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Mental Health Nurses' Experiences of Caring for Suicidal Patients in Psychiatric Wards: An Emotional Endeavor

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A B S T R A C T

The purpose of the study is to investigate mental health nurses' experiences of recognizing and responding to suicidal behavior/self-harm and dealing with the emotional challenges in the care of potentially suicidal inpatients. Interview data of eight mental health nurses were analyzed by systematic text condensation. The participants reported alertness to patients' suicidal cues, relieving psychological pain and inspiring hope. Various emotions are evoked by suicidal behavior. Mental health nurses seem to regulate their emotions and emotional expressions, and balance involvement and distance to provide good care of patients and themselves. Mental health nurses have an important role and should receive sufficient formal support.

Caring for patients with suicidal behavior is one of the most challenging tasks for mental health nurses in psychiatric wards, and preventing suicidal acts may be difficult. Suicide prevention in mental health services involves suicide risk assessments that should not only be based on standard risk factors (Cassells, Paterson, Dowding, & Morrison, 2005; Paterson et al., 2008), but warning signs; 'what is my patient doing (observable signs) or saying (expressed symptoms) that elevates his or her risk to die by suicide …'(Rudd, 2008, p. 88). The latter requires more involvement with the patient, exploring aspects relevant to the individual's suicide risk at that particular moment. In Norway, it is the therapist (psychiatrist/psychologist) who has the main responsibility for performing and documenting assessments of inpatients' suicide risk (National guidelines for Prevention of Suicide in Mental Health Care, Norwegian Directorate of Health and Social Affairs, 2008). However, nurses provide most of the direct care of the patients and have the opportunity to identify warning signs of suicide and prevent suicidal behavior (Bolster, Holliday, Oneal, & Shaw, 2015; Cutcliffe & Barker, 2002). According to Sun, Long, Boore, and Tsao (2005); Sun, Long, Boore, and Tsao (2006), nurses assessed patients' suicide risk through vigilant observation, recognizing warning signs, using their interviewing skills and gathering information about cues to suicide. Assessing the patients continuously throughout the hospital stay seems important to capture the patient's changing state of mind (Aflague & Ferszt, 2010; Sun et al., 2005). However, some nurses are not properly educated and trained in suicide assessments (Bolster et al., 2015).

The recognition of patients' suicide risk should lead to meaningful interventions (Cutcliffe & Stevenson, 2007, 2008a). The literature has pointed to the importance of nurses engaging in a close relationship with the suicidal patient (Cutcliffe & Barker, 2002; Cutcliffe & Stevenson, 2008b; Gilje & Talseth, 2014), where the patient feels confirmed as a significant human being (Samuelsson, Wiklander, Åsberg, & Saveman, 2000; Talseth, Lindseth, Jacobsson, & Norberg, 1999; Vatne & Nåden, 2014) and is moved from a 'death-oriented' position to a 'life-oriented' position through the process of 're-connecting with humanity' (Cutcliffe & Stevenson, 2007; Cutcliffe, Stevenson, Jackson, & Smith, 2006). However, patients have reported that experiences of not being sufficiently cared for (e.g. lack of confirmation, not being seen) have led to increased suicidal behavior while hospitalized (Talseth et al., 1999; Samuelsson et al., 2000).

Caring for suicidal patients is emotionally demanding (Cutcliffe & Barker, 2002; Cutcliffe & Stevenson, 2008a, 2008b), and suicide/suicide attempt/self-harm evoke painful feelings in the professionals (Bohan & Doyle et al., 2008; Castelli-Dransart et al., 2014; Joyce & Wallbridge, 2003; Séguin, Bordeleau, Drouin, Castelli-Dransart, & Giasson, 2014; Takahashi et al., 2011; Valente & Saunders, 2002; Wilstrand, Lindgren, Gilje, & Olofsson, 2007; Wurst et al., 2010). It has been suggested that nurses may distance themselves in meetings with suicidal patients to protect themselves from emotional discomfort (Carlén & Bengtsson, 2007; Talseth, Lindseth, Jacobsson, & Norberg, 1997). To cope with the challenges involved in the care of potentially suicidal patients the literature has emphasized sufficient education, training, supervision and support (Bohan & Doyle, 2008; Cutcliffe & Barker, 2002; Cutcliffe & Stevenson, 2008a; Gilje & Talseth, 2014; Takahashi et al., 2011; Talseth & Gilje, 2011; Wilstrand et al., 2007).

The aim of this study is to extend the existing literature and develop further the knowledge of how mental health nurses deal with the variety of demands in the care of potentially suicidal patients in psychiatric

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wards: How do they experience their skills with regard to recognizing and responding to suicidal behavior/self-harm among patients? How do they react to suicide and suicidal acts, and deal with the emotional challenges in the care of patients at risk of suicide? We use the term 'suicidal patient' with an awareness of the diversity and complexity of each person's suicidality and related problems.

