a too broad approach, leaving potential important information out. Another limitation is that I am relatively inexperienced with doing qualitative research interviews, and the sensitive themes they illuminate. Telling and listening to existential and traumatic life-events is not easy, and may create both conscious and unconscious resistance and defences on both parts. On several occasions, at least in the first interviews (Papers I and II), the participants and the interviewer were emotionally touched by what was told, leading to silence, shift of theme, interruptions or difficulties for me to form narrative-pointed follow-up questions (Wengraf, 2001).

The interviews were audiotaped and transcribed verbatim by myself. In Paper I, pauses, broken sentences and other non-verbal communication were indicated. As this information was not used very much in the final analysis, this was not done in Paper III. This may be a limitation with regard to comprehensive understanding. It was difficult to translate the metaphors from Norwegian to English in Paper II, as metaphors by definition are closely tied to particular meaning-making. However, we had to translate them in order to get the article accepted in an English speaking scientific journal.

As I ran the two focus-groups alone and without a co-moderator in Paper IV, this may have made me more occupied with “running the group” than listening to what was said and facilitating further reflections. However, the phenomenon of preventing life-threatening overdoses in Oslo was more broadly elucidated by this data collection than by individual interviews, and the participants influenced each other by listening and discussing.

Originally, a paper focusing on some father’s lived experiences of their relationship to their sons with substance abuse and suicidal behaviour was planned. For various reasons only three interviews have been conducted so far. Such a paper may have illuminated the fathers’ voice and perceptions and added to the findings.

### 6.3. Conclusions and implications for further research

1. To young men experiencing substance abuse and suicidal behaviour, the constructed meaning of these phenomena can be understood as goal-oriented, communicative and meaning-making activities about the individuals’ balance between death as an escape from pain and the hope of a life. Reducing 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.

2. To young men experiencing substance abuse and suicidal behaviour, the constructed meaning of the sense of self by the use of metaphors can be understood as an experience of a dynamic shifting sense of self, balancing being a victim or an agent. Enhancing the sense of a more active self is of importance to prevent suicidal behaviour.

3. Metaphors impart subjective knowledge about experiences of suicidality. To identify and facilitate its construction, mental health professionals should provide holistic care. In recovery, enhanced sensitivity about a client's sense of self could be an important part of the suicide risk assessment in the treatment team, as shifting use of metaphors as a marker of client change may reflect suicide ideation.

4. To young men experiencing emigration, substance abuse and suicidal behaviour, the constructed meaning of these phenomena can be understood as goal-oriented, communicative and meaning-making activities about the individuals' living in a maze. Ill health involved impaired possibilities to define and redefine goals by having a sense of liminality in an unknown environment. Substance abuse and suicidal behaviour were explicit expressions of not being well. Different coping responses were used in different situations to enhance health and well-being.

5. To male drug users in Oslo, life-threatening overdoses are experienced as a communicative activity and a process of coping in an ambivalent, vulnerable and stressful life-situation. Individuals do not necessarily express a wish or need for medical or psychosocial follow-up, so health and social professionals must adopt a sensitive approach in every encounter. If hiding behind a still face, medical or psychosocial follow-up are specifically indicated, and the person should not be left behind. However, individuals seem to be satisfied with the service they have received from the emergency and social street-based service when they have experienced a life-threatening overdose.

6. To health and social professionals in Oslo, the prevention of life-threatening overdoses is experienced differently. Social workers find the lack of goals and professional guidelines for cooperation most frustrating, while paramedics seem to be more satisfied, as their life-saving task is clearer. Both parts address the need for better practice. Neither social workers nor health care professionals in Oslo seem to be supported structurally and in a planned fashion with their task of preventing life-threatening overdoses. Professionals themselves have to decide about what is good practice.

In order to refine our understanding of substance abuse and suicidal behaviour, and to enhance promotive and preventive interventions, I suggest we need more data about:

- how ideological and moral condemnation of substance abuse can be reduced
- what factors hinder individual's from joining drug user organizations
- how user organizations can be engaged in relevant research
- the language of suicidality from other ages, ethnic groups and from women
- how family practice could be strengthened to prevent disruption
- how fathers perceive their relationships with their sons living with substance abuse and suicidal behaviour
- why political goals of preventing life-threatening overdoses in Oslo are not adopted.

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## REFERENCES

- Acheson, D. (1988). *Public health in England: The report of the committee of inquiry into the future development of the public health function*. London: Great Britain Secretary of State for Social Services.
- Allardt, E. (1978). On the relationship between objective and subjective indicators in the light of a comparative study. *Comparative Studies in Sociology*, 1, 203-215.
- Allebeck, P., Allgulander, C., Henningsohn, L., & Jakobsson, S. W. (1991). Causes of death in a cohort of 50,465 young men--validity of recorded suicide as underlying cause of death. *Scandinavian Journal of Social Medicine*, 19(4), 242-247.
- Allwood, C. M., & Erikson, M. G. (1999). *Vetenskapsteori för psykologi och andra samhällsvetenskaper*. Lund: Studentlitteratur.
- Anker, J., Asmussen, V., Kouvonon, P., & Tops, D. (2006). *Drug users and spaces for legitimate action*. Helsinki: Nordic Council for Alcohol and Drug Research.
- Antonovsky, A. (1987). *Unraveling the mystery of health*. San Francisco: Jossey-Bass.
- Barbosa da Silva, A., & Wahlberg, V. (1994). Vetenskapsteoretisk grund för kvalitativ metod. In B. Starrin, & P. Svensson (Eds.), *Kvalitativ metod och vetenskapsteori* (pp. 41-70). Lund: Studentlitteratur.
- Barbosa da Silva, A. (2002). An Analysis of the Uniqueness and Theoretical Foundations of Qualitative Methods. In L.R.-M. Hallberg (Ed.), *Qualitative Methods in Public Health Research-Theoretical Foundations and Practical Examples* (pp. 39-70). Lund: Studentlitteratur.
- Barth, F. (1994). Rolledilemmaer og far-sønn-dominans i slektsskapssystemer i midtøsten. In F. Barth (Ed.), *Manifestasjon og prosess* (pp. 66-74). Oslo: Universitetsforlaget.
- Bauman, Z. (1991). *Modernity and ambivalence*. Cambridge: Policy Press.

- Bäärnhielm, S., Ekblad, S., Ekberg, J., & Ginsburg, B.E. (2005). Historical Reflections on Mental Health Care in Sweden: The Welfare State and Cultural Diversity. *Transcultural Psychiatry*, 42(3), 394-419.
- Beaglehole, R., & Bonita, R. (1997). *Public health at the crossroads : Achievements and prospects*. Cambridge: Cambridge University Press.
- Beautrais, A. L. (2002). Gender issues in youth suicidal behaviour. *Emergency Medicine*, 14, 35-42.
- Beck, U. (1992). *Risk society: Towards a new modernity*. London: Sage.
- Bennett, P., & Murphy, S. (2001). *Psychology and health promotion*. Buckingham: Open University Press.
- Berg, E. (2004). "Sønn, far og mann- de tre er jeg". Trenger mannlige stoffmisbrukere med innvandrerbakgrunn kjønns-spesifikk behandling? *Nordisk alkohol- & narkotikatidsskrift*, 21(1), 43-55.
- Berger, P. L., & Luckmann, T. (1967). *The social construction of reality: A treatise in the sociology of knowledge*. New York: Anchor Books.
- Beskow, J. (1979). *Suicide and mental disorder in Swedish men*. Copenhagen: Munksgaard.
- Beskow, J., Eriksson, B. E., & Nikku, N. (1999). *Självmordsbeteende som språk*. Stockholm: Forskningsrådsnämnden.
- Beskow, J. (2005). Suicidalitet som språk. In H. Herrestad, & L. Mehlum (Eds.), *Utholdelige liv. Om selvmord, eutanasi og behandling av døende* (pp. 43-59). Oslo: Gyldendal akademisk.
- Bille-Brahe, U., Andersen, K., Wasserman, D., Schmidtke, A., Bjerke, T., Crepet, P., et al. (1996). The WHO-EURO multicentre study: Risk of parasuicide and the comparability of the areas under study. *Crisis*, 17(1), 32-42.

- 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.
- Black, D., Townsend, P., & Davidson, N. (1982). *Inequalities in health: The Black report*. London: Penguin Books.
- Bordo, S. (1993). *Unbearable Weight. Feminism, Western Culture, and the Body*. Berkeley: University of California Press.
- Borup, I. K. (1999). *Learning about health: The pupils' and the school health nurses' assessment of the health dialogue*. Doctoral thesis. Göteborg: Nordic School of Public Health.
- Botten, G., Elvbakken, K.T., & Kildal, N. (2003). The Norwegian welfare state on the threshold of a new century. *Scandinavian Journal of Public Health, 31*, 81-84.
- Bramness, J. G., Walby, F. A., & Tverdal, A. (2007). The sales of antidepressants and suicide rates in Norway and its counties 1980-2004. *Journal of Affective Disorders, 102*(1-3), 1-9.
- Bretteville-Jensen, A.L. (2005). Økonomiske aspekter ved sprøytemisbrukeres forbruk av rusmidler. En analyse av intervjuer foretatt i 1993 og 2004. *SIRUS-rapport Nr. 4*. Retrieved 9 May 2008, from <http://www.sirus.no/internett/narkotika/publication/181.html>
- Brockmeier, J., & Carbaugh, D. (2001). *Narrative Identity. Studies in Autobiography, Self and Culture*. Philadelphia: John Benjamins Publishing Company.
- Bruner, J. (2001). Self-making and world-making. In J. Brockmeier & D. Carbaugh (Eds.), *Narrative and Identity. Studies in Autobiography, Self and Culture* (pp. 25-37). Philadelphia: John Benjamins Publishing Company.
- Burr, V. (2003). *Social constructionism*. London: Routledge.
- Canetto, S. S. (1992-93). She died for love and he for glory: Gender myths of suicidal behaviour. *Omega, 26*(1), 1-17.