MATERIALS AND METHODS

Participants

A purposive sample of eight mental health nurses (seven women, one man) aged 43–60 years working in two different hospitals and five different psychiatric wards in Norway participated in the study. The lack of gender difference largely reflects the situation in many psychiatric wards where the majority of mental health nurses are female. In addition, the units' management assisted in recruiting mental health nurses with experience of caring for suicidal patients in psychiatric wards, thus, clinical experience and willingness to participate was emphasized regardless of gender. Thereby, the strategy for selecting the study subjects (purposefully) was influenced by homogenous sampling (in terms of professional background and clinical experience) and convenience sampling (Patton, 1990). Their professional experience in psychiatric hospital ranged from 5–25 years. Seven nurses had 15 years of experience or more. Five of the nurses worked in an acute ward, one in an acute/crisis unit, one in a specialized ward and one worked in a rehabilitation ward.

Interview Procedure

The first author conducted the interviews. Seven of the nurses were interviewed at their respective working places (available office/meeting room in or outside the ward, one interview was conducted in a vacant patient room), and one of the participants was interviewed in a meeting room not located at the hospital. The interviews lasted from 48 minutes to 1 hour and 22 minutes. A semi-structured interview guide was used as a tool to obtain detailed descriptions of the nurses' caring experiences, including both good interactions with suicidal patients and challenging experiences involving suicidal acts and suicide among patients. Main questions were: How do you experience working in a psychiatric ward? How do you experience meetings with suicidal patients? Can you describe a situation where you did/did not achieve a good relationship with a suicidal patient? Have you experienced that a patient have attempted suicide or taken his/her life? Can you describe your experiences with regard to that? All interviews were recorded and transcribed verbatim.

Data Analysis

The data were analyzed by means of systematic text condensation (Malterud, 2011, 2012). The approach is inspired by Giorgi's phenomenological analysis (Giorgi, 1985, cited in Malterud, 2011), and is described as a four-step procedure: (1) reading the transcripts to get an overall impression and identifying preliminary themes (e.g. emotional burdens, colleague support); (2) extracting meaning units from the transcripts and sorting them into codes (e.g. being calm and steady), and code groups (e.g. managing emotion); (3) condensing the meaning within each code group; (4) summarizing the content into meaningful descriptions (Malterud, 2011, 2012). Two simplified examples of the analytic approach are illustrated in Table 1. All authors read the transcripts, and the first author conducted all steps of the analysis and discussed the interpretations with the second and third author during the process. The first author's background as mental health nurse with knowledge and experience within the field has influenced the process of collecting and interpreting data. The final descriptions were developed and refined over time, and transcripts were read repeatedly during this hermeneutical process (moving back and forth between data and the literature) to ensure that the constructed descriptions were grounded in the empirical data (Malterud, 2011, 2012).

Ethical Considerations

The Regional Committee for Medical and Health Research Ethics approved the study. The mental health nurses signed an informed consent to participate. They were informed that they at any time could withdraw from the study (until publication) without giving any reason. Data were treated confidentially and information about the nurses and their interactions with suicidal patients is presented in such a way that they are not identifiable. All nurses and described patients are referred to as "she" to protect their anonymity.

FINDINGS

We found that the mental health nurses' experiences involve being alert to suicidal cues, relieving the patients' psychological pain and inspiring hope. Further, experiences of suicide and suicidal acts evoke various emotions. The nurses seem to regulate their emotions and emotional expressions and balance their emotional involvement and professional distance in the relationships with the patients in order to provide good care of the patients as well as themselves. These findings are elaborated below.

Alertness to Suicidal Cues

Seven of the mental health nurses' accounts indicate that they are sensitive and alert to the patients' emotional state and pick up suicidal cues or warning signs, which they act upon to prevent self-harm/suicidal acts. Three of the nurses use the phrase *"gut feeling"* to describe their feelings or sensations of the patient's mental state and the situation. It appears that they very much rely on intuitive knowledge, although they acknowledge that they sometimes may be wrong. Several participants believe that they have saved patients by acting at the right time.

> *We have saved many people, we managed to, so in the moment we should be there, we were there. We managed to save them. (…)… gut-feeling is very important then. And then, so it has happened that,*

Table 1
Examples of the Analytic Approach.

Excerpt of meaning unit	Codes	Code group *condensed unit	Description
Experience over many years, signals emitted that are a bit difficult to explain. But – but many patients we know (…) Signals that the other sends out that – that tells me a little bit about plans.. of self-harm that could lead to something more, that is.	Experience, signals emitted, capture signals of self-harm	Responding to suicidality * The informant seems sensitive, and picks up signs of self-harm/suicidal acts	Alertness to suicidal cues
…if there are too many admissions in here, then I am little afraid that we quickly may become both mom, sister, aunt, friend, etc. *And what is then left of the motivation to go out in the world and find it, I think. So to be warm and empathetic on the one hand, but do not become everything for the patient on the other hand, that is an art as I see it.*	Many admissions, danger of becoming mom, sister, friend warm and empathetic, but do not become everything, an art	Managing emotion *It seems important to be close, but prevent being too emotional close to the patients	Balancing emotional involvement and professional distance