- Charmaz, K. (1997). Identity dilemmas of chronically ill men. In A. L. Strauss, & J. M. Corbin (Eds.), *Grounded theory in practice* (pp. 35-62). Thousand Oaks: Sage.
- Christiansen, E., & Møller, S. (2004). Antallet af unge pigers selvmordsforsøg er tredoblet siden 1990. *Nyt Fra Center for Selvmordsforskning*, 1(1) 1-2.
- 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: John Wiley.
- Colman, I., Newman, S. C., Schopflocher, D., Bland, R. C., & Dyck, R. J. (2004). A multivariate study of predictors of repeat parasuicide. *Acta Psychiatrica Scandinavica*, 109(4), 306-312.
- Connell, R. W. (2005). *Masculinities*. Cambridge: Polity Press.
- Courtenay, W. H. (2000). Constructions of masculinity and their influence on men's well-being: A theory of gender and health. *Social Science & Medicine*, 50(10), 1385-1401.
- Cullberg, J. (1991). *Om den psykiska obälsans orsaker och hur den psykiska hälsan kan främjas. Ekspertdokument för folkhälsogruppen*. Stockholm: Enheten för Psykososial Forskning och Utveckling.
- 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.
- Dahlgren, L., Emmelin, M., & Winkvist, A. (2004). *Qualitative methodology for international public health*. Umeå: Print and Media, Umeå Universitet.
- De Leon, G. (1996). Integrative recovery: A stage paradigm. *Substance Abuse*, 17(1), 51-63.
- Denzin, N. K., & Lincoln, Y. S. (1994). *Handbook of qualitative research*. London: Sage.

- Diekstra, R. F. (1993). The epidemiology of suicide and parasuicide. *Acta Psychiatrica Scandinavica*, 371(Suppl.), 9-20.
- Douglas, J. D. (1967). *The social meanings of suicide*. Princeton: Princeton University Press.
- 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). *Selv mordet: En sosiologisk undersøkelse*. Oslo: Gyldendal.
- Eastmond, M. (2007). Stories as lived experience: Narratives in forced migration research. *Journal of Refugee Studies*, 20(2), 248-264.
- Ekeberg, Ø. (2006). Akutt selvpåført forgiftning: Risikofaktorer, klinisk vurdering og oppfølging. *Impuls. Tidsskrift for Psykologi*, 60(1), 53-60.
- Eklund, L. (1999). *From citizen participation towards community empowerment*. Doctoral thesis. Tampere: Faculty of Medicine, University of Tampere.
- Erikson, E. H. (1977). *Barnet och sambället*. Stockholm: Natur och Kultur.
- 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.
- Ferrell, B., Grant, M., Padilla, G., Vemuri, S., & Rhiner, M. (1991). The Experience of pain and Perceptions of Quality of Life: Validation of a Conceptual Model. *The Hospice Journal*, 7(3), 9-24.
- Ferrell, B. R. (1995). The impact of pain on quality of life. A decade of research. *The Nursing Clinics of North America*, 30(4), 609-624.

- Foss, C., & Ellefsen, B. (2002). The value of combining qualitative and quantitative approaches in nursing research by means of method triangulation. *Journal of Advanced Nursing*, 40(2), 242-248.
- Frank, A. W. (1995). *The wounded storyteller : Body, illness and ethics*. Chicago: University of Chicago Press.
- Gergen, K. J. (1985). The social constructionist movement in modern psychology. *American Psychologist*, 40, 266-275.
- Gergen, K. J. (1994). Mind, text and society: Self-memory in social context. In U. Neisser, & R. Fivush (Eds.), *The remembering self: Construction and accuracy in the self-narrative* (pp. 78-104). Cambridge: Cambridge University Press.
- Gibbons, R. D., Hur, K., Bhaumik, D. K., & Mann, J. J. (2005). The relationship between antidepressant medication use and rate of suicide. *Archives of General Psychiatry*, 62(2), 165-172.
- Gibson, B., Acquah, S., & Robinson, P. G. (2004). Entangled identities and psychotropic substance use. *Sociology of Health & Illness*, 26(5), 597-616.
- Giddens, A. (1991). *Modernity and self-identity: Self and society in the late modern age*. Cambridge: Polity Press.
- Gilje, F., Talseth, A. G., & Norberg, A. (2005). Psychiatric nurses' response to suicidal psychiatric inpatients: Struggling with self and sufferer. *Journal of Psychiatric and Mental Health Nursing*, 12(5), 519-526.
- Gjertsen, F. (2003). *Utviklingstendenser i selvmord : Datagrunnlag, kvalitet og sammenlignbarhet*. Master of Public Health, Uppsats. Göteborg: Nordiska högskolan för folkhälsovetenskap.
- Gjertsen, F. (2007). *Suicide statistics in Norway, the Nordic and the Baltic countries*. Retrieved 25 September 2007, from [http://www.med.uio.no/ipsy/ssff/statistikk/figur\\_og\\_tabelloversikt.html](http://www.med.uio.no/ipsy/ssff/statistikk/figur_og_tabelloversikt.html)
- Goffman, E. (1959). *The presentation of self in everyday life*. New York: Anchor.

- Gossop, M., Marsden, J., Stewart, D., Edwards, C., Lehmann, P., Wilsom, A., & Segar, G. (1997). The National Treatment Outcome Research Study in the United Kingdom: Six-Month Follow Up Outcomes. *Psychology of Addictive Behaviours*, *11*(4), 324-337.
- Grad, O. (2005). Suicide survivorship: An unknown journey from loss to gain - from individual to global perspective. In K. Hawton (Ed.), *Prevention and treatment of suicidal behaviour: From science to practice* (pp. 351-369). New York: Oxford University Press.
- Graneheim, U.H., & Lundman, B. (2004). Qualitative content analysis in nursing research: Concepts, procedures and measures to achieve trustworthiness. *Nurse Education Today*, *24*, 105-112.
- Grøholt, B., Ekeberg, O., & Haldorsen, T. (2006). Adolescent suicide attempters: What predicts future suicidal acts? *Suicide & Life-Threatening Behavior*, *36*(6), 638-650.
- Hallberg, M. (1999). Hermeneutik. In C. M. Allwood, & M. G. Erikson (Eds.), *Vetenskapsteori för psykologi och andra samhällsvetenskaper* (pp. 73-100). Lund: Studentlitteratur.
- Hammerlin, Y., & Enerstvedt, R. T. (1988). *Selv mord i virksomhetsforståelsens perspektiv*. Oslo: Falken.
- Hammerlin, Y. (2005). En resept på et selvmordsfritt samfunn. Ansatser til en kritisk refleksjon. In H. Herrestad, & L. Mehlum (Eds.), *Uutholdelige liv: Om selvmord, eutanasi og behandling av døende* (pp. 243-262). Oslo: Gyldendal akademisk.
- Hammersley, M., & Atkinson, P. (1987). *Feltmetodikk: Grunnlaget for feltarbeid og feltforskning*. Oslo: Gyldendal.
- Hardey, M. (1998). *The social context of health*. Buckingham: Open University Press.
- 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., Fagg, J., Platt, S., & Hawkins, M. (1993). Factors associated with suicide after parasuicide in young people. *British Medical Journal*, 306(6893), 1641-1644.
- 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: John 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.
- Hägglblom, A. (2008). *Love that turns into terror: Intimate partner violence in Åland- nurses' encounters with battered women in the context of a government-initiated policy program*. Doctoral thesis. Göteborg: Nordic School of Public Health.
- Hedelin, B. (2000). *Med gemenskap som grund - psykisk hälsa och ohälsa hos äldre människor och psykiatrisköterskans hälsofrämjande arbete*. Doctoral thesis. Göteborg: Nordiska hälsovårdshögskolan.
- Hellevik, O. (1991). *Forskningsmetode i sosiologi og statsvitenskap*. Oslo: Universitetsforlaget.
- Hjelmeland, H., Knizek, B. L., & Nordvik, H. (2002). The communicative aspect of nonfatal suicidal behavior--are there gender differences? *Crisis*, 23(4), 144-155.
- Hjort, P. F. (1993). *Forebyggende og helsefremmende arbejde: Mål, filosofi, ansvar og opgaver*. Vejle: Dansk selskab for social og administrativ medicin, Samfundsmedicinsk Forlag.
- Hjortsjö, T. (1983). *Själv mord i Stockholm: En epidemiologisk studie av 686 konsekutiva fall*. Doctoral thesis. Göteborg: Nordiska hälsovårdshögskolan.

- Hogstedt, C., Lundgren, B., Moberg, H., Pettersson, B., & Ågren, G. (2004). The Swedish public health policy and the national institute of Public Health. *Scandinavian Journal of Public Health, Supplement 64*, 18-59.
- Honkasalo, M. L. (1998). Space and embodied experience: Rethinking the body in pain. *Body & Society, 4*(2), 35-57.
- Hummelvoll, J. K. (1995). *Psychiatric nursing in a public health perspective. A study of how a holistic-existential psychiatric nursing model contributes to work in public health*. Doctoral thesis. Göteborg: Nordiska hälsovårdshögskolan.
- Hydén, L. (1997). Illness and narrative. *Sociology of Health & Illness, 19*(1), 48-69.
- 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.
- Johansson, L. M., DeMarinis, V., Sundquist, J., & Bergman, B. (1997). Contributions of Meaning-Making Systems to Psychosocial Assessment and Diagnosis: A Cross-Cultural Study of Suicidal Swedish and Immigrant Women. Unpublished manuscript. In L.M. Johansson, *Migration, mental health and suicide: An epidemiological, psychiatric and cross-cultural study*. Doctoral thesis. Stockholm: Department of Clinical Neuroscience and Family Medicine, Psychiatry Section, Huddinge Hospital, Karolinska Institute.
- 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.
- Johnsson, E. (2002). *Självordsförsök bland narkotikamissbrukare*. Lund: Socialhögskolan, Lunds Universitet.

- 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*. 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: John 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.
- Kirmayer, L.J. (2004). The cultural diversity of healing: meaning, metaphor and mechanism. *British Medical Bulletin*, 69, 33-48.
- Kitzinger, J. (1995). Qualitative Research: Introducing focus groups. *British Medical Journal*, 311, 299-302.
- Kleinman, A. (1988). *The illness narratives: Suffering, healing, and the human condition*. New York: Basic Books.
- 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. (1989). *Issues of validity in qualitative research*. Lund: Studentlitteratur.
- Kvale, S. (1997). *Det kvalitative forskningsintervju*. Oslo: Ad notam Gyldendal.
- Kvist, J. (2003). A Danish welfare miracle? Policies and outcomes in the 1990s. *Scandinavian Journal of Public Health*, 31(4), 241-245.

- Labov, W. (1982). Speech actions and reactions in personal narrative. In D. Tannen (Ed.), *Analyzing discourse: Text and talk* (pp. 219-247). Washington, D.C.: Georgetown University Press.
- Lakoff, G., & Johnson, M. (2003). *Metaphors we live by*. Chicago: University of Chicago Press.
- Lamberg, L. (2000). Domestic violence: What to ask, what to do. *JAMA: The Journal of the American Medical Association*, 284(5), 554-556.
- Landheim, A. S., Bakken, K., & Vaglum, P. (2006a). What characterizes substance abusers who commit suicide attempts? Factors related to axis I disorders and patterns of substance use disorders. A study of treatment-seeking substance abusers in Norway. *European Addiction Research*, 12(2), 102-108.
- Landheim, A. S., Bakken, K., & Vaglum, P. (2006b). Impact of comorbid psychiatric disorders on the outcome of substance abusers: A six year prospective follow-up in two Norwegian counties. *Biomedcentral Psychiatry*, 6(44), Retrieved 8 May 2008, from <http://www.biomedicalcentral.com/1471-244X/6/44>.
- Laur, P. (2005). *External causes of death in estonia 1970 - 2002 - a special reference to suicide, traffic accidents and alcohol poisoning*. Master of Public Health Uppsats. Göteborg: Nordic School of Public Health.
- Lazarus, R. S., & Folkman, S. (1984). *Stress, appraisal, and coping*. New York: Springer.
- Lazarus, R.S. (1993). From psychological stress to the emotions: A history of changing outlooks. *Annual Review of Psychology*, 44, 1-21.
- Leenaars, A. A. (2002). In defense of the idiographic approach: Studies of suicide notes and personal documents. *Archives of Suicide Research*, 6(1), 19-30.
- Lester, D. (2001). Nonfatal suicidal behavior as a communication. *Crisis*, 22(2), 49-51.

- Lester, D. (2002). Qualitative versus quantitative studies in psychiatry: Two examples of cooperation from suicidology. *Archives of Suicide Research*, 6(1), 15-18.
- Levitt, H., Korman, Y., & Angus, L. (2000). A metaphor analysis in treatment of depression: metaphor as a marker of change. *Counselling Psychology Quarterly*, 13, 23-35.
- Lieblich, A., Tuval-Mashiach, R., & Zilber, T. (1998). *Narrative research: Reading, analysis, and interpretation*. Thousand Oaks: Sage.
- Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry*. Beverly Hills: Sage.
- 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.
- Lindström, B. (1994). *The Essence of Existence. On the Quality of Life of Children in the Nordic countries*. Doctoral thesis. Göteborg: Nordic School of Public Health.
- Linehan, M. M., Armstrong, H. E., Suarez, A., Allmon, D., & Heard, H. L. (1991). Cognitive-behavioral treatment of chronically parasuicidal borderline patients. *Archives of General Psychiatry*, 48(12), 1060-1064.
- 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.
- Lorant, V., Kunst, A.E., Huisman, M., Bopp, M., & Mackenbach, J. (2005). A European comparative study of marital status and socio-economic inequalities in suicide. *Social Science & Medicine*, 60(11), 2431-2441.

- Lundberg, O., & Palme, J. (2002). A balance sheet for welfare: Sweden in the 1990s. *Scandinavian Journal of Public Health*, 30(4), 241-243.
- Luoma, J. B., Martin, C. E., & Pearson, J. L. (2002). Contact with mental health and primary care providers before suicide: A review of the evidence. *The American Journal of Psychiatry*, 159(6), 909-916.
- MacDonald, T.H. (1997). *Rethinking Health Promotion*. London: Routledge.
- Mahler, M.S., Pine, F., & Bergman, A. (1975). *The Psychological Birth of the Human Infant*. New York: Basic Books.
- Malterud, K. (2001). Qualitative research: standards, challenges, and guidelines. *The Lancet*, 358, 483-488.
- Malterud, K., & Solvang, P. (2005). Vulnerability as strength: Why, when, and how? *Scandinavian Journal of Public Health*, 33(Suppl 66), 3-6.
- Mann, J. J., Wateraux, C., Haas, G. L., & Malone, K. M. (1999). Toward a clinical model of suicidal behavior in psychiatric patients. *The American Journal of Psychiatry*, 156(2), 181-189.
- Maris, R. W., & Lazerwitz, B. M. (1981). *Pathways to suicide: A survey of self-destructive behaviors*. Baltimore: Johns Hopkins University Press.
- Mattingly, C. (1998). *Healing dramas and clinical plots: The narrative structure of experience*. Cambridge: Cambridge University Press.
- McMullen, L.M. (1989). Use of Figurative Language in Successful and Unsuccessful Cases of Psychotherapy: Three comparisons. *Metaphor and Symbolic Activity*, 4, 203-225.
- McQueen, C., & Henwood, K. (2002). Young men in 'crisis': Attending to the language of teenage boys' distress. *Social Science & Medicine*, 55(9), 1493-1509.
- McQueen, D. V., & Kickbusch, I. (2007). *Health and Modernity: The Role of Theory in Health Promotion*. New York: Springer.

- Merriam, S.B. (1994). *Fallstudien som forskningsmetod*. Lund: Studentlitteratur.
- 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.
- Morano, C. D., Cisler, R. A., & Lemerond, J. (1993). Risk factors for adolescent suicidal behavior: Loss, insufficient familial support, and hopelessness. *Adolescence*, 28(112), 851-865.
- Moore, B.E., & Fine, B.D. (1971). *A Glossary of psychoanalytic terms and concepts*. New York: The American Psychoanalytic Association.
- Moscicki, E. K. (2001). Epidemiology of completed and attempted suicide: Toward a framework for prevention. *Clinical Neuroscience Research*, 1(5), 310-323.
- Möller-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.
- National Bureau of Crime Investigation. (2008). *Narkotikastatistikk 2007. (Statistics of drug related issues)*. Retrieved 6 June 2008, from [http://www.politi.no/pls/idesk/docs/f425684756/narkotikastatistikk\\_2007.pdf](http://www.politi.no/pls/idesk/docs/f425684756/narkotikastatistikk_2007.pdf)

- National committees for research ethics in Norway. (2006). *Guidelines for research ethics in the social sciences, law and the humanities*. Retrieved 6 June 2007, from <http://www.etikkom.no/English/NESH/guidelines>
- 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, 17*(4), 157-166.
- Nijhuis, H. G., & van der Maesen, J.G. (1994). The philosophical foundation of public health: An invitation to debate. *Journal of Epidemiology and Community Health, 48*(1), 1-3.
- Nordentoft, M. (1994). *Selv mord og selvmordsforsøg*. Master of Public Health Uppsats. Göteborg: Nordiska hälsovårdshögskolan.
- Nordentoft, M., Branner, J., Drejer, K., Mejsholm, B., Hansen, H., & Petersson, B. (2005). Effect of a Suicide Prevention Centre for young people with suicidal behaviour in Copenhagen. *European Psychiatry, 20*, 121-128.
- Nordentoft, M., & Søgaard, M. (2005). Registration, psychiatric evaluation and adherence to psychiatric treatment after suicide attempt. *Nordic Journal of Psychiatry, 59*(3), 213-216.
- Nordentoft, M. (2007). *Prevention of suicide and attempted suicide in Denmark. Epidemiological studies of suicide and intervention studies in selected risk groups*. Doctoral thesis. København: Faculty of health sciences, Copenhagen University Hospital.
- Nordic Council of Ministers. (2006). *Nordic statistical yearbook 2006*. Copenhagen: Nordic Council of Ministers.
- Ólafsdóttir, H. (2007). Trends in alcohol consumption and alcohol-related harms in Iceland. *Nordic Studies on Alcohol and Drugs, 24*(Suppl.), 47-60.
- Oquendo, M. A., Bongiovi-Garcia, M. E., Galfalvy, H., Goldberg, P. H., Grunebaum, M.F., 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.
- Pallikkathayil, L. & Morgan, S.A. (1988). Emergency Department Nurses' Encounters with Suicide Attempters: A qualitative Investigation. *Scholarly Inquiry for Nursing Practice*, 2(3), 237-253.
- Patton, M.Q. (2002). *Qualitative evaluation and research methods*. (3<sup>rd</sup> ed.). Thousand Oaks: Sage.
- Petronis, K. R., Samuels, J. F., Moscicki, E. K., & Anthony, J. C. (1990). An epidemiologic investigation of potential risk factors for suicide attempts. *Social Psychiatry and Psychiatric Epidemiology*, 25(4), 193-199.
- Phillips, M.R., Li, X., & Zhang, Y. (2002/3). Suicide rates in China 1995-99. *Lancet*, 359(9309), 835-840.
- Platt, S., Bille-Brahe, U., Kerkhof, A., Schmidtke, A., Bjerke, T., Crepet, P., et al. (1992). Parasuicide in Europe: The WHO/EURO Multicentre study on parasuicide. Introduction and preliminary analysis for 1989. *Acta Psychiatrica Scandinavica*, 85(2), 97-104.
- 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.
- Polkinghorne, D. E. (1991). Narrative and self-concept. *Journal of Narrative and Life History*, 1(2-3), 135-153.
- Pollock, L. R., & Williams, J. M. (1998). Problem solving and suicidal behavior. *Suicide & Life-Threatening Behavior*, 28(4), 375-387.
- Povlsen, L. (2008). *Diabetes in children and adolescents from non-western immigrant families - health education, support and collaboration*. Doctoral thesis. Göteborg: Nordic School of Public Health.

- Prilleltensky, I. (2005). Promoting well-being: Time for a paradigm shift in health and human services. *Scandinavian Journal of Public Health*, 33(Suppl 66), 53-60.
- Pörn, I. (1993). Health and Adaptedness. *Theoretical Medicine*, 14(4), 295-303.
- 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). *Selvmondsadfærd, kommunikation og sprog - teoretiske perspektiver*. Stockholm: Forskningsrådsnämnden.
- Rappaport, J. (1981). In praise of paradox: A social policy of empowerment over prevention. *American Journal of Community Psychology*, 9(1), 1-25.
- Ravndal, E., Hammer, T., & Vaglum, P. (1984). *Work instead of drugs? About vocational training, work and drug abuse*. Oslo: Universitetsforlaget.
- Ravndal, E., & Vaglum, P. (1994). Why do drug abusers leave the therapeutic community? Problems with attachment and identification in a hierarchical therapeutic community. *Nordic Journal of Psychiatry*, 33(Suppl.), 4-55.
- Ravndal, E., & Vaglum, P. (1999). Overdoses and suicide attempts: Different relations to psychopathology and substance abuse? A 5-year prospective study of drug abusers. *European Addiction Research*, 5(2), 63-70.
- Reinås K., Waal H., Buster M., Harbo M., Noller P., Schardt S., et al. (2002). *Drug overdoses and overdose deaths in four european cities: A baseline report from the project strategic choices for reducing overdose deaths: A joint project of the cities Oslo, Amsterdam, Copenhagen, and Frankfurt am Main*. Oslo: Rusmiddeletaten.
- Retterstøl, N., Mehlum, L., & Ekeberg, Ø. (2002). *Selv mord: Et personlig og samfunnsmessig problem*. Oslo: Gyldendal akademisk.

- Rhodes, L.A. (1984). "This Will Clear Your Mind": The Use of Metaphores for Medication in Psychiatric Settings. *Culture, Medicine, and Psychiatry*, 8, 49-70.
- Richman, N. (1998). Looking before and after: Refugees and asylum seekers in the West. In P. J. Bracken, & C. Petty (Eds.), *Rethinking the trauma of war* (pp. 170-186). London: Free Association Books.
- Ricoeur, P. (1976). *Interpretation theory: Discourse and the surplus of meaning*. Fort Worth: Texas Christian University Press.
- Ricoeur, P. (1984). *Time and narrative*. Chicago: University of Chicago Press.
- Ricoeur, P. (2003). *The rule of metaphor: The creation of meaning in language*. London: Routledge.
- Riessman, C. K. (1993). *Narrative analysis*. Newbury Park: Sage.
- Riksförbundet för SuicidPrevention och Efterlevandes Stöd (SPES). *Nollvision suicid*. Retrieved 25 September 2007, from <http://www.spesriks.com/index.php?id=29,63,0,0,1,0>
- Robins, E., Gassner, S., Kayes, J., Wilkinson, R. H., & Murphy, G. E. (1959). The communication of suicidal intent: A study of 134 consecutive cases of successful (completed) suicide. *The American Journal of Psychiatry*, 115(8), 724-733.
- Rolfe, G. (2006). Validity, trustworthiness and rigour: Quality and the idea of qualitative research. *Journal of Advanced Nursing*, 53(3), 304-310.
- Rosaldo, M. Z., & Lamphere, L. (1974). *Woman, Culture, and Society*. Stanford: Stanford University Press.
- 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.
- Rutter, M., & Smith, D. J. (1995). *Psychosocial disorders in young people: Time trends and their causes*. Chichester: John Wiley.

- Råheim, M., & Håland, W. (2006). Lived Experiences of Chronic Pain and Fibromyalgia: Women's Stories From Daily Life. *Qualitative Health Research*, 16(6), 741-761.
- Sagvaag, H. (2007). *Alkoholbruk i tilknytning til arbeid- ein kvalitativ studie i eit folkehelsevitskapeleg perspektiv*. Doctoral thesis. Göteborg: Nordic School of Public Health.
- Sandelowski, M. (1993). Rigor or rigor mortis: The problem of rigor in qualitative research revisited. *Advances in Nursing Science*, 16(2), 1-8.
- Sandelowski, M., & Barroso, J. (2002). Reading qualitative studies. *International Journal of Qualitative Methods*, 1(1), 1-47.
- 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.
- Sällfors, C. (2003). *Pain: Coping and well-being in children with chronic arthritis*. Doctoral thesis. Göteborg: Nordic School of Public Health.
- Scourfield, J. (2005). Suicidal masculinities. *Sociological Research on-Line*, 10(2) Retrieved 1 October 2006, from <http://www.socresonline.org.uk/10/2/scourfield.html>
- Shneidman, E. S. (1985). *Definition of suicide*. New York: John Wiley.
- Shneidman, E. S. (1993). Suicide as psychache. *The Journal of Nervous and Mental Disease*, 181(3), 145-147.
- Shneidman, E.S. (1998). Suicide on my mind, Britannica on my table. *American Scholar*, 67, 93-104.
- Silverman, M. M. (2006). The language of suicidology. *Suicide & Life-Threatening Behavior*, 36(5), 519-532.
- Skogman, K. (2006). *Understanding suicidality: Suicide risk, sex differences and views of suicide attempters*. Doctoral thesis. Lund: Department of Clinical Sciences, Lund University.

- Skogman, K., Ågren Bolmsjö, I., & Öjehagen, A. (2006). Processes preceding attempted suicide and possible preventive factors: Experiences and views of suicide attempters. Unpublished manuscript. In K. Skogman, *Understanding suicidality: Suicide risk, sex differences and views of suicide attempters*. Doctoral thesis. Lund: Department of Clinical Sciences, Lund University.
- Smith, B. A. (1998). The problem drinker's lived experience of suffering: An exploration using hermeneutic phenomenology. *Journal of Advanced Nursing*, 27(1), 213-222.
- Smith, B., & Sparkes, A.C. (2005). Men, sport, spinal cord injury, and narratives of hope. *Social Science & Medicine*, 61(5), 1095-1105.
- Steger, T. (2007). *The stories metaphors tell: Metaphors as a tool to decipher tacit aspects in narratives*. Retrieved 14 November 2007, from <http://fmx.sagepub.com/cgi/content/abstract/19/1/3>
- Stern, D. N. (1989). Developmental prerequisites for the sense of a narrated self. In A. M. Cooper, O. F. Kernberg & E. S. Person (Eds.), *Psychoanalysis: Toward the second century* (pp. 168-178). New Haven: Yale University Press.
- Sundhedsstyrelsen. (1998). *Forslag til handlingsplan til forebyggelse af selvmordsforsøg og selvmord i Danmark*. København: Sundhedsstyrelsen.
- Sundquist, J., Bayard-Burfield, L., Johansson, L.M., & Johansson, S.E. (2000). Impact of ethnicity, violence and acculturation on displaced migrants: Psychological distress and psychosomatic complaints among refugees in Sweden. *Journal of Nervous and Mental Disorder*, 188(6), 357-365.
- 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.
- Svensson, T., & Hyltén, B. (1995). *Vardagsföreställningar om "sinnessjukdom"*. Jönköping: Ekbacken Förlag.

- 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.
- Tengland, P. A. (2007). A two-dimensional theory of health. *Theoretical Medicine and Bioethics, 28*(4), 257-284.
- The Ministry of Health and Care Services. (2006-2007). *National strategy to reduce social inequalities in health. Report No. 20*. Oslo: The Ministry of Health and Care Services.
- Topor, A., Borg, M., Mezzina, R., Sells, D., Marin, I., & Davidson, L. (2006). Others: The role of family, friends, and professionals in the recovery process. *American Journal of Psychiatric Rehabilitation, 9*(1), 17-37.
- Trulsson, K. (1999). Moderskap och missbruk. *Nordisk Alkohol och Narkotikatidsskrift, 16*(6), 335-351.
- Wallerstein, N. (2002). Empowerment to reduce health disparities. *Scandinavian Journal of Public Health, 59*(Suppl.), 72-77.
- Wasserman, D. (2001). *Suicide: An unnecessary death*. London: Martin Dunitz.
- 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.
- Wenneberg, S. B. (2000). *Socialkonstruktivisme: Positioner, problemer og perspektiver*. Malmö: Liber.
- Wiklund, L., Lindholm, L., & Lindström, U. Å. (2002). Hermeneutics and narration: A way to deal with qualitative data. *Nursing Inquiry, 9*(2), 114-125.

- Wiklund, L., Lindström, U. Å, & Lindholm, L. (2006). Suffering in addiction - a struggle with life. *Journal of Nursing Theory*, 15(2), 7-16.
- Willersrud, A.B., & Olsen, H. (2006). Democracy or Closer Control? Emergence of Drug User Participation in Norway. In J. Anker, V. Asmussen, P. Kouvonen & D. Tops (Eds), *Drug Users and Spaces for Legitimate Action*. Helsinki: Nordic Council for Alcohol and Drug Research.
- Williams, G. (1984). The genesis of chronic illness: narrative reconstruction. *Sociology of Health and Illness*, 16(2), 175-200.
- Williams, F. (1999). Good-enough principles for welfare. *Journal of Social Policy*, 28(04), 667-687.
- Williams, J. M. G. (2001). *Suicide and attempted suicide: Understanding the cry of pain*. London: Penguin.
- Willumsen, E. (2006). *Interprofessional collaboration in residential childcare*. Doctoral thesis. Göteborg: Nordic School of Public Health.
- Witz, A., & Marshall, B. L. (2003). The quality of manhood: Masculinity and embodiment in the sociological tradition. *The Sociological Review*, 51(3), 339-356.
- World Health Organisation. (1978). *Declaration of Alma-Ata. Primary Health Care, Report of International Conference at Alma Ata*. Geneva: WHO.
- World Health Organisation. (1986a). *Ottawa charter for health promotion. First international conference on health promotion, Ottawa, 21 november 1986*. Retrieved 24 September 2007, from <http://www.who.int/healthpromotion/conferences/previous/ottawa/en/print/html>
- World Health Organisation. (1986b). *Summary report: Working group in preventive practices in suicide and attempted suicide*. Copenhagen: WHO Regional Office of Europe.

- World Health Organisation. (1996). *New challenges for public health. Report of an interregional meeting*. Retrieved 25 September 2007, from [http://whqlibdoc.who.int/hq/1996/WHO\\_HRH\\_96.4.pdf](http://whqlibdoc.who.int/hq/1996/WHO_HRH_96.4.pdf)
- World Health Organisation. (1998). *Health 21- The health for all policy for the WHO European region- 21 targets for the 21st century*. Copenhagen: WHO, Regional Office of Europe.
- World Health Organisation. (2005a). *Mental health declaration for Europe. Facing the challenges, building solutions*. Helsinki: WHO European Ministerial Conference on Mental Health.
- World Health Organisation. (2005b). *Mental health action plan for Europe. Facing the challenges, building solutions*. Helsinki: WHO European Ministerial Conference on Mental Health.
- World Health Organisation. (2007). *Suicide prevention*. Retrieved 24 April 2007, from [http://www.who.int/mental\\_health/prevention/suicide/suicideprevent/en/](http://www.who.int/mental_health/prevention/suicide/suicideprevent/en/)
- World Medical Association. (2004). *Declaration of Helsinki. Ethical principles for medical research involving human subjects*. Retrieved 26 September 2006, from <http://www.wma.net/e/policy/b3.html>
- Yin, R. K. (2003): *Case study research: Design and methods* (3rd ed.). London: Sage.
- Zøllner, H. (2002). National policies for reducing social inequalities in health in Europe. *Scandinavian Journal of Public Health*, 59(Suppl.), 6-11.
- Ødegard, E., Amundsen, E. J., & Kielland, K. B. (2007). Fatal overdoses and deaths by other causes in a cohort of Norwegian drug abusers--a competing risk approach. *Drug and Alcohol Dependence*, 89(2-3), 176-182.
- Ågren, G., Anderzon, K., Berglund, E., & Dundar, A. (1993), *Narkotika i Stockholm. Rapport nr. 17*. Stockholm: Socialtjänsten, FoU-byrån.